SOCIAL SECURITY AMENDMENTS OF 1960

HEARINGS

BEFORE THE

COMMITTEE ON FINANCE

UNITED STATES SENATE

EIGHTY-SIXTH CONGRESS

SECOND SESSION

ON

H.R. 12580

AN ACT TO EXTEND AND IMPROVE COVERAGE UNDER THE FEDERAL OLD-AGE, SURVIVORS, AND DISABILITY INSURANCE SYSTEM AND TO REMOVE HARDSHIPS AND INEQUITIES, IMPROVE THE FINANCING OF THE TRUST FUNDS, AND PROVIDE DISABILITY BENEFITS TO ADDITIONAL INDIVIDUALS UNDER SUCH SYSTEM; TO PROVIDE GRANTS TO STATES FOR MEDICAL CARE FOR AGED INDIVIDUALS OF LOW INCOME; TO AMEND THE PUBLIC ASSISTANCE AND MATERNAL AND CHILD WELFARE PROVISIONS OF THE SOCIAL SECURITY ACT; TO IMPROVE THE UNEMPLOYMENT COMPENSATION PROVISIONS OF SUCH ACT; AND FOR OTHER PURPOSES

JUNE 29, 30, 1960

Printed for the use of the Committee on Finance

UNITED STATES
GOVERNMENT PRINTING OFFICE
58387 WASHINGTON : 1960

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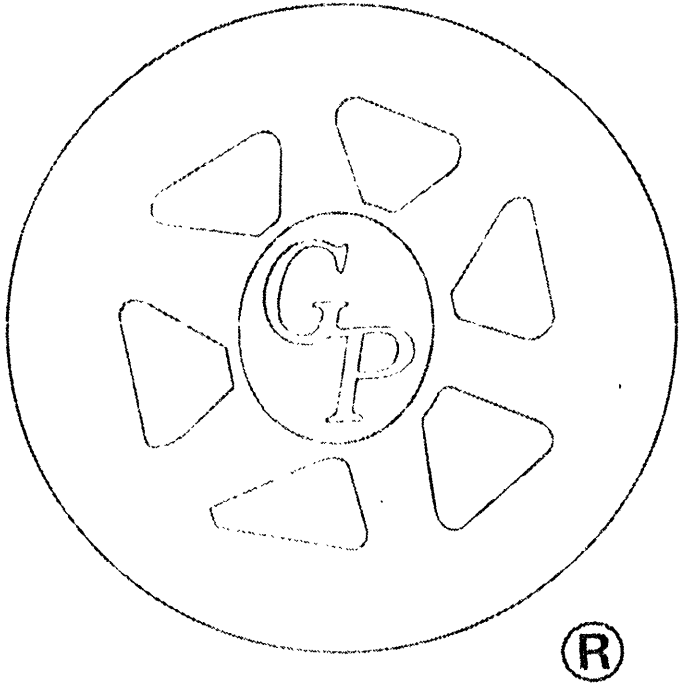
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SOCIAL SECURITY AMENDMENTS OF 1960

WEDNESDAY, JUNE 29, 1960

UNITED STATES SENATE,
COMMITTEE ON FINANCE,
Washington, D.C.

The committee met, pursuant to notice, at 10:20 a.m., in room 2221 Senate Office Building, Senator Harry F. Byrd (the chairman) presiding.

Present: Senators Byrd, Kerr, Frear, Smathers, Anderson, Douglas, Gore, Talmadge, Hartke, McCarthy, Williams, Carlson, Bennett, Butler, and Curtis.

Also present: Elizabeth Springer, chief clerk.

The CHAIRMAN. The meeting will come to order. The hearing today is on the bill H.R. 12580, the Social Security Amendments of 1960. I place in the record at this point a committee print showing in tabular form the major differences in the present social security law and H.R. 12580 as passed by the House of Representatives. This is an excellent document which was prepared for the use of the Committee on Finance by the Education and Public Welfare Division of the Legislative Reference Service of the Library of Congress, under the direction of Miss Helen E. Livingston, Chief of the Division, and Frederick B. Arner, specialist in social legislation.

(The material referred to follows:)

COMMITTEE ON FINANCE
UNITED STATES SENATE

Harry Flood Byrd, *Chairman*

JUNE 24, 1960

MAJOR DIFFERENCES IN THE PRESENT SOCIAL SECURITY LAW AND H.R. 12580 AS PASSED BY THE HOUSE OF REPRESENTATIVES

Printed for the use of the Committee on Finance

UNITED STATES
GOVERNMENT PRINTING OFFICE
WASHINGTON : 1960

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ELIZABETH B. SPRINGER, *Chief Clerk*

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OLD-AGE, SURVIVORS, AND DISABILITY INSURANCE

MEDICAL SERVICES FOR THE AGED

(New Title XIV)

Major differences in the present social security law and H.R. 12580 as passed by the House of Representatives

OLD-AGE, SURVIVORS, AND DISABILITY INSURANCE

I. COVERAGE

[References are to the sections of the bill as referred to the Senate, and the pages to H. Rept. 1799, 86th Cong., 2d sess.]

Item	Present law	H.R. 12580
A. Self-employed:		
1. Professional groups.	Covers all professional groups except physicians.	Covers physicians. Effective date: Taxable years ending on or after Dec. 31, 1960. Bill: Sec. 104. House report, pp. 4, 5, 17, 75-77. (Also covers as employees medical and dental interns and medical and dental residents in training who are employed in hospitals of the Federal Government, and interns in the employ of a privately operated hospital who have completed a 4-year course in a medical school chartered according to State law.)
2. Ministers.	*Covers* duly ordained, commissioned or licensed ministers, Christian Science practitioners, and members of religious orders (other than those who have taken a vow of poverty) serving in the United States, and those serving outside the country who are citizens and either working for United States employers or serving a congregation predominantly made up of United States citizens. Coverage is available under the self-employment coverage provisions on an individual voluntary basis regardless of whether they are employees or self-employed.	
	Allows election of coverage by filing of certificate for present minister, generally up until Apr. 15, 1959.	Extends the period of time generally through Apr. 15, 1962, within which present ministers may elect coverage. Bill: Sec. 101. House report, pp. 21, 22, 59. Permits the validation of coverage of certain clergymen who filed tax returns reporting self-employment earnings from the ministry for certain years after 1954 and before 1960 even though, through error, they had not filed waiver certificates effective for those years. Waiver certificate must be filed and taxes for these years must be paid by Apr. 15, 1962. Bill: Sec. 101(c). House report: Pp. 22, 59, 60.

OLD-AGE, SURVIVORS, AND DISABILITY INSURANCE—Continued

I. COVERAGE—Continued

Item	Present law	H.R. 12580
B. Employees	*Covers* employees including certain agent or commission drivers, life-insurance salesmen, homeworkers, traveling salesmen, and officers of corporations regardless of the common law definition of employee.	No change.
1. Domestic workers	*Covers* persons performing domestic service in private nonfarm homes if they receive $50 or more during a calendar quarter from 1 employer. Noncash remuneration is excluded. *Excludes* students performing domestic service in clubs or fraternities if enrolled and regularly attending classes at a school, college, or university.	Lowers coverage requirements to $25 or more during a calendar quarter from 1 employer. Excludes from coverage all earnings of domestic workers who are under the age of 16. Effective date: Jan. 1, 1961. Bill: Sec. 108. House report: Pp. 17–18, 83–84.
2. Casual labor	*Covers* cash remuneration for service not in the course of the employer's trade or business if the remuneration is $50 or more from 1 employer during a calendar quarter.	Lowers coverage requirements to $25 or more during a calendar quarter from 1 employer. Excludes from coverage all earnings of casual workers who are under the age of 16. Effective date: Jan. 1, 1961. Bill: Sec. 108. House report: Pp. 17–18, 83–84.
3. State and local government employees.	*Covers* employees of State and local governments *provided* the individual State enters into an agreement with the Federal Government to provide such coverage, with the following special provisions: a. Employees who are in positions covered under an existing State or local retirement system (except policemen and firemen in most States) may be covered under State agreements only if a referendum is held by a secret written ballot, after not less than 90 days' notice, and if the majority of eligible employees under the retirement system vote in favor of coverage. The Governor of a State must personally certify that certain Social Security Act requirements under the referendum procedure have been properly carried out.	Permits the Governor of a State to delegate to a designated State official the making of the certifications required under the referendum procedure. Bill: Sec. 102(a). House report: pp. 24, 61, 62.
	In most States, all members of a retirement system (with minor exceptions) must be covered if any members are covered.	
	Employees of any institution of higher learning (including a junior college or a teachers' college) under a retirement system can, if the State so desires, be covered as a seperate coverage group. 1 or more political subdivisions may be considered as a separate coverage group even though its employees are under a statewide retirement system.	Allows employees of municipal or county hospital to be treated as a separate coverage group if the State so desires. Bill: Sec. 102(g). House report: pp. 25, 67, 68.

OLD-AGE, SURVIVORS, AND DISABILITY INSURANCE—Continued

I. COVERAGE—Continued

Item	Present law	H.R. 12580
B. Employees—Continued		
3. State and local government employees—Con.	*Retroactive coverage.*—An agreement, or modification of an agreement, agreed to prior to 1960 could be made effective as early as Jan. 1, 1956. Agreements or modifications made after 1959 could only be made retroactive to the 1st day of the year in which they were agreed to. Coverage must begin on the same date for all persons in a coverage group	Allows agreements or modifications made after 1959 to begin as early as 5 years before the year in which an agreement is made, but no earlier than Jan. 1, 1956. Where a retirement system is covered as a single retirement system coverage group, permits the State to provide different beginning dates for coverage of the employees of different political subdivisions. Bill: Sec. 102(c). House report: pp. 22-23, 62-63.
	Exceptions to general law authorizing coverage in named States: (1) *Split-system provision.*—Authorizes California, Connecticut, Florida, Georgia, Hawaii, Massachusetts, Minnesota, New York, North Dakota, Pennsylvania, Rhode Island, Tennessee, Vermont, Washington, and Wisconsin, and all inter-State instrumentalities, at their option, to extend coverage to the members of a State retirement system by dividing such a system into 2 divisions, 1 to be composed of those persons who desire coverage and the other of those persons who do not wish coverage, provided that new members of the retirement system coverage group are covered compulsorily. Also authorizes similar treatment of political subdivision retirement systems of these States.	Provides that where an individual who has chosen not to be covered under the divided retirement system provision becomes a member of a different retirement system group because of the annexation of the employing political subdivision by another political subdivision, or through some other action taken by a political subdivision, such individual will continue to be excluded from coverage. Bill: Sec. 102(b). House report: pp. 23-24, 62.
	(2) *Policemen and firemen.*—Allows the States of Alabama, California, Florida, Georgia, Hawaii, Kansas, Maryland, New York, North Carolina, North Dakota, Oregon, South Carolina, South Dakota, Tennessee, Vermont, and Washington and all inter-State instrumentalities to make coverage available to policemen and firemen in those States, subject to the same conditions that apply to coverage of other employees who are under State and local retirement systems, except that where the policemen and firemen are in a retirement system with other classes of employees the policemen and firemen may, at the option of the State, hold a separate referendum and be covered as a separate group.	Adds Virginia to the list. Bill: Sec. 102(d). House report: p. 24, 63. *Validation of coverage.*—Validates the coverage of certain teachers and school administrative personnel who, for the period Mar. 1, 1951, to Oct. 1, 1959, were reported under the Mississippi coverage agreement as State employees, rather than as employees of the various school districts in Mississippi. Bill: Sec. 102(h). House report: p. 25, 68.
4. Employees of nonprofit organizations.	*Covers* employees of religious, charitable, educational, and other nonprofit organizations (which are exempt from income tax and are described in sec. 501(c)(3) of the Internal Revenue Code) *on a voluntary basis* if—	

OLD-AGE, SURVIVORS, AND DISABILITY INSURANCE—Continued

I. COVERAGE—Continued

Item	Present law	H.R. 12580
B. Employees—Continued 4. Employees of nonprofit organization—Con.	a. the employer organization certifies that it desires to extend coverage to its employees, and b. at least ⅔ of the organization's employees concur in the filing of a waiver certificate. Employees who do not concur in the filing of the certificate are not covered *except* that all employees hired after a certificate becomes effective are covered. Waiver certificate may be made effective at the option of the organization on the 1st day of the quarter in which the certificate is filed or the 1st day of the succeeding quarter.	Eliminates requirement that ⅔ of the employees concur in filing a certificate. Effective date: Certificates filed after date of enactment. Bill: Sec. 106(a). House report: pp. 20, 78-79.
	Employees of nonprofit organizations who are in positions covered by State and local retirement systems and are members or eligible to become members of such systems must be treated apart from those not in such positions. Certificates must be filed separately for each group and ⅔ of the employees in each group must concur in the filing of its certificate. All new employees who belong to a group for which a certificate has been filed are automatically covered, and new employees who belong to a group for which a certificate has not been filed are not covered.	Eliminates requirement that ⅔ of the employees in the group concur in filing a certificate. Effective date: Certificates filed after date of enactment. Bill: Sec. 106(a). House report: pp. 20, 78-79.
		Validates wages for services performed after 1950 and before July 1, 1960, by certain employees of nonprofit organizations where the organization has been reporting and paying taxes but did not comply with certain provisions of the law: i.e., failed to file a certificate, filed it too late to cover employees who had left, or failed to obtain the signatures of employees who wished coverage. Effective date: No benefits payable or increased for month of enactment or prior month; no lump sum death payment payable or increased if individual died prior to date of enactment. Bill: Sec. 106(b). House report: pp. 20-21, 79-80. Validates remuneration erroneously reported as self-employment income for taxable years ending after 1954 and before 1962 by certain lay missionaries (and others). Effective date: No benefits payable or increased for months of enactment or prior month; no lump sum death payment payable or increased if individual died prior to date of enactment. Bill: Sec. 106(c). House report: pp. 20, 80-81.

OLD-AGE, SURVIVORS, AND DISABILITY INSURANCE—Continued

I. COVERAGE—Continued

Item	Present law	H.R. 12580
B. Employees—Continued]		
5. Family employment.	*Excludes* persons in the employ of a son, daughter, or spouse; or child under 21, if in the employ of a parent.	Covers parents in the employ of their children, but not if it is domestic service performed in the home of the child or other work not in the course of the child's trade or business. Effective as to services after 1960. Bill: Sec. 105. House report: pp. 18-19, 78.
C. Geographical scope.....	*Covers* the 50 States, Puerto Rico and the Virgin Islands, and the District of Columbia.	Extends coverage to Guam and American Samoa. Effective for employees, except governmental employees, on Jan. 1, 1960, and for self-employed for taxable years beginning after 1960. Coverage of employees of the governments of Guam and American Samoa—including members of the legislature, their political subdivisions, and their wholly owned instrumentalities—would be on a mandatory basis rather than under the State-Federal agreement method. Coverage will not be extended to these employees until the legislatures of these territories express a desire for coverage. In no event can this coverage start before 1961. Filipino workers who come to Guam under contract to work temporarily will be excluded from coverage. The Secretary of the Treasury would have the tax-collecting authority, and would be authorized to delegate this function. Bill: Sec. 103. House report: pp. 19-20, 68-75.
	Excludes the following from coverage within the United States: a. Nonresident aliens engaged in self-employment.	No change except—
	b. Employees of foreign governments and their instrumentalities.	b. Covers U.S. citizens so employed within the United States on self-employment basis. Effective as to taxable years ending after 1960; for retirement test purposes effective for years beginning after date of enactment. Bill: Sec. 107. House report: pp. 22, 82-83.
	c. Employees of international organizations entitled to certain privileges under the International Organizations Immunities Act.	c. Covers as in b. (above).
	d. Employees on foreign registered aircraft or ships who also perform services while the plane or ship is outside of the United States, if the employee is not a citizen of the United States or the employer is not an American employer.	

OLD-AGE, SURVIVORS, AND DISABILITY INSURANCE—Continued

I. COVERAGE—Continued

Item	Present law	H.R. 12580
C. Geographical scope—Con.	*Coverage outside of the United States is limited to—* a. American citizens either self-employed or employed by an American employer, except ministers outside the United States if they serve a congregation predominantly made up of United States citizens even though their employer may not be a United States employer. b. Citizens of the United States employed by certain foreign subsidiaries of American corporations are covered by voluntary agreements between the Federal Government and the parent American company. The domestic corporation can include some or all of its foreign subsidiaries in the agreement and must agree to pay the equivalent of both employer and employee taxes on behalf of the subsidiaries included. c. Individuals, regardless of citizenship, who are employed on American registered ships and aircraft if either the contract of service was entered into in the United States or the plane or vessel touches a port in the United States.	a. Covers service of U.S. citizens after 1960 working for certain labor organizations organized in the Panama Canal Zone by modifying the definition of American employer to include labor organizations which are chartered by labor organizations created or organized in the United States. Validates certain wage credits for which taxes were erroneously paid for service after 1954 and before 1961 for such employees. Effective date: No benefits payable or increased for month of enactment or prior month. No lump sum death payments payable or increased if individual died prior to date of enactment. Bill: Sec. 106(d). House report: pp. 21, 81-82. b. and c. No change.

II. PROVISIONS RELATING TO PERMANENT AND TOTAL DISABILITY

A. Nature of the Provisions		
1. Benefits	Provides an insurance benefit (for months beginning July 1057) for disabled workers between ages of 50 and 65 meeting eligibility requirements. Benefits are computed in the same way as retirement benefits and are payable from the Federal Disability Insurance Trust Fund.	Eliminates the requirement that an individual must have attained age 50 in order to be eligible for benefits. Effective date: 2d month after the month of enactment. Bill: Sec. 401. House report: pp. 12, 102.
2. Disability "freeze"	Provides that when an individual for whom a period of disability has been established dies or retires on account of age or disability his period of disability will be disregarded in determining his eligibility for benefits and his average monthly wage for benefit computation purposes.	
B. Eligibility requirements		
1. Definition	For benefits an individual must be precluded from engaging in any substantial gainful activity by reason of a physical or mental impairment. The impairment must be medically determinable and one which can be expected to be of long-continued and indefinite duration or to result in death.	No change.

OLD-AGE, SURVIVORS, AND DISABILITY INSURANCE—Continued

II. PROVISIONS RELATING TO PERMANENT AND TOTAL DISABILITY.—Continued

Item	Present law	H.R. 12580
B. Eligibility requirements—Con.		
2. Waiting period	A 6 months' "waiting period" is required before disability insurance benefits can begin.	Provides that people who become disabled within 60 months (5 years) after termination of a period of disability would not be required to serve another 6-month "waiting period" before they are again eligible to receive benefits. Effective date: Benefits payable for month of enactment and subsequent months. Bill: Sec. 402. House report: pp. 13–14, 103–4.
3. Work requirement	To be eligible for disability benefits, an individual must— (1) Have acquired at least 20 quarters of coverage out of the last 40 quarters ending with the quarter in which the period of disability begins; (2) be fully insured.	Provides alternative work requirement for individuals who have (1) 20 quarters of coverage, whenever acquired, and (2) quarters of coverage in all calendar quarters elapsing after 1950 up to the quarter in which they become disabled, but not less than 6 quarters. Bill: Sec. 404. House report: pp. 14, 106–107.
C. Rehabilitation	The policy of Congress is stated that disabled persons applying for a determination of disability be promptly referred to State vocational rehabilitation agencies for necessary rehabilitation services. Act provides for deduction of benefits for refusal, without good cause, to accept rehabilitation services available under a State plan approved under the Vocational Rehabilitation Act in such amounts as the Secretary shall determine. A member or adherent of a recognized church or religious sect that relies on spiritual healing who refuses rehabilitation services is deemed to have done so with good cause. A disabled person who is receiving rehabilitation services from a State vocational rehabilitation agency and returns to work shall not, for at least 1 year after his work first started, be regarded as able to engage in substantial gainful activity solely by reason of such work.	Broadens present provision to allow, in effect, a 12-month trial work period for *all* beneficiaries (including childhood disability beneficiaries) who attempt to work. If, after 9 months, the beneficiary has demonstrated that he is no longer disabled within the meaning of the law, he will receive benefits for an additional 3 months. (Only 1 trial work period permitted for each period of disability; no trial work period for persons disabled a 2d time within 60 months.) Any beneficiary who has been determined to be no longer disabled within the meaning of the law will be given an additional 3 months of benefits as above. Effective date: Month beginning after month of enactment. Bill: Sec. 403. House report: Pp. 12–13, 104–106.

OLD-AGE, SURVIVORS, AND DISABILITY INSURANCE—Continued

III. ELIGIBILITY FOR BENEFITS

Item	Present law	H.R. 12580
A. Insured status	To be fully insured an individual who was living on Sept. 1, 1950, must have either: (1) 40 quarters of coverage, *or* (2) 1 quarter of coverage (acquired at any time after 1936) for every 2 calendar quarters elapsing after 1950 (or after quarter in which age 21 was attained, if later) and before quarter of death or attainment of retirement age whichever first occurs, but such individual must have at least 6 quarters of coverage.	(2) Liberalizes alternative requirement so that an individual will need 1 quarter of coverage (acquired at any time after 1936), for every 4 calendar quarters elapsing after 1950, or after the calendar year in which he attained the age of 21 (if that was later) and up to the beginning of the calendar year in which he attained retirement age or died, whichever occurred first, but such individual must have at least 6 quarters of coverage.

Number of quarters of coverage required for fully insured status under present law and under H.R. 12580

Year of death, disability, or attainment of retirement age	Required quarters	
	Present law	H.R. 12580
1953 and earlier	6	6
1954	6- 7	6
1955	8- 9	6
1956	10-11	6
1957	12-13	6
1958	14-15	7
1959	16-17	8
1960	18-19	9
1961	20-21	10
1966	30-31	15
1971	40	20
1976	40	25
1981	40	30
1986	40	35
1991 and after	40	40

[1] This column represents the requirement under the basic insured status formula in existing law; for those individuals who meet the "special (continuous coverage) insured status" test established by the Social Security Amendments of 1954, the requirement would be somewhat less for persons dying or reaching retirement age before October 1960.

OLD-AGE, SURVIVORS, AND DISABILITY INSURANCE—Continued

III. ELIGIBILITY FOR BENEFITS—Continued

Item	Present law	H.R. 12580
	Persons who died before Sept 1, 1950, and after 1939 with at least 6 quarters of coverage are considered fully insured for purposes of survivors' benefits (other than for former wife divorced).	Provides that any person who died or attained retirement age before 1951 and had at least 6 quarters of coverage would be fully insured. Effective for benefits starting with the month after the enactment of the bill; effective for lump-sum death payments based on deaths occurring after month of enactment. Bill: Sec. 204. House report, pp. 14–15, 86–88.
B. Survivors of workers who died prior to 1940.	Benefits are not payable to otherwise eligible widows, children, and parents if the wage earner had died prior to 1940.	Allows benefits to such individuals even though earner died before 1940 if he had at least 6 quarters of coverage. Effective for month after month of enactment. Bill: Sec. 205. House report: pp. 16, 88–89.
C. Widowers of workers who died prior to 1950.	Benefits are not payable to eligible widowers unless the insured worker's death was after August 1950 and she was fully and currently insured.	Eliminates August 1950 cutoff date. Effective for month after month of enactment. Bill. Sec. 205. House report: pp. 16, 88–89.
D. Children born or adopted after parent's disability.	Benefits are not payable to an otherwise eligible child unless he was born, or adopted, or became a stepchild before the worker became disabled.	Permits payment of benefits to children born or adopted after worker's disability. A child cannot become entitled unless he is the natural child or stepchild of the disabled worker or is adopted within 2 years after the month in which the worker became entitled to benefits. Effective for September 1958. Bill: Sec. 201. House report: pp. 33, 84–85.
E. Dependency of stepchild on natural father.	A child is deemed dependent on natural father or adopting father for benefit purposes unless the father is not contributing to the child's support *and* the child is living with and being supported by the stepfather at the time he files application.	Provides for payment of child's benefit even though the child was living with and receiving more than ½ of his support from his stepfather. Effective for month of enactment. Bill: Sec. 202. House report: pp. 16, 85.
F. Time needed to acquire status of wife, child, or husband for retirement or disability benefit purposes.	A wife, stepchild, or husband must be in this relationship for 3 years prior to the application for benefits.	Provides that the 3-year duration requirement be changed to 1 year. Effective for month of enactment Bill: Sec. 207. House report: pp. 17, 90.
G. Invalid marriages.....	The validity of a marriage (under the law of the State in which the worker lives) may determine eligibility for mother's, wife's, husband's, widow's, widower's, and child's benefits.	Provides that certain invalid marriages of insured workers will not result in ineligibility. Applicant must have gone through the marriage ceremony with insured worker in the belief that it would create a valid marriage and the couple must have been living together at the time of the worker's death or, be living together at the time of application for benefits. Effective for month of enactment. Bill: Sec. 208. House report: pp. 16, 91–92.

OLD-AGE, SURVIVORS, AND DISABILITY INSURANCE—Continued

III. ELIGIBILITY FOR BENEFITS—Continued

Item	Present law	H.R. 12580
H. Lump sum death payment..	Lump sum death payment paid (in cases where no eligible spouse survives) only after burial expenses are paid.	Allows lump sum to be sent directly to funeral director on application of person who assumes responsibility for funeral home expenses. If any of the lump sum remains, it is paid to person who paid funeral bill; if any still remains to persons who paid other burial expenses in a certain order of priority. Effective date: For deaths after enactment and for deaths before enactment if no application is filed before the 3d month after month of enactment. Bill: Sec. 203. House report: pp. 30-31, 85-86.

IV. BENEFIT AMOUNTS

A. Computing average monthly wage.	In general, an individual's average monthly wage for computing his monthly old-age insurance benefit amount is determined by dividing the total of his creditable earnings after the applicable starting date and up to the applicable closing date, by the number of months involved. Excluded from this computation are all months and all earnings in any year any part of which was included in a period of disability under the disability "freeze" (except that the months and earnings in the year in which the period of disability begins may be included if the resulting benefit would be higher). Also excluded from the computation are all months in any year prior to the year the individual attained age 22 if less than 2 quarters of such year were quarters of coverage. Starting dates may be last day of (1) 1936, or (2) 1950, or, if later, the year of attainment of age 21. The closing date may be either (1) the 1st day of the year the individual died or became entitled to benefits or (2) the 1st day of the year in which he was fully insured and attained retirement age, whichever results in a higher benefit. Applicable starting and closing dates are those which yield the highest benefit amount. The minimum divisor is 18 months.	Provides for computation of the average monthly wage, in retirement cases, on the basis of a constant number of years, regardless of when, before age 22, the person started to work or when, after age 65 (age 62 in the case of a woman), he files application for benefits. The number of years would be equal to 5 less than the number of years (excluding years in periods of disability) elapsing after 1950 or after the year in which the individual attained age 21, whichever is later, and up to the year in which the person was first eligible for old-age insurance benefits (generally the year in which he attained age 65—or age 62 in the case of a woman). In death and disability cases the number of years would be determined by the date of death or disability. In those cases where a larger benefit would result (because the individual's best earnings were in years before 1951) the number of years would be those elapsing after 1936, rather than 1950; this alternative is similar to the 1936 alternative "starting date" available under present law in such cases. The subtraction of 5 from the number of elapsed years is the equivalent of the present dropout of the 5 years during which the individual's earnings were the lowest.

OLD-AGE, SURVIVORS, AND DISABILITY INSURANCE—Continued

IV. BENEFIT AMOUNTS—Continued

Item	Present law	H.R. 12580
A. Computing average monthly wage—Con.	Individuals can "drop out" up to 5 years of lowest or no earnings in computing average monthly wage.	The earnings used in the computation would be earnings in the highest years. Earnings in years prior to attainment of age 22 or after attainment of retirement age could be used if they were higher than earnings in intervening years. The span of years could never be less than 2. Generally, the span of years to be used for the benefit computation in retirement cases could not be less than 5—the number of years that would have to be used under the present law by people who attain retirement age in 1960. Effective, in general, on Jan. 1, 1961. Bill: Sec. 303(a). House report: pp. 28-29, 94-96.
B. Child's survivor benefit.....	Benefit payable to each child is ½ of workers' benefit plus ½ of his benefit divided by the number of children he has (if he has 2 children, each child will get ½ plus ½ (¼) of his benefit).	Benefit payable to each child would be ¾ of workers' benefit. Effective for 3d month after enactment. Bill: Sec. 301, House report: pp. 15-16, 93.

V. FINANCING

A. Investment of the trust funds.	Provides that the managing trustee (Secretary of the Treasury) shall invest such portion of the trust funds as is not, in his judgment, needed to meet current withdrawals. Investments must be made in interest-bearing obligations of the United States or in obligations guaranteed as to both interest and principal by the United States.	No change.
	Such obligations issued for purchase by the trust funds shall have maturities fixed with due regard for the needs of the funds, and bear interest at a rate equal to the average rate of all marketable interest-bearing obligations not due or callable until after the expiration of 5 years from the date of original issue. This interest rate, if not a multiple of ⅛ of 1 percent, is rounded to the nearest multiple of ⅛ of 1 percent.	Changes interest provision so that obligations shall bear interest at a rate equal to the average market yield (computed by the managing trustee on the basis of market quotations as of the end of the calendar month next preceding the date of such issue) on all marketable interest-bearing obligations of the United States then forming a part of the public debt which are not due or callable until after the expiration of 4 years from the end of such calendar month.
	The special obligations shall be issued for purchase by the trust fund only if the managing trustee determines that the purchase in the market of other interest-bearing obligations of the United States, or of obligations guaranteed as to both principal and interest by the United States, on original issue or at the market price, is not in the public interest.	Reverses the provision so that the managing trustee is authorized to make purchases in the open market when he deems it is within the public interest.

OLD-AGE, SURVIVORS, AND DISABILITY INSURANCE—Continued

V. FINANCING—Continued

Item	Present law	H.R. 12580
A. Investment of the trust funds—Continued	Bonds purchased may be acquired— (1) on original issue at par or (2) by purchase of outstanding obligations at the market price.	Changes (1) so that bonds may be purchased on original issue at the issue price. Effective date: 1st day of the month after the month of enactment. Bill: Sec. 701(d). House report: pp. 26–28, 137.
B. Review of status of trust funds.		
1. Board of Trustees..	These funds are administered by a Board of Trustees consisting of the Secretary of the Treasury, as managing trustee, the Secretary of Labor, and the Secretary of Health, Education, and Welfare, all ex officio (with the Commissioner of Social Security as secretary). It shall be the duty of the Board of Trustees to—	
	(1) Hold the trust funds;	No change.
	(2) Report to the Congress not later than the 1st day of March of each year on the operation and status of the trust funds during the preceding fiscal year and on their expected operation and status during the next ensuing 5 fiscal years;	No change.
	(3) Report immediately to the Congress whenever it is their opinion that during the ensuing 5 fiscal years either of the trust funds will exceed 3 times the highest annual expenditures anticipated during the next 5 years, or whenever in their opinion either of the trust funds is unduly small.	(3) Changes requirement so that Board has to report immediately only if it believes that the amount of either trust fund is unduly small.
	(4) Recommend improvements in administrative procedures and policies designed to effectuate the proper coordination of the old-age and survivors insurance and Federal-State unemployment compensation programs.	No change.
		Adds requirements that the Board review the general policies followed in managing the trust funds, and recommend changes in such policies, including necessary changes in the provisions of the law which govern the way in which the trust funds are to be managed. The Board is also required to meet at least once each 6 months. Effective date: 1st day of the month after the month of enactment. Bill: Sec. 701 (a), (b), (c). House report: pp. 26–28, 137.
2. Advisory Council...	An Advisory Council on Social Security Financing will periodically review the status of the Federal Old-Age and Survivors Insurance Trust Fund and the Federal Disability Insurance Trust Fund in relation to the long-term commitments of the programs.	

OLD-AGE, SURVIVORS, AND DISABILITY INSURANCE—Continued

V. FINANCING—Continued

Item	Present law	H.R. 12580
B Review of status of trust funds—Continued		
2. Advisory Council—Continued	The first such Council will be appointed by the Secretary after February 1957 and before January 1958 and will consist of the Commissioner of Social Security, as Chairman, and 12 other persons representing employers and employees, in equal numbers, self-employed persons and the public. The Council shall make its report, including recommendations for changes in the tax rate, to the Board of Trustees of the trust funds before Jan. 1, 1959. The Board shall submit the recommendations to Congress before Mar. 1, 1959, in its annual report.	
	Other advisory councils with the same functions and constituted in the same manner will be appointed by the Secretary not earlier than 3 years nor later than 2 years prior to Jan. 1 of the years in which the tax rates are scheduled to be increased. These advisory councils will report to the Board on Jan. 1 of the year before the tax increase will occur and the Board will report to Congress not later than Mar. 1 of the same year.	Changes appointment and report dates of advisory councils: will be appointed during 1963, 1966, and every 5th year thereafter and will report not later than Jan. 1 of the 2d year after the year in which they are appointed. The advisory council appointed in 1963 shall, in addition to the other findings it is required to make, include its findings and recommendations with respect to extensions of the coverage, benefit adequacy, and all other aspects of the program. Effective date: Date of enactment. Bill: Sec. 704. House report: pp. 31–32, 138.
C. Maximum taxable amount.	$4,800 a year.	No change.
D. Tax rate for self-employed..	Taxable years beginning after— *Percent* 1959 ..... 4½ 1962 ..... 5¼ 1965 ..... 6 1968 ..... 6¼	Do.
E Tax rate for employees and employers.	Calendar years: 1960–62 ..... 3 1963–65 ..... 3½ 1966–68 ..... 4 1969 and after 4½	Do.

MEDICAL SERVICES FOR THE AGED

(New title XVI)

Item	H.R 12580
I. Purpose	The new title XVI provides for Federal payments to States which institute programs to make medical benefits available to aged persons of low income who are unable to meet the cost of their medical needs. Such benefits would be provided only in the form of direct payments to providers of medical services. Federal payments to States would reimburse the States for a portion of their expenditures under approved plans according to the equalization formula now used to compute the Federal portion of old-age assistance payments between $30 and $65 per month. The Federal share will range from 50 to 65 percent depending upon the per capita income of the State as related to the national per capita income. As under the public assistance program the Federal Government would bear half of the administrative expenses. (For State matching percentages under public assistance (approximate) see p.—) In order to be eligible for such payments, the State must operate a program according to a plan submitted to the Secretary of Health, Education, and Welfare, and approved by him, which meets the requirements set out in the bill. The administrative provisions are essentially the same as now required for State old-age assistance plans. The requirements relating to medical benefits are outlined below. The Secretary may suspend payments to States, in whole or part, when he finds that the State is not complying with its plan, or that the plan no longer complies with the requirements of the bill.
II. Scope of benefits	The State plan may specify medical services of any scope and duration, provided that both institutional and noninstitutional services are included, and provided further that the medical benefits are not greater in scope, amount or duration than those available for old-age assistance recipients in the State. Moreover, the Secretary may not approve any plan which will result in a reduction in old-age assistance, aid to the totally and permanently disabled, aid to the blind, or aid to dependent children. The Federal Government would share in the expense of providing the following kinds of medical services without limit: 1. Skilled nursing home services; 2. Physicians' services; 3. Outpatient hospital services; 4. Organized home care services; 5. Private duty nursing services; 6. Therapeutic services; and 7. Major dental care. The Federal Government would share in the expense of providing the following medical services up to the limits stated: 1. Inpatient hospital services—up to 120 days per year; 2. Laboratory and X-ray services (other than those included as inpatient hospital services)—up to $200 per year; and, 3. Prescribed drugs—up to $200 per year. The Federal Government would *not* share in the expense of providing the following kinds of medical benefits: 1. Services not determined to be medically necessary by a physician; 2. Services rendered to patients in mental or tuberculosis hospitals; 3. Services rendered to persons in hospitals (other than mental or tuberculosis hospitals) on a diagnosis of tuberculosis or psychosis, after the first 42 days; 4. Services rendered to inmates of public institutions (other than medical institutions); and, 5. Any other type of medical service not mentioned above. The State plan must designate or establish an agency which will be responsible for setting and maintaining standards for the providers of hospital, nursing home, and organized home care services. The plan must also include methods for determining rates of payment for institutional services, and methods for determining schedules of fees or rates of payment for other medical services.

MEDICAL SERVICES FOR THE AGED—Continued

Item	H.R. 12580
II. Scope of benefits—Continued	The State plan must provide medical benefits to all persons who— 1. Have attained age 65; 2. Have income and resources, considering their other living requirements as determined by the State, which are insufficient to meet the cost of their medical services; 3. Are citizens of the United States; and, 4. Are residents of the State (provision must also be made, in accordance with the Secretary's regulations, which will make benefits available to residents of the State who are absent therefrom).
III. Eligibility for benefits	The State plan must exclude from eligibility for medical benefits all persons who— 1. Are receiving payments, or are having payments made in their behalf, under the programs for aid to the blind, aid to the totally and permanently disabled, aid to dependent children, or old-age assistance; or 2. Are under age 65. The State plan must contain provisions, in accordance with the Secretary's regulations, which will make benefits available to residents of the State who are absent therefrom. The plan may not require a premium or enrollment fee as a condition of eligibility. The State plan must include reasonable standards for determining eligibility, but such standards may not be inconsistent with the above requirements. The plan must provide that no lien may be imposed against the property of a beneficiary prior to his death (or the death of his spouse, whichever is later) on account of any benefit he may have correctly received, and that there may be no recovery of any benefits correctly paid until after the death of the recipient (or the death of his spouse, whichever is later).
IV. Beginning date	Payments to State will first be made for calendar quarter beginning July 1, 1961. Bill: Sec. 601. House report: pp. 2-3, 6-9, 10-11, 129-135.
V. Planning grants	Authorizes appropriation of Federal funds to the States to make plans and initiate administrative arrangements for the new programs under title XVI. Such grants shall be made upon application of the State agency, and may not exceed 50 percent of the cost of planning with the further limitation that aggregate payments to a State may not exceed $50,000. Effective date: Date of enactment. Funds appropriated would be available for grants to and obligation by the States through June 30, 1962. Bill: Sec. 603. House report: pp. 9, 130.

PUBLIC ASSISTANCE

Item	Present law	H.R. 12580
I. Old-age assistance medical program.	The following formula is applicable for a combined program which includes both money payments and vendor expenditures for medical care.	No change.
A. Matching formula.	Federal matching share is $24 of the 1st $30 (¾ of the 1st $30) with matching above this amount varying from 50 to 65 percent. States whose per capita income is equal to or above the per capita income for the United State have 50 percent Federal matching, while those States below the national average have Federal matching which varies up to a maximum of 65 percent.	

PUBLIC ASSISTANCE—Continued

Item	Present law	H.R. 12580
I. Old-age assistance medical program—Continued A. Matching formula—Continued	The Federal percentages as promulgated for the period Oct. 1, 1958, through June 30, 1961, are as follows: State. *Federal percentage* Alabama ..... 65.00 Alaska ..... 50.00 Arizona ..... 63.23 Arkansas ..... 65.00 California ..... 50.00 Colorado ..... 53.42 Connecticut ..... 50.00 Delaware ..... 50.00 District of Columbia ..... 50.00 Florida ..... 59.68 Georgia ..... 65.00 Hawaii ..... 50.00 Idaho ..... 65.00 Illinois ..... 50.00 Indiana ..... 50.00 Iowa ..... 63.23 Kansas ..... 60.78 Kentucky ..... 65.00 Louisiana ..... 65.00 Maine ..... 65.00 Maryland ..... 50.00 Massachusetts ..... 50.00 Michigan ..... 50.00 Minnesota ..... 58.57 Mississippi ..... 65.00 Missouri ..... 53.42 Montana ..... 54.07 Nebraska ..... 63.41 Nevada ..... 50.00 New Hampshire ..... 57.91 New Jersey ..... 50.00 New Mexico ..... 65.00 New York ..... 50.00 North Carolina ..... 65.00 North Dakota ..... 65.00 Ohio ..... 50.00 Oklahoma ..... 65.00 Oregon ..... 52.58 Pennsylvania ..... 50.00 Rhode Island ..... 50.00 South Carolina ..... 65.00 South Dakota ..... 65.00 Tennessee ..... 65.00 Texas ..... 61.36 Utah ..... 65.00 Vermont ..... 65.00 Virginia ..... 65.00 Washington ..... 50.00 West Virginia ..... 65.00 Wisconsin ..... 54.60 Wyoming ..... 50.92 [23 F.R. 7150]	

PUBLIC ASSISTANCE—Continued

Item	Present law	H.R. 12580
I. Old-age assistance medical program—Continued A. Matching formula—Continued	The maximum amount, upon which the Federal Government will match, is $65 a month, times the number of people on the old-age assistance roll (on an averaging basis).	If a State submits to the Secretary of Health, Education, and Welfare a modification of its plan which satisfies the Secretary that it will result in a substantial improvement in its old-age assistance medical program, it will receive additional Federal matching. An increase of 5 percentage points in the Federal share of the additional vendor medical expenditures up to an average of $5 a month per recipient would be made. For example: (1) It will increase the Federal share on the additional amount, within the matching maximum of $65 per month, from 65 to 70 percent in the lowest income States. (2) It will increase the Federal share on the additional amount, within the matching maximum of $65 per month, from 50 to 55 percent in the highest income States. (3) For States who are over the $65-a-month matching maximum, the Federal share would be 5 percent of the additional amount. Effective for quarter beginning Oct. 1, 1960. Bill: sec. 602. House report, pp. 9-11, 135, 136.
B. Definition of old-age assistance.	For Federal matching purposes excludes any money or vendor medical care payments for persons who have been diagnosed as having tuberculosis or psychosis and are patients in medical institutions as a result thereof.	Modifies exclusion as to vendor medical care payments to permit Federal sharing as to an individual in a medical institution as a result of a diagnosis of tuberculosis or psychosis for a period of 42 days. Effective date: July 1, 1961. Bill: Sec. 602. House report: p. 136.
II. Medical care guides and reports.	No provision.	Provides that the Secretary would develop and revise from time to time guides or recommended standards as to the level, content, and quality of medical care and medical services for the use of the States in evaluating and improving their public assistance medical care programs and their programs of medical services for the aged. For this purpose, the Secretary would also be directed to secure information from the States on their medical care and medical services under these programs and to publish these reports and other necessary information. Bill: Sec. 705. House report: pp. 9-10, 139.

PUBLIC ASSISTANCE—Continued

Item	Present law	H.R. 12580
III. Temporary extension of certain special provisions relating to State plans for aid to the blind.	Temporary legislation (sec. 344(b) of the Social Security Amendments of 1950) relates to the approval by the Secretary of certain State plans for aid to the blind which do not meet in full the requirements of clause (8) of sec. 1002(a) of title X relating to the "needs" test. Expires June 30, 1961.	Postpones termination date until June 30, 1964. Bill: Sec. 706. House report: pp. 57, 139.

MATERNAL AND CHILD WELFARE SERVICES

I. Maternal and child health services:		
A. Authorization of annual appropriation	Authorizes $21,500,000 per year	Authorizes $25 million per year. Effective date: Fiscal year 1961. Bill: Sec. 707(a)(1)(A) House report: pp. 5, 34, 49, 139.
B. Allotment to States.	Out of the sum appropriated— 1. $10,750,000 shall be allotted as follows: to each State a uniform base grant of $60,000 and the remainder in the proportion of live births in that State to the whole United States. 2. The other $10,750,000 is allotted according to the financial need of each State after taking into consideration the number of live births in that State [proportionate reduction in amounts if full authorized sum is not appropriated].	Substitutes $12,500,000 for $10,750,000 in both 1 and 2 and also provides that the uniform grant in 1 be increased from $60,000 to $70,000. Bill: Sec. 707(a)(1)(B). House report: p. 139.
C. Special project grants.	No specific provision in the law	Adds provision that not more than 25 percent of the sums under B-2 (above) shall be available for grants to State health agencies, and to public or other nonprofit institutions of higher learning for special projects of regional or national significance which may contribute to the advancement of maternal and child health. Bill: Sec. 707(b)(1)(A). House report: pp. 34, 50, 139-140.
II. Crippled children's services:		
A. Authorization of annual appropriation.	Authorizes $20 million per year	Authorizes $25 million per year. Effective date: Fiscal year 1961. Bill: Sec. 707(2)(A). House report: pp. 5, 34, 49, 139.
B. Allotment to States.	Out of the sum appropriated— 1. $10 million shall be allotted as follows: to each State $60,000 and the remainder according to need after taking into consideration the number of crippled children in each State in need of services and the cost of furnishing such services. 2. The other $10 million according to need of State as determined after taking into consideration the number of crippled children in each State in need of services and the cost of furnishing such services to them.	Same as B above. Bill: Sec. 707(a)(2)(B).

MATERNAL AND CHILD WELFARE SERVICES—Continued

Item	Present law	H.R. 12580
II. Crippled children's services—Continued		
C. Special project grants.	No specific provision in the law	Same as C above. Bill: Sec. 707(a)(2)(B).
III. Child welfare services:		
A. Authorization of annual appropriation.	Authorizes $17 million per year.	Authorizes $20 million per year. Effective date: Fiscal year 1961. Bill: Sec. 707(a)(3)(A). House report: pp. 5, 34, 49, 139.
B. Allotment to States.	Out of the sum appropriated allots to a State such portion of $60,000 as the amount appropriated bears to the amount authorized to be appropriated. The remainder of sums appropriated shall be alloted so that each State shall have an amount which bears the same ratio to the total remainder as the product of (1) the population of each State under the age of 21 and (2) the allotment percentage (based on relative per capita income) bears to the sum of the corresponding products of all the States.	Changes the $60,000 to $70,000. Bill: Sec. 707(a)(3)(A)(B). House report: pp. 5, 34, 49, 139.
C. Research and demonstration projects.	No provision.	Authorizes appropriation for grants by the Secretary of Health, Education, and Welfare to public or other nonprofit institutions of higher learning and to public and nonprofit agencies and organizations engaged in research or child welfare activities, for special research or demonstration projects for the demonstration of new methods or facilities which show promise of substantial contribution to the advancement of child welfare. Bill: Sec. 707(b)(3). House report: pp. 50, 140.

EMPLOYMENT SECURITY (UNEMPLOYMENT COMPENSATION)

Item	Present law	H.R. 12580
I. Coverage	In general, the unemployment compensation program covers all employees in commerce and industry who are employed by an employer of 4 or more workers on at least 1 day of 20 weeks in a calendar year. 17 specific exclusions from coverage are spelled out in the Federal Unemployment Tax Act (sec. 3306(c)).	Coverage is extended, generally effective in 1962, to several categories of employees presently specifically excluded. These include: (1) Employees of certain instrumentalities of the United States which are neither wholly or partially owned by the United States, including Federal Reserve banks, Federal credit unions, Federal land banks, and others. Employees of partially owned instrumentalities such as banks for cooperatives and Federal intermediate credit banks are brought under the unemployment compensation program for Federal employees, effective in 1961. (2) Employees serving on or in connection with American aircraft outside the United States. (3) Employees of "feeder organizations," all of whose profits are payable to a nonprofit organization and employees of nonprofit organizations which are not exempt from income tax. (4) Certain employees of certain tax-exempt organizations, including agricultural and horticultural organizations, voluntary employee beneficiary associations, and fraternal beneficiary societies. Bill: Secs. 531-535. House report, pp. 55-56, 124-126.
II. Extension to Puerto Rico	The Commonwealth of Puerto Rico has an independent unemployment compensation program. Employers in Puerto Rico are not subject to the Federal unemployment tax and Puerto Rico is not entitled to Federal grants to cover the administrative expenses of its unemployment compensation program. The cost of employment service, however, is covered by Federal grants under the Wagner-Peyser Act.	Puerto Rico will be treated as a State for the purposes of the Federal-State unemployment compensation system beginning Jan. 1, 1961. Federal employees and ex-servicemen will not have their benefits computed under Puerto Rican law until 1966. Bill: Secs. 541-543. House report, pp. 57, 127-128.
III. Administrative financing:		
A. Federal unemployment tax rate.	Each employer is taxed 3 percent on the 1st $3,000 of an employees' covered wages, of which 90 percent (2.7 percent of taxable payrolls) may be offset by unemployment taxes paid under State law or tax savings allowed under State law through experience rating. The net Federal tax is 0.3 percent of taxable payroll.	Effective in 1961, the tax rate is raised to 3.1 percent on the 1st $3,000 of covered wages, which results in a net Federal tax of 0.4 percent of taxable payroll. Bill: Sec. 523. House report, pp. 55, 118.
B. Unemployment Trust Fund.	Receipts from State taxes go into the various State accounts in the Unemployment Trust Fund. The sums allocated to State accounts are generally available for benefit payments.	No change in State accounts.

EMPLOYMENT SECURITY (UNEMPLOYMENT COMPENSATION)—Continued

Item	Present law	H.R. 12580
III. Administrative financing —Continued B. Unemployment Trust Fund—Continued	Receipts from the net Federal unemployment tax (0.3 percent) are used to pay the cost of administering Federal and State operations of the employment security program. At the end of each fiscal year, after Federal and State administrative expenses have been paid, any excess net Federal unemployment tax receipts are earmarked and placed in the Federal unemployment account to maintain a balance of $200,000,000 in that account. This account is used to make advances to the States with depleted reserve accounts. Any excess receipts not required to maintain the $200,000,000 balance in the Federal unemployment account is allocated to the trust accounts of the various States in the proportion that their covered payrolls bear to the aggregate of all the States. These excess receipts may, under certain conditions, be used by a State to supplement Federal grants in financing administrative operations.	A new account, called the employment security administration account, will be established in the Unemployment Trust Fund. All receipts from the net Federal unemployment tax (0.4 percent) will be credited initially to this new account. Federal and State administrative expenses will be paid out of this account with a maximum of $350,000,000 per year allowable for State administrative expenses. At the end of a fiscal year, excess receipts after administrative expenses will be credited to the Federal unemployment account to build up and maintain a maximum balance of $550,000,000 or 0.4 percent of covered payrolls, whichever is greater, for use in making advances to States. After the Federal unemployment account reaches its statutory limit, any remaining excess of net Federal unemployment taxes over administrative expenses will be retained in the employment security administration account until that account shows a net balance at the close of the fiscal year of $250,000,000. This net balance is to be used to provide funds out of which administrative expenses may be paid during each fiscal year prior to the receipt of the bulk of Federal unemployment taxes in January and February. Pending the building up of the $250,000,000 balance in the employment security administration account, advances to the account are authorized from a revolving fund which would be financed by a continuing appropriation from the general fund of the Treasury. These advances will be repaid with interest. After the Federal unemployment account is built up to its statutory limit, and the year-end net balance of the employment security administration account reaches $250,000,000, and after any advances from the general fund of the Treasury have been repaid, any excess in the employment security administration account will be distributed to the accounts of the various States in the same manner as is provided under present law, except that if any State has outstanding advances from the Federal unemployment account its share of the surplus funds will be used to reduce these outstanding advances. Effective date: Fiscal year 1961. Bill: Sec. 521. House report, pp. 51-53, 108, 116.

EMPLOYMENT SECURITY (UNEMPLOYMENT COMPENSATION)—Continued

Item	Present law	H.R. 12580
III. Administrative Financing—Continued C. Advances to the States:		
1. Eligibility for advances.	A State whose reserve account at the end of any quarter is less than the amount of benefits paid in the last four preceding quarters may apply for an advance from the Federal unemployment account.	A State's eligibility for advances (applied for after enactment) may be determined at any time. Advances will be made only if in the account of the State requesting an advance the sum of reserves on hand plus expected tax receipts will be inadequate to meet the expected level of benefit payments during the current or following month. Bill: Sec. 522(a). House report, pp. 53-54, 116-117.
2. Amount of advances.	A State is advanced the amount specified in the State's application but such amount may not exceed the largest amount of benefits paid by it in any one of the last four preceding quarters.	Advances will be made in amounts which the Secretary of Labor estimates will be required to pay compensation during the current or following month, including amounts to cover unexpected contingencies. The aggregate amount of loans approved by the Secretary of Labor may not exceed the amount available for advances in the Federal unemployment account. Bill: Sec. 522(a). House report, pp. 53-54, 116-117.
3. Repayment of advances.	The Governor of any State may at any time request that funds be transferred from the State's account to the Federal unemployment account in repayment of part or all of the balance of advances made to the State.	Same as present law.

EMPLOYMENT SECURITY (UNEMPLOYMENT COMPENSATION)—Continued

Item	Present law	H.R. 12580
III. Administrative Financing—Continued C. Advances to the States—Continued 3. Repayment of advances—Con.	If an advance to any State has been outstanding at the beginning of four consecutive years, the employers' credit in that State against the Federal tax is reduced from 2.7% to 2.55%. This increase in the net Federal tax is used to pay off the advance. During successive years in which the advance is outstanding the employers' credit is reduced by an additional 0.15% a year. If a State repays outstanding advances by Dec. 1 of any year the reduced credit provisions do not come into operation for that year.	If an advance to any State made after enactment is outstanding at the beginning of two consecutive years, the employers' credit in that State against the Federal tax is reduced from 2.7% to 2.4%. During successive years in which the advance is outstanding the employers' credit is reduced by an additional 0.3% a year. If a State repays outstanding advances by Nov. 10 of any year the reduced credit provisions do not come into operation for that year. In addition to the reduction of 0.3% a year in the employers' tax credit against the Federal tax two other possible credit reductions are provided. The first provides that beginning in the third year in which an advance is outstanding the maximum employers' credit is reduced by the amount, if any, by which the average employer contribution rate in the preceding year was less than 2.7%. The second credit reduction provides that in the fifth year in which an advance is outstanding if the State's benefit-cost rate over the preceding five years is higher than 2.7% then the employers' credit shall be reduced by the amount, if any, by which the State's average contribution rate in the preceding year is less than such benefit-cost rate. Bill: Sec. 522(a), 523(b). House report, pp. 54–55, 118–124.

TABLES ON PUBLIC ASSISTANCE MEDICAL PROGRAMS

TABLE 1.—Summary information on medical care available to old-age assistance recipients through federally aided public assistance vendor payments, and other resources (based on information supplied by Bureau of Public Assistance, June 1960)

State	Vendor payment method used	Vendor payments					Other resources for medical care available to old-age assistance (OAA) recipients
		Practitioner	Hospitalization (including controls or limitations on hospital days)	Drugs	Nursing home care	Other	
Alabama	No	No	No	No	No	No	Maximum OAA money payment of $75 may be exceeded up to $110 for nursing home care. Recipient in hospital continues to receive money payment. State has program of hospitalization for medically indigent, administered by State health department.
Alaska	No	No	No	No	No	No	Maximum OAA money payment of $100 available for nursing home care. For nonnatives, State program of general assistance is used to meet medical needs, including hospitalization and nursing-convalescent home care not met in the money payment to the recipient. For natives, Bureau of Indian Affairs is a resource for medical care including hospitalization.
Arizona	No	No	No	No	No	No	Nursing home care provided through money payment up to maximum of $80 for OAA recipients. Recipients in hospital continue to receive money payment. Hospitalization and general medical care are county responsibility. For reservation Indians, Indian Health Service is a resource.
Arkansas	Yes	Yes [1]	As recommended by physician for all acute illnesses and injuries. General rule: 30 days a year; extension possible.	No [2]	$90 maximum, plus $5 in money payment for personal needs.	Yes	
California	Yes	Yes	No (vendor payments for OAA recipients in public medical insti-	Yes	No	Yes	Nursing home care provided through money payment of $115 or $95 maximum (depending on recipients income). Hospitalization available in

			tutions after 1st 60 days).				all locations from county hospitals.
Colorado	Yes	Yes	All recommended by physician, except for purpose of diagnosis only. General rule: 30 days; extension possible.	Yes	Money payment $106, plus $20 to $95 vendor payment based on patient's needs.	Yes	
Connecticut	Yes	Yes	All recommended by physician for definitive medical treatment. No limitation on number of days.	Yes	No	Yes	Nursing home care provided through money payment to recipient. Pay budgetary deficit up to approved rate. Maximum rate: $212.33.
Delaware	No	No	No	No	No	No	Nursing home care provided through money payment. Maximum of $75 may be supplemented up to approved rate. Hospitalization for indigent persons reported as provided by county governments.
District of Columbia.	Yes	Yes	All essential surgical and medical care and treatment. No limitation on number of days.	No [3]	No	Yes [3]	Nursing home care provided through money payment to $100 maximum, plus $10 for personal needs. Drugs available through District of Columbia Public Health.
Florida	Yes	No	Limited to acute injuries and illness. Maximum: 30 days a year.	Yes	No	No	Nursing home care provided through money payment to $66 maximum, which may be supplemented from other sources up to rate determined for community.
Georgia	No	No	No	No	No	No	Nursing home care provided through money payment to $65 maximum, which may be supplemented from other sources up to maximum rate. Limited hospitalization through board of commissioners. Hospital care for medically indigent enacted in 1958, but not in operation.

[1] Applicable only if surgery is authorized by remedial eye services section for cooperating ophthalmologist.

[2] Some drugs provided by vendor payment when dispensed by hospital for continuation of treatment after discharge of a patient who has received inpatient care for the same condition.

[3] Vendor payments may be made for drugs, appliances, dental services, and optical supplies recommended by physician, hospital, or clinic when such are not available without cost to the agency through other services.

TABLES ON PUBLIC ASSISTANCE MEDICAL PROGRAMS—Continued

State	Vendor payment method used	Vendor payments					Other resources for medical care available to old-age assistance (OAA) recipients
		Practitioner	Hospitalization (including controls or limitations on hospital days)	Drugs	Nursing home care	Other	
Guam	No	No	No	No	No	No	Hospitalization and other medical care available through Government hospital.
Hawaii	Yes	No	All recommended by physician except Hansen's disease (leprosy). No day limitation.	No	No	Yes	Nursing home care provided through money payment. State agency and medical care provisions being reorganized. Outpatient care provided by State paid physicians who also dispense drugs to limited extent.
Idaho	Yes	No	No	No	$150 maximum, plus money payment for personal needs; maximum may be exceeded.	No	Hospitalization furnished under annual contract with private hospitals in some counties; general assistance used primarily for medical care. Public assistance recipient in a public medical institution can continue to receive assistance grant.
Illinois	Yes	Yes	All recommended by physician. General rule: 2 weeks, with provision for extension.	Yes	To meet need for care, not to exceed "going rate" in community.	Yes	
Indiana	Yes	Yes	Limited to nonelective surgery, injuries, acute illness, diagnosis. No day limitation.	Yes	Money payment or vendor, as determined by county. Rates negotiated in each county.	Yes	Scope of medical care determined by individual counties in line with content recommended by State agency.
Iowa	Yes	Yes	No	Yes	No	No	Nursing home care provided through money payment to meet rate for needed care; basic rate $80, plus amounts for additional care needed. Hospitalization available through general assistance and Iowa University Hospital.

Kansas	Yes	Yes	All recommended by physician. No day limitation.	Yes	No	Yes	Nursing home care provided through money payment to meet budgetary deficit of recipient up to the local rate. No statewide rates or ranges.
Kentucky	No	No	No	No	No	No	Nursing home care provided through money payment up to $66 (for total needs). New legislation to start in 1961. Covers all types of medical care to limited amount. Some counties make contributions to local hospitals for care of needy.
Louisiana	Yes	Yes	No	Yes	$110 maximum, plus $17 money payment for personal needs. $105 money payment in home not subject to license.	Yes	Practitioner services paid by vendor payment in nursing home cases only; in other circumstances, provided through money payment. Hospitalization available through State hospital program.
Maine	Yes	No	All recommended by physician. Maximum: 45 days a year.	No	$65 maximum money payment, remainder by vendor payment up to $130 or $165.	No	Other medical care must be met by recipient from money payment. OAA maximum is $65.
Maryland	Yes	Yes	All recommended by physician; 21 days for illness, exception possible upon medical recommendation.	Yes	No	Yes	Nursing home care provided through money payment up to $115.50 for total care. Maximums of $190, $200, $210 (according to group into which county is classified) on total money payment for total needs of recipient.
Massachusetts	Yes	Yes	All recommended by physician. No day limitation.	Yes	$6.50 maximum a day; may be exceeded. All other medical needs are met.	Yes	
Michigan	Yes	Applicable only if connected with hospitalization.	do	Applicable only if connected with hospitalization.	No	Applicable only if connected with hospitalization.	Nursing home care provided through money payment, $90 maximum; may be supplemented from State and local general assistance funds to maximum regional rate ($150 to $175). Practitioner services are in money payment. OAA maximum $80.

TABLES ON PUBLIC ASSISTANCE MEDICAL PROGRAMS—Continued

State	Vendor payment method used	Vendor payments					Other resources for medical care available to old-age assistance (OAA) recipients
		Practitioner	Hospitalization (including controls or limitations on hospital days)	Drugs	Nursing home care	Other	
Minnesota	Yes	Yes	All recommended by physician. Maximum: 30 days; extension on recommendation of county medical advisory committee.	Yes	$60 by money payment, plus vendor up to $150, may be exceeded.	Yes	
Mississippi	No	No	No	No	No	No	Nursing home care provided through money payment, $33 administrative maximum; may be supplemented from local or private funds to $150 maximum. Some hospitalization available through State subsidies. Some counties contribute.
Missouri	Yes	No	For acute illness and injury when recommended by physician. Maximum: 14 days per hospital admission.	No	No	No	Nursing home care provided through money payment, $65 maximum, except $100 for "completely bedfast and totally disabled." Other medical care by money payment. Provisions being revised.
Montana	Yes	Yes	Limited to remedial eye care.	Yes	No	No	Nursing home care and all other medical care provided through money payment, $85 maximum. "Medical component" of nursing home care paid through general assistance. Vendor payment method limited to prevention of blindness and restoration of sight.
Nebraska	Yes	No	All recommended by physician. General rule: 31 days; extension possible.	No	Meet budgetary deficit up to fee range negotiated in each county.	No	Practitioner services and other medical services are in money payment up to $70 maximum for OAA.

Nevada	Yes	Yes	No	Yes	No	Yes	Nursing home care provided through money payment, $130 maximum, plus $8 for personal needs. Hospitalization is responsibility of county commissioners. Hospitalized recipients may continue to receive money payments to $75 maximum.
New Hampshire	Yes	Yes	All recommended by physician. General rule: 14 days; extension possible.	Yes	No	Yes	Nursing home care provided through money payment, $150 maximum; may be exceeded in unusual circumstances.
New Jersey	Yes	No	No	No	$180 basic; $190, including physician and prescriptions. Cash payment for personal use.	No	All medical care except nursing home provided through money payment. No maximum.
New Mexico	Yes	Yes	All except elective. No maximum; 7 days with reauthorization required.	Yes	$55 maximum on money payment, plus vendor to $150.	Yes	
New York	Yes	Yes	All recommended by physician. No day limitation.	Yes	Rates set locally. Personal needs met by money payment.	Yes	Counties have option as to method of payment for each of the services provided, subject to State approval.
North Carolina	Yes	No	All recommended by by physician. Maximum: 180 days.	No	No	No	Nursing home care provided through money payment, $175 maximum, applicable only to need for skilled nursing service following hospitalization; limited to 3 months; may be extended 3 times. All other medical care provided through money payment. No maximum. Average OAA payment, $40.
North Dakota	Yes	Yes	All recommended by physician. Maximum: 60 days.	Yes	Meet budgetary deficit up to maximum rates from $100 to $175.	Yes	

TABLES ON PUBLIC ASSISTANCE MEDICAL PROGRAMS—Continued

State	Vendor payment method used	Vendor payments					Other resources for medical care available to old-age assistance (OAA) recipients
		Practitioner	Hospitalization (including controls or limitations on hospital days)	Drugs	Nursing home care	Other	
Ohio	Yes	Yes	All recommended by physician; nonelective surgery only, except after special review; 10 days each admission with possible extension.	Yes	No	Yes	Nursing home care provided through money payment to meet budgetary deficit for care needed up to approved rates, $65 to $160.
Oklahoma	Yes	Yes	Limited to life endangering conditions and conditions producing or alleviating blindness; 21 days per admission.	No	$66 maximum on money payment, plus $69 vendor payment.	Yes	Hospitalization limited; no specific items of medical care provided in budgeting for money payment.
Oregon	Yes	Yes	All recommended by physician. No maximum; reauthorization every 7 days.	Yes	$124 to $184 according to care needed. Personal items in money payment.	Yes	In lieu of nursing-home care, housekeeping or nursing service in own home provided in special payment directly to recipient.
Pennsylvania	Yes	Yes	No	Yes	No	Yes	Nursing-home care provided through money payment, $100 to $165 maximum, according to type of care; plus $5 for personal needs in money payment. Hospitalization through State-owned and State-aided hospitals.
Puerto Rico	No	No	No	No	No	No	Medical services of all types available from resources of public health department.
Rhode Island	Yes	Yes	All recommended by physician. Gen-	Yes	No	Yes	Nursing-home care provided through money payment, $182 maximum, de-

			eral rule: 21 days with provision for extension.				pending on type of care, plus $6 for clothing and personal needs.
South Carolina	Yes	No	Acute illness and injury. 30 days maximum.	No	(1) For continuing care, money payment to $60, plus supplement to $150 from other sources; (2) for persons who have been hospitalized, up to $94 vendor payment, plus $60 money payment.	No	Medicine provided through money payment; OAA maximum, $60.
South Dakota	No	No	No	No	No	No	Nursing home care provided through money payment of $75 to $165 depending on type of care needed. Hospitalization provided by county poor relief fund, financed in part by return to county of portion of State taxes earmarked for this purpose. Specified drugs and appliances provided in money payment. No maximum except for nursing home.
Tennessee	Yes	No	Acute illness or injury, and illnesses and injuries requiring hospitalization; 10-day maximum.	No	No	No	Nursing home care provided through money payment of $60 maximum; may be supplemented from other sources to $150, plus allowance for personal needs. No other items of medical care specified in provisions for money payment. OAA maximum, $55.
Texas	No	No	No	No	No	No	Nursing home care provided through money payment, $67 maximum; may be supplemented from county funds up to $100 for nursing care, plus $64.50 for maintenance. Limited medical care through money payment. County commissioners generally maintain county hospitals or make payment to private hospitals.

TABLES ON PUBLIC ASSISTANCE MEDICAL PROGRAMS—Continued

State	Vendor payment method used	Vendor payments					Other resources for medical care available to old-age assistance (OAA) recipients
		Practitioner	Hospitalization (including controls or limitations on hospital days)	Drugs	Nursing home care	Other	
Utah	Yes	Yes	All recommended by physician, except elective surgery. General rule: 30 days; extension possible.	Yes	No	Yes	Nursing home care provided through money payment of $87.50, $110 maximum, which may be supplemented from other sources to $200; $5 allowance for personal items.
Vermont	Yes	No	No	No	$165 for skilled nursing care; $135 for personal nursing service; $5 money payment for personal needs.	No	Hospitalization provided by "town" general assistance; other medical needs included in money payment. OAA maximum, $75.
Virgin Islands	Yes	No	No	Yes	No	No	Other medical treatment through department of health. Hospitalization available under system of municipal hospitals.
Virginia	Yes	No	Extension of vendor payment provisions to hospital care effective July 1, 1960.	No	$150 maximum, plus $6 money payment for personal items.	No	Other medical care provided through money payment; average OAA money payment, $37. (To July 1, 1960, hospitalization provided through State-local payments, not part of public assistance program.)
Washington	Yes	Yes	All recommended by physician. No day limitation.	Yes	$102 to $192 according to type of home. Personal items through money payment.	Yes	

West Virginia	Yes	Yes	Limited to acute illness, immediate surgery, diagnostic services; exceptions if will increase capacity for self-care. Maximum 30 days.	Yes	No	Yes	Nursing home care provided through money payment, $60 maximum a person, $165 a household, supplemented by general assistance under specified conditions. Practitioner services through money payment.
Wisconsin	Yes	Yes	All recommended by physician. No day limitation; reauthorization stipulated.	Yes	Pay budgetary deficit to meet rate for care needed; rates negotiated in each county. Allowance for personal needs in money payment.	Yes	
Wyoming	Yes	Yes	All recommended by physician. No day limitation.	No	$85 maximum money payment for maintenance, plus vendor payment up to $100.	No	Other medical services are responsibility of counties.

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TABLES ON PUBLIC ASSISTANCE MEDICAL PROGRAMS—Continued

Table 2.—Old-age assistance: Payments for vendor medical bills: Total amount, amount for which type of service was not reported, and amount in all States reporting for specified type of service, by State, fiscal year 1959 (supplied by the Bureau of Public Assistance) [1]

State	Total	Type of service not reported	In all States reporting for specified type of service				
			Practitioners' services	Hospitalization	Drugs and supplies	Nursing and convalescent home care	Other
Total	$220,749,925	$24,953,705	$21,344,694	$71,879,997	$31,877,084	$56,944,998	$13,749,447
Alabama	17,473		2,329	15,144			
Alaska							
Arizona							
Arkansas	2,989,720		21,393	1,671,037		1,294,030	3,260
California	22,140,019		6,649,307		13,100,862		2,389,850
Colorado	7,739,663		1,097,093	4,878,353	77,096	1,624,167	62,954
Connecticut	3,710,081		453,372	2,259,290	940,438	1,494	55,487
Delaware							
District of Columbia	202,936			196,454			6,482
Florida	1,390,427				1,390,427		
Georgia							
Hawaii	99,977	99,977					
Idaho	24,130					24,130	
Illinois	24,788,904		2,022,275	6,612,511	2,722,576	12,541,541	890,001
Indiana	5,807,135		1,277,606	1,619,147	872,201	1,849,526	188,655
Iowa	667,938		315,954		334,334		17,650
Kansas	3,913,454		622,473	1,366,940	795,779		1,128,262
Kentucky							
Louisiana	2,394,230		32,935		115,304	2,239,448	6,543
Maine	1,354,849			625,785		729,064	
Maryland	463,099	463,099					
Massachusetts	29,654,045		683,863	10,306,418	4,640,549	13,030,875	992,340
Michigan	4,985,744	4,985,744					
Minnesota	14,723,821		1,419,212	6,027,400	1,536,242	5,354,227	386,740
Mississippi							
Missouri							
Montana	17,855		6,916	9,878	17		1,044
Nebraska	3,391,745			1,044,795		2,346,950	
Nevada	229,642		79,443		82,553		67,646
New Hampshire	1,222,136		178,044	709,419	274,920	32,661	27,092
New Jersey	5,800,800	5,800,800					
New Mexico	914,908		143,955	420,400	120,940	190,197	39,416
New York	26,050,471			14,766,084		4,918,973	6,365,414
North Carolina	832,317			832,317			
North Dakota	2,027,898		243,415	1,086,083	219,043	421,484	57,873
Ohio	9,402,926		1,543,879	5,747,637	1,753,514	17,721	340,175
Oklahoma	11,233,765		1,688,688	4,346,185		5,182,308	16,584

Oregon	4,335,246		170,611	912,817	404,232	2,805,116	42,470
Pennsylvania	2,708,931		588,050		1,197,393	687,050	236,438
Puerto Rico							
Rhode Island	980,836	980,836					
South Carolina							
South Dakota							
Tennessee	1,394,994			1,394,994			
Texas							
Utah	593,496		71,664	130,380	264,556	88,099	38,797
Vermont							
Virgin Islands	3,657	3,657					
Virginia	445,582					445,582	
Washington	8,326,489		1,843,036	4,113,408	913,708	1,071,204	385,133
West Virginia	745,866		113,924	591,393	19,758		20,791
Wisconsin	12,619,592	12,619,592					
Wyoming	403,128		75,257	178,078	100,642	49,151	

[1] In some instances, figures are presented where no federally aided vendor payments are made; in others, no figures are presented where vendor payment programs are now in existence. These discrepancies are generally the result of the method and of the timing of the State reports. For example, Alabama, although it has no federally approved plan for vendor method payment, reports total payments of $17,473. This amount, however, represents payments from local funds only. New York, which has a vendor program for all types of services, reported its payments for practitioners' services and drugs and supplies under the heading designated "Other." Another example is the fact that no hospitalization payments are listed for Florida, because the program did not go into effect until October 1959.

The CHAIRMAN. I have instructed the committee clerk to insert in the record at the end of the hearings, a copy of each amendment which has been introduced in the Senate to be proposed to H.R. 12580, accompanied by a brief analysis and a statement of views thereon by the Department of Health, Education, and Welfare.

(The amendments, analyses, and departmental reports thereon appear on pages 451 to 531.)

The CHAIRMAN. The first witness is the Honorable Arthur S. Flemming, Secretary of Health, Education, and Welfare.

Mr. Flemming, you may proceed, sir.

STATEMENT OF ARTHUR S. FLEMMING, SECRETARY OF HEALTH, EDUCATION, AND WELFARE, ACCOMPANIED BY CHARLES E. HAWKINS, W. L. MITCHELL, ROBERT J. MYERS, ROBERT M. BALL, SOCIAL SECURITY ADMINISTRATION; AND ROBERT A. FORSYTHE, ASSISTANT SECRETARY, DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE

Secretary FLEMMING. Mr. Chairman and members of the committee, I appreciate very much having the opportunity of appearing before the committee in order to discuss H.R. 12580 and some of the issues that underlie it. The bill as you know was developed after long and careful consideration in the Ways and Means Committee of the House of Representatives.

It makes a substantial number of significant changes in the programs of old-age, survivors, and disability insurance, maternal and child welfare, public assistance, and unemployment compensation. It also would establish a new program for low income aged persons who need help in meeting their medical bills.

The changes that the bill would make in the OASDI provisions would accomplish some important basic program improvements. In addition, the bill would remedy some minor inequities that exist under the present provisions, and would make many technical improvements and administrative simplifications.

The program of old-age, survivors, and disability insurance provides basic protection to the American people against the risk of earning loss resulting from retirement, death, or permanent and total disability. Over 14 million individuals now receive benefits under this program. Nearly 900,000 additional persons would almost immediately become eligible for benefits under the provisions of this bill.

In addition, some 400,000 children would receive increased benefits immediately and approximately 300,000 persons would be brought under the coverage of the system so that their earnings would count toward eligibility for benefits on retirement, death, or disability.

Among the most significant of the old-age, survivors, and disability insurance provisions are those concerned with disability. The minimum age of 50 for receipt of disability insurance benefits would be eliminated. This would result in immediate benefits for 125,000 disabled workers and approximately a like number of their dependents. I am very glad that experience under the disability insurance program indicates that this significant change can now be made without increasing the tax rates necessary to finance the disability benefit

program. Another change in the disability provisions would eliminate a second 6-month waiting period for disability benefits for persons who had had a prior period of disability within 5 years.

Under present law disabled persons who return to work pursuant to a State-approved vocational rehabilitation plan may continue to draw benefits for as many as 12 months even though they are engaged in work activity which is such that, without this provision, they would have their benefits terminated.

The bill would broaden this provision so that disability beneficiaries who work under other rehabilitation plans or are rehabilitating themselves would also be allowed a similar trial work period during which their benefits would be continued.

One of the important changes in the old-age, survivors, and disability insurance system would revise the present insured status provision to make the requirements that apply to people attaining retirement age in the next few years more nearly comparable to those that will prevail over the long run.

At present, an individual, to be eligible for benefits on retirement, has to have had coverage in a number of calendar quarters equal to one-half of the quarters elapsing after 1950 and before he attained retirement age.

For persons brought into coverage in 1954 and 1956 and reaching retirement age at the present time, almost all of the quarters that have elapsed since their jobs were covered have to be quarters of coverage.

Under the bill, a person would be fully insured if he had one quarter of coverage for every four quarters elapsing after 1950 (instead of one quarter of coverage for every two elapsed quarters as required by present law).

This change is consistent with the longrun requirement that an individual is permanently insured if he has 40 quarters of coverage—about one-fourth of a working lifetime in covered work. The change would make approximately 600,000 persons immediately eligible for benefits.

The bill provides a number of extensions of coverage recommended by the administration, including coverage for self-employed physicians, parents employed in a business by their sons or daughters, additional employees of nonprofit organizations, workers in Guam and American Samoa, and a few other small groups.

In addition, various provisions affecting nonprofit employees and State and local employees are liberalized and improved. Among other changes, the time within which ministers can elect coverage is extended, and further opportunity for retroactive coverage under State and local agreements is provided.

Under present law, the amount payable to a child of a deceased worker is equal to one-half of the benefit amount the worker would have been paid if he had lived, plus an additional amount derived by dividing one-fourth of the worker's benefit amount by the number of children getting benefits.

The bill would increase the benefits payable to children of a deceased worker so that each child would get an amount equal to three-fourths of the worker's benefit amount, subject of course to the family maximum provision.

The bill would also provide benefits for survivors of workers who died fully insured before 1940. About 25,000 people—chiefly widows over age 72—would qualify as a result of this change.

The provisions relating to the investment of trust funds would be changed so as to make interest earnings on the Government obligations held by those funds more nearly equivalent to the rate of return being received by people who buy Government obligations in the open market. The changes would make for more equitable treatment of the trust funds and are generally in line with the recommendations that were made by the Advisory Council on Social Security Financing.

The long-run benefit cost of the old-age, survivors, and disability insurance system as modified by the bill is very closely in balance with contribution income, according to our intermediate cost estimate. This of course is true under present law and it would continue to be so after enactment of the bill.

Our latest long-range cost estimates show, on a level-premium intermediate-cost basis, a surplus of 0.15 percent of payroll for the disability part of the program.

H.R. 12580 would increase the level-premium cost of the disability provisions by 0.21 percent of payroll. The resulting net insufficiency of 0.06 percent of payroll would be small enough so that the disability part of the program would still be in actuarial balance.

The old-age and survivors insurance part of the program now shows an actuarial insufficiency of 0.20 percent of payroll on the intermediate-cost basis. The estimated level-premium cost of the provisions increasing children's benefits and the provision liberalizing the insured status requirements total 0.06 percent.

The provisions for extending the coverage of the program and the provisions relating to the investments of the trust funds would provide increased income equivalent to 0.03 percent of payroll.

Therefore, the present actuarial insufficiency of 0.20 percent of payroll would be increased to 0.23 percent. An insufficiency of this size is small enough so that the old-age and survivors insurance part of the program would continue to be on an actuarially sound basis.

Income and expenditures of the old-age and survivors insurance trust fund are estimated under the bill to be in close balance during calendar year 1961, and it is expected that expenditures will be somewhat larger than income during 1962.

Beginning in 1963, income is expected to exceed disbursements, and the long-range upward trend in the size of the trust fund will be resumed.

An important result of the changes in the OASDI program made by the bill is an estimated savings in public assistance costs of about $85 million in calendar year 1961 and larger annual savings in future years.

The old-age, survivors, and disability insurance provisions would contribute substantially to the protection afforded under the program and would be a desirable step at this time.

MATERNAL AND CHILD HEALTH AND WELFARE PROVISIONS

The bill would increase the amounts authorized to be appropriated for maternal and child health and for crippled children's services to

$25 million each. They are presently $21,500,000 and $20 million, respectively. Provision is made for direct grants for special projects to public and nonprofit institutions.

The appropriation ceiling for child welfare services would also be increased from $17 million to $20 million. The bill also contains an authorization for grants to public and nonprofit institutions of higher learning, agencies and organizations for research, and demonstration projects related to child welfare consistent with a recommendation of the Advisory Council on Child Welfare Services authorized by the Senate as a part of the 1958 amendments.

MEDICAL CARE PROVISIONS

The bill contains a number of provisions concerned primarily with medical care for older persons. It instructs the Secretary of Health, Education, and Welfare to develop guides or recommended standards as to level, content, and quality of medical care for the use of the States in evaluating and improving their public assistance medical care programs and the new program authorized in the bill.

The Secretary is also required to secure periodic reports from the States on items included in, and quantity of, medical care for which expenditures are made under these programs.

This is in accord with a recommendation made by the Advisory Council on Public Assistance which was established pursuant to an amendment made by this committee in the Social Security Amendments of 1958. The House Ways and Means Committee, in its report on this bill, has asked the Department to undertake a study of other medical resources available to public assistance recipients.

The bill also provides for somewhat increased Federal participation under the old-age assistance program in increased expenditures to suppliers of medical care under State plans which make significant improvements in assistance for medical care.

The Ways and Means Committee, in its report on the bill, stated:

> In order to further encourage the States, particularly those which have made but limited efforts in the medical area, to increase their effort, the bill includes a provision giving each State an additional amount of Federal funds for old-age assistance where its expenditures are increased through vendor payments for medical care.

The stated objective is a desirable one, and while there is some question whether the provision in the bill would produce the intended result, it is probably worth trying.

Title VI of H.R. 12580 would establish a new Federal-State grant-in-aid program intended to assist in meeting the acute problems of medical care encountered by aged persons. The program would permit States to pay for the medical expenses of low-income aged persons who are not so needy as to require old-age assistance but whose income and resources, after taking into account amounts needed for current living expenses, are insufficient to meet their medical bills.

States would have broad latitude in determining who needed such assistance and in determining what medical expenditures would be made under the plan. Such a program looks in the direction of attempting to meet a part of the problem of medical care for older persons by dealing with crises after they arise. It puts the State government, with the assistance of Federal funds, in a position to

deal with these crises. It does not, of course, put the individual in a position where he can obtain protection in advance against the hazards of long-term illnesses.

In view of the fact that the title would put States that take advantage of it in a better position to deal with illnesses incurred by low-income aged persons, we favor its inclusion in the bill.

HEALTH INSURANCE FOR THE AGED

In addition to the issues I have just discussed, the Congress has before it the question of what the Federal Government should do in order to help the aged make provision in advance for meeting the costs of illness.

The members of this committee are aware that tremendous efforts have been made by various groups and individuals to bring to public attention the problems faced by many of our aged in meeting the costs of health services and medical care.

A considerable segment of this effort has been directed to the Members of the Congress—with assertion of the virtues of one method of meeting the problem over another.

The executive branch of the Government fully recognizes and accepts the fact that the Federal Government should take additional action in this field. A careful consideration of facts such as the following can lead to no other conclusion:

1. There are 16 million persons aged 65 and over. Four million pay income taxes. Of the 12 million who do not pay income taxes, 2.4 million are recipients of public assistance.

2. A 1958 study identified 60 percent, or 9.6 million, of the aged as having incomes of $1,000 or less, and 80 percent, or 12.8 million, as having incomes of $2,000 or less.

These figures should be discounted, because they include situations where a wife has an income of less than $1,000 and the husband has a substantial income, and because they include situations where other members of the family have substantial resources. Nevertheless, we are dealing with a group in our population which contains an unusually large percentage of persons with very limited resources.

3. A 1957–58 study shows that the average annual expenditures of this group for health and medical expenses was $177, not including nursing home care, as compared with $84 for the rest of the population. But it is important to note that 15 percent of the persons 65 and over, or 2.25 million, had total medical expenditures, on the average, of $700 per year, not including nursing home care.

The expenditures for this group represented 60 percent of the total medical care expenditures of the aged. Since 1957, costs for medical care have increased at least 20 percent. Also, it should be noted that the high average expenditures for the aged is attributable to the fact that $6,000, for example, is a conservative estimate of total medical expenditures incurred by persons who are continuously ill for an entire year.

4. According to the Health Insurance Association of America, approximately 49 percent of the persons in this age group have some kind of health and medical insurance.

But, only a comparatively small percentage of this group have policies that protect them against long-term illnesses. This is true

of those who are covered by group policies, as well as those who are covered by individual policies. There is a trend in the direction of extending beyond the retirement age provisions in group policies that cover major medical expenses. There is also a trend in the direction of making individual policies that cover major medical expenses available to persons 65 and over. These policies call for payment of premiums ranging from $60 to $130 a year per individual. They include deductible provisions ranging from $250 to $500. They ordinarily establish annual or lifetime dollar ceilings on benefits. Most contain coinsurance provisions of 20 percent to 25 percent.

It follows, therefore, that a large percentage of persons aged 65 and over do not have protection against long-term illnesses, and either cannot obtain protection at rates they can afford to pay, or cannot obtain adequate protection.

PENDING LEGISLATIVE PROPOSALS

There are several bills before this committee (S. 881, S. 1151, S. 2915, and S. 3503) which would amend the Social Security Act to impose an additional payroll tax to finance hospitalization and other medical care benefits for persons eligible for old-age and survivors insurance benefits.

In addition, the administration has outlined a proposal for a program of Federal-State matching grants to provide approximately 12 million persons 65 and over who have limited resources with the opportunity of taking steps which, if taken, will enable them to cope with the heavy economic burden of long-term or other expensive illnesses.

As this committee undoubtedly knows, the executive branch has given careful consideration to proposals that have been made to deal with the health and medical expenses of the aged through the social security system. Our reasons for rejecting this approach include the following:

1. It is not pinpointed to the need. There are 4 million of the 16 million in our aged population who are not covered by social security. Approximately one-half of these persons have incomes of $1,000 or less.

At the same time there are many persons who are covered by social security who have no interest in and no need for the type of protection that would be afforded.

2. We feel it would constitute a serious threat to the orderly development of present retirement, survivorship, and disability benefit features of the social security system.

The payroll tax which finances the OASDI program is already scheduled to rise in 1969 to 4.5 percent each on employees and employers (6¾ percent on self-employed)—a total of 9 percent of payrolls.

Further liberalization in retirement, survivorship, and disability benefits will call for additional revenues. These revenues can only come from increases in the payroll tax or increases in the earnings base, or both.

If health insurance is added to the social security system it will be even more difficult to predict where we will end up as far as the payroll tax is concerned.

Pending proposals would call for an addition of 1 percent to the tax. It is generally recognized that these proposals are inadequate when looked at from the point of view of taking care of the costs of long-term illnesses. Unquestionably, therefore, if health insurance becomes a part of the social security system, there will be insistent demands for improving the schedule of benefits.

In addition, there will be insistent pressures for reducing or eliminating the age requirement. A combination of increased benefits with the lowering or elimination of the age requirement could easily lead to an addition of 4 to 5 percent to the presently scheduled 9 percent rate.

This increase plus the increase that will be required under the retirement, survivorship, and disability features of the program, could very well bring the payroll tax up to somewhere between 15 and 20 percent. We believe it is unsound to assume that revenue possibilities from a payroll tax are limitless.

We decided therefore that it was far better to reserve the payroll tax for the retirement, survivorship, and disability features of the social security system.

Whatever the Government needs to do in the area of health care for the aged should be done by the appropriation of general revenues. This will safeguard the orderly development of the retirement, survivorship, and disability features of the social security system.

Moreover, taking into consideration that in the medical benefits area we are dealing with benefits that are not related to wages, the appropriation of general revenues will provide for a more equitable distribution of the fiscal load. A system of raising the Federal share of revenues that relies primarily on the use of the progressive income tax is fairer for health benefits than one that places one-half the burden on earnings of $4,800 or less.

In other words, the use of the social security system for health insurance purposes would give rise to some very serious problems. Once the step is taken it is irreversible and we would have to continue to live with these problems.

As I have indicated, the administration has developed a proposal that would help approximately 12 million persons who are over 65 years of age and have limited resources to cope with the financial burdens of long-term or other expensive illness.

We have developed this proposal in the belief that any program undertaken by the Federal Government in this area should meet the following tests:

1. It should provide the individual with the opportunity of deciding for himself whether or not he desires to be a participant in the program.

2. It should make available a system of comprehensive health and medical benefits which provide adequate protection against the costs of long-term and other expensive illnesses.

3. It should make available all the benefits of the program to public assistance recipients at public expense.

4. It should provide for some financial contribution on the part of those participants who are not on public assistance.

5. It should provide private insurers with the opportunity of expanding their programs of extending health protection to the over-65 age group.

6. It should provide for a Federal-State partnership in dealing with the problem.

We have developed a program that is consistent with these guidelines. We believe that if it is put into operation it will provide the aged with the type of assistance they most need. We want to make it clear, however, that we will be glad to discuss any suggestions for improvements that are consistent with the basic guidelines that I have just outlined.

Specifically, we have recommended that the Federal Government assist the States in establishing a program of medical benefits for the aged in accordance with the following specifications:

1. Eligibility for participation in program: The program would be open to all persons aged 65 and over who did not pay an income tax in the preceding year and to taxpayers 65 and over whose adjusted gross income, plus social security benefits, railroad retirement benefits, and veterans pensions, in the preceding year did not exceed $2,500 ($3,800 for a couple).

2. Eligibility for benefits: Persons eligible for participation in the program would be entitled to the benefits of the program if they had paid an enrollment fee each year of $24 and after they had incurred health and medical expenses of $250 ($400 for a couple).

Public assistance recipients would be entitled to the benefits of the program without paying the enrollment fee and with the States paying the initial $250 of expenses under the regular public assistance program.

3. Benefits: The program would pay 80 percent (100 percent for public assistance recipients) of the costs of the following comprehensive health and medical services for all participants who had established their eligibility and if such services had been determined to be medically necessary.

(*a*) Inpatient hospital services for not to exceed 180 days in any enrollment year;

(*b*) Skilled nursing-home services, all of these others are unlimited, I might say.

(*c*) Physicians' services;

(*d*) Outpatient hospital services;

(*e*) Organized home health care services;

(*f*) Private duty nursing services;

(*g*) Physical restorative services;

(*h*) Dental treatment;

(*i*) Laboratory and X-ray services not in excess of $200 in any enrollment year; and

(*j*) Prescribed drugs not in excess of $350 in any enrollment year.

4. Optional benefits: Each State would provide that an aged person eligible for participation in the program could elect to purchase from a private group a major medical expense insurance policy with the understanding that 50 percent of the cost would be paid for him from Federal-State matching funds up to a maximum of $60.

The States would be responsible for establishing the minimum specifications for such policies in accordance with broad standards established by the Federal Government.

5. Continuation of eligibility: Once a person had qualified for participation in the program, he could maintain his eligibility by the pay-

ment of the annual fee. If his income rose above the figure specified for eligibility, his fee would be raised on a graduated basis for each $500 of increase in income until the fee covered the full per capita cost of the benefits made available to him.

6. Administration: The program would be administered by the States, under State plans approved by the Secretary of Health, Education, and Welfare. The State would be authorized to use appropriate private organizations as agents.

7. Financing: The governmental cost of the program would be financed by the Federal Government and the States on a matching basis. Federal matching would be 50 percent on the average with an equalization formula ranging from 33⅓ to 66⅔ percent for the Federal share.

8. Cost: Assuming that all States participate and that 80 percent of those who are eligible enroll for the program, it is estimated that the annual Federal-State cost of this plan would be $1.2 billion with the Federal share estimated at $600 million. There would be some reduction to the extent that persons eligible for participation in the plan elected to purchase insurance policies providing for the optional benefits. It is impossible to estimate the number of persons who would elect the optional benefits.

On the other hand, however, it should be noted that increases in costs and increased utilization of facilities over and above that included in the cost estimates could lead to an increase in these estimates.

Also, there would be some increase in Federal payments for public assistance. This increase might reach $100 million per year.

The makeready cost during fiscal year 1960–61—including grants to States to help them develop their programs—would be about $5 million. The fiscal year 1961–62 cost would depend on many factors. We estimate that this would run in the neighborhood of $400 million—of which $200 million would be the Federal share.

We believe that the plan which I have just described would achieve the following results:

1. It would permit the individual to decide for himself whether or not he will participate in the program.

2. It would preserve the opportunity for private insurers to continue to demonstrate their ability to develop major medical expense programs for the aged.

3. It would divide the cost equitably among the entire population by providing for financing the Federal share out of general revenues, contrasted with a payroll tax that places half the burden on earnings of less than $4,800.

4. It would provide a wide range of benefits without placing a premium on institutional care as opposed to alternative lower-cost services. Thus, it would facilitate the most effective and economical use of available medical facilities and services.

5. It would provide a built-in incentive for judicious use of health facilities and services by requiring the individual (other than public assistance recipients) to share in the cost above the deductible of $250.

Most important, however, the program is designed to pin-point the area of greatest need, namely, the large number of persons over 65 who do not have the resources or the opportunity to obtain adequate protection against the staggering financial burdens of long-term ill-

ness. This is the most serious problem in financing health care for the aged.

The administration's proposal would guarantee comprehensive health and medical services to all aged public assistance recipients in States that avail themselves of the program.

Benefits would be available to all persons in the lower income brackets, regardless of whether they happen to be covered by social security. Individual eligibility to participate in the program would be determined by a simple income test, without subjecting the individual to a detailed and involved means test.

In summary, we believe that our program for helping the aged obtain protection against the costs of long-term or other expensive illness will concentrate governmental assistance in such a manner as to provide the most effective and most responsible use of Federal and State funds. We believe this program represents a practical solution to a pressing human problem.

(The following tables were submitted by Secretary Flemming for the record.)

ESTIMATED FEDERAL AND STATE-LOCAL EXPENDITURES AS A RESULT OF MEDICARE PROGRAM FOR THE AGED, BY STATE, IF ALL STATES PARTICIPATE, AS OF JANUARY 1960

TABLE 1.—*Population aged 65 and over: Estimated total and number eligible and participating under medicare program for the aged, as of Jan. 1, 1960*

[In thousands]

State	Total aged 65 and over [1]	Under medicare program			
		Eligible [2]	Participants		
			Total	Now receiving old-age assistance [3]	Others [4]
U.S. total	15,720	12,500	9,970	2,400	7,570
Alabama	250	223	192	99	93
Alaska	6	4	3	1	2
Arizona	80	60	48	14	34
Arkansas	190	158	132	56	76
California	1,220	1,001	815	258	557
Colorado	140	125	105	47	58
Connecticut	230	185	143	15	128
Delaware	34	26	20	1	19
District of Columbia	60	38	29	3	26
Florida	490	385	306	70	236
Georgia	270	233	199	98	101
Hawaii	30	21	16	1	15
Idaho	58	46	36	7	29
Illinois	937	705	548	76	472
Indiana	435	341	263	29	234
Iowa	325	236	186	35	151
Kansas	235	172	136	29	107
Kentucky	278	228	185	57	128
Louisiana	213	204	184	125	59
Maine	105	87	68	12	56
Maryland	205	145	111	10	101
Massachusetts	520	450	358	81	277
Michigan	617	504	394	63	331
Minnesota	348	259	206	48	158
Mississippi	175	166	145	81	64
Missouri	472	393	324	118	206
Montana	65	49	39	7	32
Nebraska	155	114	89	15	74
Nevada	17	12	10	3	7
New Hampshire	68	52	40	5	35
New Jersey	522	416	317	19	289

See footnotes at end of table.

TABLE 1.—*Population aged 65 and over: Estimated total and number eligible and participating under medicare program for the aged, as of Jan. 1, 1960*—Con.

[In thousands]

State	Total aged 65 and over [1]	Under medicare program			
		Eligible [2]	Participants		
			Total	Now receiving old-age assistance [3]	Others [4]
New Mexico	48	35	29	11	18
New York	1,585	1,227	941	84	857
North Carolina	292	234	188	49	139
North Dakota	50	42	33	7	26
Ohio	860	671	525	89	436
Oklahoma	232	201	173	91	82
Oregon	185	145	113	17	96
Pennsylvania	1,082	829	634	50	584
Rhode Island	88	73	57	7	50
South Carolina	150	115	95	33	62
South Dakota	70	52	41	9	32
Tennessee	285	223	181	56	125
Texas	680	565	479	223	256
Utah	57	45	36	8	28
Vermont	44	34	27	6	21
Virginia	267	187	144	15	129
Washington	207	225	181	50	131
West Virginia	172	135	106	20	86
Wisconsin	398	311	242	36	206
Wyoming	27	18	14	3	11
Puerto Rico	125	95	81	40	41
Virgin Islands	2	1	1	1	(5)

[1] The State distribution of the aged population as of Jan. 1, 1960, was estimated by the Division of Program Research, based on Census Bureau estimates of the distribution by State on July 1, 1958, adjusted by the differential changes in the Census Bureau estimates of the aged population between July 1, 1957, and July 1, 1958. (Census Bureau reports, series P–25, Nos. 194 and 214).

[2] It is assumed that the 12.5 million aged estimated to be eligible would be distributed by State in the same manner as the unduplicated number receiving OASI or old-age-assistance in mid-1959.

[3] For December 1959.

[4] It is assumed that 75 percent of the non-old-age-assistance eligibles will participate.

[5] Less than 500.

TABLE 2.—*Medicare program: Total estimated annual expenditures [1] by State, if all States participate, as of Jan. 1, 1960*

[In millions]

State	Governmental expenditures					Enrollment fees paid by participants
	Total	Total amounts for—		Source of funds		
		Present OAA recipients	Others	Federal [2]	State-local [2]	
U.S. total	$1,229.7	$436.5	$793.2	$602.5	$627.2	$181.7
Alabama	23.5	14.9	8.6	15.6	7.9	2.2
Alaska	.5	.2	.3	.3	.2	(3)
Arizona	5.8	2.3	3.5	3.3	2.5	.8
Arkansas	14.4	7.9	6.5	9.6	4.8	1.8
California	125.2	53.9	71.3	46.9	78.3	13.4
Colorado	13.5	7.7	5.8	7.0	6.5	1.4
Connecticut	21.6	4.4	17.2	7.2	14.4	3.1
Delaware	2.4	.2	2.2	.8	1.6	.5
District of Columbia	3.7	.6	3.1	1.4	2.3	.6
Florida	35.8	11.7	24.1	19.7	16.1	5.7
Georgia	24.5	15.0	9.5	15.7	8.8	2.4
Hawaii	1.7	.2	1.5	.9	.8	.4
Idaho	4.3	1.2	3.1	2.5	1.8	.7
Illinois	65.0	12.6	52.4	25.7	39.3	11.3
Indiana	28.4	4.8	23.6	14.1	14.3	5.6

See footnotes at end of table.

TABLE 2.—*Medicare program: Total estimated annual expenditures*[1] *by State, if all States participate, as of Jan. 1, 1960*—Continued

[In millions]

State	Governmental expenditures					Enrollment fees paid by participants
	Total	Total amounts for—		Source of funds		
		Present OAA recipients	Others	Federal[2]	State-local[2]	
Iowa	17.9	4.9	13.0	10.2	7.7	3.6
Kansas	13.1	4.0	9.1	7.3	5.8	2.6
Kentucky	21.9	9.2	12.7	14.5	7.4	3.1
Louisiana	23.0	17.9	5.1	14.4	8.6	1.4
Maine	7.3	1.9	5.4	4.2	3.1	1.3
Maryland	12.2	1.7	10.5	5.7	6.5	2.4
Massachusetts	62.7	27.5	35.2	27.1	35.6	6.6
Michigan	52.9	12.5	40.4	23.8	29.1	7.9
Minnesota	31.8	15.2	16.6	17.3	14.5	3.8
Mississippi	16.1	10.9	5.2	10.8	5.3	1.5
Missouri	36.7	17.7	19.0	19.0	17.7	4.9
Montana	4.2	1.1	3.1	2.2	2.0	.8
Nebraska	8.5	2.1	6.4	4.9	3.6	1.8
Nevada	1.3	.5	.8	.5	.8	.2
New Hampshire	5.2	1.6	3.6	2.8	2.4	.8
New Jersey	35.2	4.2	31.0	13.5	21.7	7.2
New Mexico	3.6	1.8	1.8	2.2	1.4	.4
New York	125.3	30.2	95.1	46.8	78.5	20.6
North Carolina	18.0	6.6	11.4	12.0	6.0	3.3
North Dakota	3.7	1.6	2.1	2.3	1.4	.6
Ohio	63.3	15.8	47.5	28.1	35.2	10.5
Oklahoma	20.1	13.0	7.1	12.0	8.1	2.0
Oregon	14.6	3.3	11.3	7.5	7.1	2.3
Pennsylvania	60.0	7.4	52.6	29.1	30.9	14.0
Rhode Island	7.9	1.5	6.4	3.8	4.1	1.2
South Carolina	8.4	3.9	4.5	5.6	2.8	1.5
South Dakota	3.8	1.2	2.6	2.5	1.3	.8
Tennessee	19.5	8.3	11.2	12.9	6.6	3.0
Texas	64.5	37.9	26.6	36.2	28.3	6.1
Utah	4.1	1.3	2.8	2.4	1.7	.7
Vermont	3.2	1.0	2.2	1.9	1.3	.5
Virginia	13.1	2.1	11.0	7.6	5.5	3.1
Washington	27.2	10.4	16.8	12.8	14.4	3.1
West Virginia	10.2	2.8	7.4	6.5	3.7	2.1
Wisconsin	31.2	11.6	19.6	16.4	14.8	4.9
Wyoming	1.6	.5	1.1	.9	.7	.3
Puerto Rico	6.0	3.7	2.3	4.0	2.0	1.0
Virgin Islands	.1	.1	[3]	.1	[3]	[3]

[1] Cost of benefits—80 percent of costs of specified services (100 percent for OAA recipients) above $250 a year—and cost of administration. State per capita costs varied from national average on basis of variations in average State per diem costs of care in non-Federal general and special hospitals, 1959.

[2] Federal share varies among States from 33⅓ percent to 66⅔ percent on the basis of variations in State per capita income.

[3] Less than $50,000.

TABLE 3.—*Annual medical care expenditures for OAA recipients under medicare proposal, if all States participate, and present annual expenditures under OAA program, as of January 1, 1960*

[In millions]

State	Total expenditures under medicare proposal			Present OAA expenditures—vendor and money payments for medical services
	Combined total—Medicare program and OAA [1]	Medicare program	OAA program	
U.S. total	$856.0	$436.5	$419.5	$364.5
Alabama	30.8	14.9	15.9	5.6
Alaska	.5	.2	.3	
Arizona	4.8	2.3	2.5	
Arkansas	16.2	7.9	8.3	3.7
California	111.0	53.9	57.1	28.9
Colorado	15.9	7.7	8.2	8.6
Connecticut	7.8	4.4	3.4	7.8
Delaware	.5	.2	.3	[2]
District of Columbia	1.3	.6	.7	.3
Florida	24.1	11.7	12.4	3.4
Georgia	30.8	15.0	15.8	1.2
Hawaii	.5	.2	.3	.1
Idaho	2.6	1.2	1.4	.5
Illinois	27.2	12.6	14.6	27.2
Indiana	9.8	4.8	5.0	7.9
Iowa	10.1	4.9	5.2	2.7
Kansas	8.3	4.0	4.3	6.4
Kentucky	18.9	9.2	9.7	.7
Louisiana	36.8	17.9	18.9	8.6
Maine	3.9	1.9	2.0	2.0
Maryland	3.4	1.7	1.7	1.4
Massachusetts	45.3	27.5	17.8	45.2
Michigan	25.8	12.5	13.3	9.5
Minnesota	23.9	15.2	8.7	23.8
Mississippi	22.3	10.9	11.4	
Missouri	36.4	17.7	18.7	9.1
Montana	2.3	1.1	1.2	.1
Nebraska	4.4	2.1	2.3	4.3
Nevada	1.0	.5	.5	.3
New Hampshire	2.5	1.6	.9	2.5
New Jersey	7.6	4.2	3.4	7.6
New Mexico	3.7	1.8	1.9	1.4
New York	46.4	30.2	16.2	46.5
North Carolina	13.6	6.6	7.0	3.0
North Dakota	2.6	1.6	1.0	2.7
Ohio	32.7	15.8	16.9	15.3
Oklahoma	26.7	13.0	13.7	11.9
Oregon	6.8	3.3	3.5	5.6
Pennsylvania	15.3	7.4	7.9	6.6
Rhode Island	3.0	1.5	1.5	1.9
South Carolina	8.1	3.9	4.2	.8
South Dakota	2.5	1.2	1.3	[2]
Tennessee	17.1	8.3	8.8	1.4
Texas	78.0	37.9	40.1	8.7
Utah	2.7	1.3	1.4	.6
Vermont	2.0	1.0	1.0	.5
Virginia	4.3	2.1	2.2	1.7
Washington	21.5	10.4	11.1	16.8
West Virginia	5.8	2.8	3.0	1.7
Wisconsin	17.5	11.6	5.9	17.5
Wyoming	1.1	.5	.6	.5
Puerto Rico	7.6	3.7	3.9	
Virgin Islands	.2	.1	.1	[2]

[1] Includes medicare program expenditures for costs above $250 and public assistance program expenditures for costs up to $250 for an individual in a year.

[2] Less than $50,000.

TABLE 4.—*Change in annual expenditures for medical care for OAA recipients as a result of medicare proposal compared with present total assistance expenditures under OAA program, if all States participate in medicare, as of Jan. 1, 1960*

[In millions]

State	Total combined change resulting from medicare proposal (medicare and OAA program)			Change in OAA expenditures resulting from medicare proposal		
	Total	Federal	State-local	Total	Federal	State-local
U.S. total	$491.5	$290.4	$201.1	$55.0	$65.5	−$10.5
Alabama	25.2	16.6	8.6	10.3	6.7	3.6
Alaska	.5	.1	.4	.3	(1)	.3
Arizona	4.8	1.6	3.1	2.5	.3	2.1
Arkansas	12.5	8.3	4.2	4.6	3.0	1.6
California	82.2	20.2	62.0	28.3		28.3
Colorado	7.4	4.0	3.4	−.3		−.3
Connecticut		1.5	−1.4	−4.3		−4.3
Delaware	.4	.2	.2	.2	.1	.1
District of Columbia	1.0	.2	.8	.4	(1)	.4
Florida	20.6	11.7	8.9	8.9	5.3	3.6
Georgia	29.7	19.1	10.5	14.7	9.5	5.1
Hawaii	.3	.1	.2	.1	(1)	.1
Idaho	2.1	.7	1.4	.9		.9
Illinois		2.6	−2.6	−12.6	−2.4	−10.2
Indiana	1.9	.9	.9	−2.9	−1.5	−1.5
Iowa	7.4	2.8	4.6	2.5		2.5
Kansas	1.9	2.2	−.3	−2.1		−2.1
Kentucky	18.3	12.0	6.3	9.1	5.9	3.2
Louisiana	28.2	11.2	17.0	10.3		10.3
Maine	1.9	1.1	.8	(1)	(1)	(1)
Maryland	2.0	1.0	1.1	.3	.2	.2
Massachusetts		11.9	−11.9	−27.5		−27.5
Michigan	16.2	5.6	10.6	3.7		3.7
Minnesota	.1	6.9	−6.8	−15.1	−1.4	−13.7
Mississippi	22.3	14.8	7.6	11.4	7.5	4.0
Missouri	27.3	14.3	13.0	9.6	5.1	4.5
Montana	2.2	.7	1.5	1.1	.1	1.0
Nebraska		.5	−.4	−2.1	−.7	−1.3
Nevada	.7	.2	.5	.2		.2
New Hampshire		.6	−.6	−1.6	−.3	−1.3
New Jersey		1.6	−1.6	−4.2		−4.2
New Mexico	2.3	1.1	1.2	.5		.5
New York		11.3	−11.4	−30.3		−30.3
North Carolina	10.6	7.0	3.6	4.0	2.6	1.4
North Dakota		1.0	−1.1	−1.7		−1.7
Ohio	17.4	7.0	10.4	1.6		1.6
Oklahoma	14.0	7.8	7.1	1.9		1.9
Oregon	1.2	1.7	−.5	−2.1		−2.1
Pennsylvania	8.7	3.6	5.1	1.3		1.3
Rhode Island	1.1	.7	.4	−.4		−.4
South Carolina	7.2	4.8	2.5	3.3	2.2	1.2
South Dakota	2.4	1.1	1.3	1.2	.3	.9
Tennessee	15.7	10.3	5.4	7.4	4.8	2.6
Texas	69.3	40.6	28.7	31.4	19.3	12.1
Utah	2.1	.8	1.3	.8		.8
Vermont	1.6	.9	.6	.6	.3	.2
Virginia	2.7	1.6	1.1	.6	.4	.2
Washington	4.8	4.9	−.1	−5.6		−5.6
West Virginia	4.1	2.6	1.4	1.3	.8	.4
Wisconsin		3.4	−3.4	−11.6	−2.7	−8.9
Wyoming	.6	.3	.3	.1		.1
Puerto Rico	7.6	2.5	5.1	3.9		3.9
Virgin Islands	.2	.1	(1)	.1	(1)	(1)

[1] Less than $50,000.

TABLE 5.—*Total combined annual governmental expenditures under medicare and OAA programs for all participants aged 65 and over and resulting increase, by source of funds, over present total assistance expenditures for OAA recipients, if all States participate in Medicare, as of Jan. 1, 1960*

[Amounts in millions]

State	Combined expenditures for persons aged 65 and over—Medicare and OAA programs	Resulting increase over present total assistance expenditures for OAA recipients			
		Total	Federal	State-local	
				Amount	Percent of 1958 expenditures from State-local funds [1]
United States	$1,649.2	$1,284.7	$668.0	$616.7	1.5
Alabama	39.4	33.8	22.3	1.5	2.5
Alaska	.8	.8	.3	.5	[2]
Arizona	8.3	8.3	3.6	4.6	1.6
Arkansas	22.7	19.0	12.6	6.4	2.7
California	182.3	153.4	46.9	106.6	2.4
Colorado	21.7	13.1	7.0	6.2	1.4
Connecticut	25.0	17.2	7.2	10.1	1.3
Delaware	2.7	2.7	.9	1.7	1.3
District of Columbia	4.4	4.1	1.5	2.7	1.4
Florida	48.2	44.8	25.0	19.7	1.9
Georgia	40.3	39.1	25.2	13.9	2.1
Hawaii	2.0	1.9	.9	.9	[2]
Idaho	5.7	5.2	2.5	2.7	2.0
Illinois	79.6	52.4	23.3	29.1	1.2
Indiana	33.4	25.5	12.7	12.8	1.4
Iowa	23.1	20.4	10.2	10.2	1.7
Kansas	17.4	11.0	7.3	3.7	.7
Kentucky	31.6	30.9	20.4	10.6	2.5
Louisiana	41.9	33.3	14.4	18.9	2.3
Maine	9.3	7.3	4.2	3.1	1.7
Maryland	13.9	12.5	5.9	6.7	1.0
Massachusetts	80.5	35.3	27.1	8.1	.6
Michigan	66.2	56.7	23.8	32.8	1.6
Minnesota	40.5	16.7	15.9	.8	.1
Mississippi	27.5	27.5	18.3	9.3	3.3
Missouri	55.4	46.3	24.1	22.2	3.1
Montana	5.4	5.3	2.2	3.0	1.8
Nebraska	10.8	6.5	4.2	2.3	.8
Nevada	1.8	1.5	.5	1.0	1.2
New Hampshire	6.1	3.6	2.5	1.1	.9
New Jersey	38.6	31.0	13.5	17.5	1.3
New Mexico	5.5	4.1	2.2	1.9	1.1
New York	141.5	95.0	46.8	48.2	.9
North Carolina	25.0	22.0	14.6	7.4	1.1
North Dakota	4.7	2.0	2.3	−.3	−.2
Ohio	80.2	64.9	28.1	36.8	1.8
Oklahoma	33.8	21.9	12.0	10.0	2.1
Oregon	18.1	12.5	7.5	5.0	1.1
Pennsylvania	67.9	61.3	29.1	32.2	1.5
Rhode Island	9.4	7.5	3.8	3.7	2.1
South Carolina	12.6	11.8	7.8	4.0	1.2
South Dakota	5.1	5.1	2.8	2.2	1.5
Tennessee	28.3	26.9	17.7	9.2	1.7
Texas	104.6	95.9	55.5	40.4	2.2
Utah	5.5	4.9	2.4	2.5	1.3
Vermont	4.2	3.7	2.2	1.5	1.5
Virginia	15.3	13.6	7.9	5.7	.8
Washington	38.2	21.4	12.8	8.8	1.1
West Virginia	13.2	11.5	7.3	4.1	1.4
Wisconsin	37.1	19.6	13.7	5.9	.6
Wyoming	2.2	1.7	.9	.8	.9
Puerto Rico	9.9	9.9	4.0	5.9	[2]
Virgin Islands	.2	.2	.1	[3]	[2]

[1] Total expenditures from own funds, exclusive of revenues from the Federal Government, insurance trust expenditures and business enterprise expenditures. Percent for United States calculated exclusive of Alaska, Hawaii, Puerto Rico, and the Virgin Islands.

[2] Data on 1958 expenditures from State-local funds not available.

[3] Less than $50,000.

TABLE 6.—*Estimated taxable earnings of workers covered under the old-age, survivors and disability insurance program in 1960, and amounts obtained by applying specified percentages to these earnings, by State* [1]

[In millions]

State	Taxable earnings			1 percent of taxable wages plus ¼ percent of self-employment income	½ percent of taxable wages plus ⅜ percent of self-employment income
	Total	Wages and salaries	self-employment		
Total [2]	$210,000	$188,000	$22,000	$2,045.0	$1,022.5
Alabama	2,389	2,133	256	23.2	11.6
Alaska	202	187	15	2.0	1.0
Arizona	1,094	984	110	10.6	5.2
Arkansas	1,003	794	209	9.5	4.8
California	18,826	16,921	1,905	183.5	91.8
Colorado	1,616	1,361	255	15.5	7.8
Connecticut	3,677	3,393	284	36.0	18.0
Delaware	614	572	42	6.0	3.0
District of Columbia	967	912	55	9.5	4.8
Florida	3,855	3,363	492	37.3	18.6
Georgia	3,135	2,810	325	30.5	15.2
Hawaii	521	470	51	5.1	2.6
Idaho	633	490	143	6.0	3.0
Illinois	12,393	10,972	1,421	120.4	60.2
Indiana	8,548	7,923	625	83.9	42.0
Iowa	2,901	2,028	873	26.8	13.4
Kansas	2,154	1,722	432	20.4	10.2
Kentucky	2,179	1,821	358	20.9	10.4
Louisiana	2,170	1,918	252	21.1	10.6
Maine	920	815	105	9.0	4.5
Maryland	3,111	2,830	281	30.4	15.2
Massachusetts	6,448	5,975	473	63.3	31.6
Michigan	10,294	9,535	759	101.1	50.6
Minnesota	3,499	2,855	544	33.4	16.7
Mississippi	1,164	997	157	11.3	5.6
Missouri	4,954	4,304	660	48.0	24.0
Montana	684	527	157	6.5	3.2
Nebraska	1,483	1,051	432	13.7	6.8
Nevada	354	318	36	3.5	1.8
New Hampshire	675	608	67	6.6	3.3
New Jersey	7,765	7,078	687	76.0	38.0
New Mexico	670	575	95	6.5	3.2
New York	27,137	25,108	2,029	266.3	133.2
North Carolina	3,525	3,064	461	34.1	17.0
North Dakota	556	323	233	4.9	2.4
Ohio	12,736	11,752	984	124.9	62.4
Oklahoma	2,091	1,738	353	20.0	10.0
Oregon	2,025	1,763	262	19.6	9.8
Pennsylvania	14,939	13,704	1,235	146.3	73.2
Rhode Island	1,092	1,010	82	10.7	5.4
South Carolina	1,726	1,552	174	16.8	8.4
South Dakota	580	336	244	5.2	2.6
Tennessee	2,847	2,502	345	27.6	13.8
Texas	8,771	7,614	1,157	84.8	42.4
Utah	848	749	99	8.2	4.1
Vermont	411	358	53	4.0	2.0
Virginia	3,104	2,786	318	30.3	15.1
Washington	3,418	3,033	385	33.2	16.6
West Virginia	1,544	1,415	129	15.2	7.6
Wisconsin	4,805	4,148	657	46.4	23.2
Wyoming	319	255	64	3.1	1.6
Puerto Rico	560	503	57	5.4	2.7
Virgin Islands	19	18	1	.2	.1
Armed Forces	6,000	6,000	----------	60.0	30.0
Instrumentalities [3]	26	26	----------	.3	.1

[1] Preliminary; State represents place where workers are employed (with the exception of Armed Forces and instrumentalities shown separately).

[2] Includes earnings of employees in the Canal Zone and outside the United States, not shown separately.

[3] Represents instrumentalities operated by 2 or more States, such as bridges, waterways, tunnels, oil conservation operations, etc.

Source: U.S. Department of Health, Education, and Welfare, Social Security Administration, Bureau of Old-Age and Survivors Insurance, Division of Program Analysis, May 9, 1960.

The CHAIRMAN. Mr. Flemming, as I understand your statement, your plan is not a substitute for the House bill but is to supplement the House bill.

Secretary FLEMMING. That is correct, Mr. Chairman. As I indicated in my opening statement, the first part of my opening statement, we favor the title VI of the House bill.

The CHAIRMAN. You say it is desirable and, while there is some question whether the provisions in the bill would produce the intended results, it is probably worth trying. That is a kind of left-handed endorsement, is it not?

Secretary FLEMMING. Mr. Chairman, that does not refer to title VI. That part of my statement refers to a proposal that was entered in the present title II dealing with old age assistance, which is designed to provide an incentive to the States to step up their medical care program for those who are covered by old age assistance.

What follows, you will notice right after that, I talk about title VI, which is the provision in the House bill which establishes a new Federal-State grant-in-aid program.

I say:

> In view of the fact that this title would put States that take advantage of it in a better position to deal with illnesses incurred by low income aged persons, we favor its inclusion in the bill.

In other words, that is a flat statement of approval.

The CHAIRMAN. Does the administration favor the House bill in toto?

Secretary FLEMMING. Yes, Mr. Chairman.

The CHAIRMAN. Do you disagree with any part of the House bill?

Secretary FLEMMING. No, Mr. Chairman; there is none.

The CHAIRMAN. Your purpose then is to supplement the House bill—if the figures I have are correct, the House bill would cost the Federal Government $175 million a year, and will cost the States $164 million a year, aggregating $339 million. Your supplement, supplemental legislation, will cost $700 million to the Federal Government, and $675 million to the States, making a total cost of $1,700 million. Are those figures correct?

Secretary FLEMMING. Mr. Chairman, those figures are substantially correct. I should qualify them in this way: If the proposal that we have made should be put into effect, there would be some overlapping between that and title VI, and that would have the effect of reducing your overall total by some really unknown amount. I couldn't estimate just what the overlapping would be. I don't think we have made any estimate along that line but there would be some reduction.

The CHAIRMAN. The figures I have read are your own figures taken from your own statement.

Secretary FLEMMING. That is right. As I say, they were figures presented first for the program that I just outlined to you.

The CHAIRMAN. What you propose to do is to add to the total cost, Federal and State $1,400 million, to the $339 million as proposed in the House bill, is that correct?

Secretary FLEMMING. Just one moment. We propose to add to the $339 million——

The CHAIRMAN. Your proposal will cost the Federal Government and the States $1,400 million in addition to the House bill, which costs around $300 million. That makes a total cost of $1,700 million.

Secretary FLEMMING. Mr. Chairman, we estimated that the cost of our proposal would be $1.2 billion, and then added to that $100 million, because of a stepup in public assistance payments making a total of a billion three hundred million. That was our estimate of the total cost of our program.

The CHAIRMAN. Take a billion three.

Secretary FLEMMING. That is right.

The CHAIRMAN. And add to it $339 million as proposed under the House bill.

Secretary FLEMMING. That's right; that would give you a billion six hundred and thirty-nine. And as I indicate there would probably be some overlapping there so that we could, I think, round that figure out at a billion six.

The CHAIRMAN. Does the administration favor an increase to the extent of one billion three above the House bill, does the Budget Director favor it?

Secretary FLEMMING. Mr. Chairman, as I know you appreciate, the billion three represents the total Federal-State costs.

The CHAIRMAN. I understand that but in order to pay—wait 1 minute.

Secretary FLEMMING. Yes.

The CHAIRMAN. In order to avail themselves, the States in order to avail themselves, they will have to increase their taxes.

Secretary FLEMMING. That is correct.

The CHAIRMAN. $800-some-million; that is correct, is it not?

Secretary FLEMMING. Approximately, that is right.

The CHAIRMAN. Then the Federal Government must get $800 million from some source.

Secretary FLEMMING. That is correct.

The CHAIRMAN. That must come from current tax revenue or from borrowing. There is this talk about a 1961 surplus which, in my judgment, has no basis in fact. This money has got to be either borrowed funds or current tax revenue. Does the administration, or the Budget Director, approve this proposal?

Secretary FLEMMING. The plan which I have just outlined to you is the plan that I outlined to the House Ways and Means Committee with the complete support of the administration.

The CHAIRMAN. Did the Budget Director approve it?

Secretary FLEMMING. Well, he testified to that effect before the House Ways and Means Committee.

The CHAIRMAN. Did he affirmatively approve it or not?

Secretary FLEMMING. Well, of course, he can be the best witness on that. All I know is that when I presented it to the Ways and Means Committee I had the complete support of the administration in presenting it.

The CHAIRMAN. Does that include the Budget Director?

Secretary FLEMMING. The Budget Director is a part of the administration, Mr. Chairman.

The CHAIRMAN. Has he affirmatively approved it?

Secretary FLEMMING. Mr. Chairman, he testified before the Ways and Means Committee and I don't want to interpret his testimony. It is available and should be read.

The CHAIRMAN. But you said it has the complete approval of all the administration, beginning with the President and running down; is that correct?

Secretary FLEMMING. Mr. Chairman, when I talk about the approval of the administration, of course, I would not come up and present a program of that kind without the approval of the President of the United States, and he is the only person who can set administration policy. No one else can set it.

The CHAIRMAN. Has the Budget Director affirmatively approved it? [Laughter.] That is a fair question.

Secretary FLEMMING. I can only testify——

The CHAIRMAN. The Budget Director represents the administration in matters of expenditures does he not?

Secretary FLEMMING. The President represents the administration, and the President——

The CHAIRMAN. Do you want us to call the President down here before the committee?

Secretary FLEMMING. Well, Mr. Chairman, I would not have presented the program to the House Ways and Means Committee without the approval of the President of the United States.

The CHAIRMAN. I have asked you a simple question——

Secretary FLEMMING. That is the administration.

The CHAIRMAN. I have asked you a simple question: Does the Budget Director affirmatively approve this increase in expenditures?

Secretary FLEMMING. I cannot testify for the Budget Director, Mr. Chairman, and I don't think it is fair to ask me to do it.

The CHAIRMAN. He has testified at different times and you have talked to him, have you not?

Secretary FLEMMING. I don't think it is fair for me to interpret the views of the Budget Director. He testified before the Ways and Means Committee. I was not there. I have not read it but I am sure the Ways and Means Committee will make it available to this committee.

The CHAIRMAN. Have you ever discussed it with the Budget Director?

Secretary FLEMMING. There were a lot of discussions on this.

The CHAIRMAN. Did he approve it?

Secretary FLEMMING. I am not in a position to speak for him.

The CHAIRMAN. Why is there any secrecy about what the Budget Director says?

Secretary FLEMMING. I am not in a position to speak for the Budget Director. I can only speak for myself and for the position of the administration.

The CHAIRMAN. Do you have a list showing the burden that is going to fall upon the States under your proposal?

Secretary FLEMMING. Pardon me?

The CHAIRMAN. Do you have a list showing what each State will have to raise in the form of taxes to meet the provisions of your proposal?

Secretary FLEMMING. Just one moment. I have a table here which I think covers the point which you have in mind.

The CHAIRMAN. I want to say you are the first witness we have had before this committee who has not been willing to say "Yes" or "No" on how the Budget Director stands. We shall be forced to call the Budget Director and get that information direct from him.

Secretary FLEMMING. Well, Mr. Chairman, I certainly don't want to be in a position of not cooperating with you on a matter of this type.

The CHAIRMAN. Mr. Flemming, the Budget Director has stated his position one way or the other in all these conferences, has he not?

Secretary FLEMMING. He participated in it but I don't think it is fair for me to present to a committee of Congress the views expressed by my colleagues on matters that were under discussion in the executive branch after the President has made a decision. As you know, if I had certain views on a matter, and the President made a decision, which was not in complete conformity with my views, I would be up here defending not my views but the views of the President of the United States. He is the only elective officer in the executive branch.

The CHAIRMAN. Is there any secret about how the Budget Director stands? You have talked to him about it; he has been in all these conferences. Is he for it or against it?

Secretary FLEMMING. Mr. Chairman, he has testified in favor of the administration proposal before the Ways and Means Committee, according to my understanding. I was not there——

The CHAIRMAN. He testified affirmatively?

Secretary FLEMMING. That is my understanding. I was not there but——

The CHAIRMAN. Why didn't you say so in the first instance?

Secretary FLEMMING. Well, I did say it in the first instance, but I wasn't there. Mr. Chairman, I don't want to be in a position of saying that the——

The CHAIRMAN. In other words you are not at liberty to state anything that occurred in conferences between you and the Budget Director; is that correct?

Secretary FLEMMING. After the President has made a decision.

The CHAIRMAN. Well, you are aware of the fact that practically every bill that is submitted by congressional committees to the different departments of Government comes back with a statement as to whether the Budget Director approves it. You know that, don't you?

Secretary FLEMMING. But he speaks in behalf of the President, and what he sends up here is in behalf of the President, and there are some matters that are so important that the policy decisions as to whether or not the administration favors or is not in favor is a policy decision that is made by the President, and in this particular instance——

The CHAIRMAN. You think it is important that you can't give definitely the position of the Budget Director as to the money involved?

Secretary FLEMMING. As to what?

The CHAIRMAN. As to the amount of money involved. Do you think that should not be disclosed here because it is so important?

Secretary FLEMMING. No.

The CHAIRMAN. How is it important?

Secretary FLEMMING. Mr. Chairman, all I am saying——

The CHAIRMAN. Let's leave that, I see you don't intend to answer.

Secretary FLEMMING. All I am saying is that I think the views of the Budget Director—he obviously is the best witness about that.

The CHAIRMAN. We'll have the Budget Director, so you just forget about it. We don't need to ask any more questions, I see you are not going to answer them so we will leave it.

I want a breakdown showing how much each State has to pay.

Secretary FLEMMING. Mr. Chairman, I have a table here headed table 2, which is a total estimated annual expenditure by States.

The CHAIRMAN. Read it.

Secretary FLEMMING. If all States participate as of January 1, 1960.

The CHAIRMAN. Would you be so kind as to read it, I would like to hear it.

Secretary FLEMMING. Mr. Chairman, do you want me to take it—you want me to take each State?

The CHAIRMAN. I am talking about the amount of money that the States are required to raise under the House bill, plus the amount of money they are required to raise under your bill.

Senator GORE. Mr. Chairman, before, if I may interrupt, since the Secretary is testifying on the administration proposal, I wonder if we might have a copy of it, the bill?

The CHAIRMAN. I don't think it has been introduced.

Senator GORE. I will be glad to introduce it so it will be before the committee.

Secretary FLEMMING. Mr. Chairman, I have a copy of the bill which I would be very glad to insert in the record at this point.

The CHAIRMAN. Without objection it will be inserted in the record.

(The draft referred to follows:)

A BILL To establish a Federal-State program under which aged individuals with low incomes may secure comprehensive protection against major medical expenses, and for other purposes

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled, That the Social Security Act is amended by adding at the end thereof the following new title:

"TITLE XVI—MEDICAL BENEFITS FOR THE AGED

"APPROPRIATION

"SEC. 1601. For the purpose of assisting the States to improve the health care of aged individuals with low incomes by enabling such individuals to secure, at low cost, protection against major medical expenses or, in the case of recipients of public assistance, to secure such protection without cost, there are hereby authorized to be appropriated for each fiscal year such sums as the Congress may determine. The sums made available under this section shall be used for making payments to States which have submitted, and had approved by the Secretary, State plans for medical benefits for the aged.

"STATE PLANS

"SEC. 1602 (a) The Secretary shall approve a State plan for medical benefits for the aged which—

"(1) provides for establishment or designation of a single State agency to administer or supervise the administration of the State plan;

"(2) provides that each eligible individual (as defined in section 1605(a)) who applies therefor (and only such an individual) shall be furnished whichever of the following he may elect:

"(A) medical benefits, which, for purposes of this title, shall consist of payment on behalf of an eligible individual of 80 per centum of the cost above the deductible amount incurred by him for the following services (hereinafter in this title referred to as 'medical services') rendered to him to the extent determined by the attending physician to be medically necessary (but subject to the limitations in section 1606):

"(i) inpatient hospital services for not to exceed 180 days in any enrollment year;

"(ii) skilled nursing-home services;

"(iii) physicians' services;

"(iv) outpatient hospital services;

"(v) organized home health care services;

"(vi) private duty nursing services;

"(vii) physical restorative services;

"(viii) dental treatment;

"(ix) laboratory and X-ray services not in excess of $200 in any enrollment year; and

"(x) prescribed drugs not in excess of $350 in any enrollment year; or

"(B) insurance benefits, which, for purposes of this title, shall consist of payment on behalf of such individual of one-half of the premiums of a major medical expense insurance policy for him up to a maximum payment of $60 for any year;

"(3) provides for granting an opportunity for a fair hearing before the State agency to any individual whose claim for benefits under the plan has been denied;

"(4) provides for payment by eligible individuals applying for medical benefits under the plan of enrollment fees equal (except as provided in section 1605(d)) to $2 per month, payable annually or more frequently, as the State may determine;

"(5) includes such methods of administration as are found by the Secretary to be necessary for the proper and efficient operation of the plan, including—

"(A) methods relating to the establishment and maintenance of personnel standards on a merit basis, except that the Secretary shall exercise no authority with respect to the selection, tenure of office, or compensation of any individual employed in accordance with such methods;

"(B) methods to assure that the applications of all individuals applying for benefits under the plan will be acted upon with reasonable promptness;

"(C) methods relating to collection of enrollment fees for medical benefits under the plan, except that the State may not utilize the services of any nonpublic agency or organization in the collection of such fees, and

"(D) methods for determining—

"(i) rates of payment for institutional services, and

"(ii) schedules of fees or rates of payment for other medical services,

for which expenditures are made under the plan;

"(6) sets forth criteria, not inconsistent with the provisions of this title, for approval by the State agency, for purposes of the plan, of major medical expense insurance policies;

"(7) provides for payment for his enrollment year of the deductible amount of any individual who is a recipient of public asistance for each month of such year, to the extent not already incurred and paid by him or on his behalf;

"(8) provides safeguards which restrict the use or disclosure of information concerning applicants for and recipients of benefits under the plan to purposes directly connected with the administration of the plan;

"(9) includes (A) provisions, conforming to regulations of the Secretary, with respect to the time within which individuals desiring benefits under the plan may elect between medical benefits or insurance benefits for any enrollment year and may apply for such benefits for such year and (B) to the extent required by regulations of the Secretary, provisions, conforming to such regulations, with respect to the furnishing of medical benefits under the plan to eligible individuals during temporary absences from the State;

"(10) provides for establishment or designation of a State authority or authorities which shall be responsible for establishing and maintaining standards for—

"(A) hospitals providing hospital services,

"(B) nursing homes providing skilled nursing home services, and

"(C) agencies providing organized home health care services,

for which expenditures are made under the plan; and

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

"(b) In the case of any individual who is a recipient of public assistance for each month of an enrollment year, the 80 per centum limitation in clause (2) of section 1602 and the requirement of payment of enrollment fees pursuant to clause (4) of such section shall not apply for such enrollment year. The Secretary shall prescribe regulations governing the extent to which such limitation and such requirement shall not apply, and the extent to which the deductible amount shall be paid on behalf of any individual who is a recipient of public assistance for only some of the months in his enrollment year.

"PAYMENTS

"SEC. 1603. (a) From the sums appropriated therefore, each State which has a plan approved under section 1602 shall be entitled to receive, for each calendar quarter, beginning with the quarter commencing July 1, 1961, an amount equal to (1) the Federal share for such State of the total amounts expended during such quarter by the State under the plan as medical or insurance benefits, plus (2) one-half of the total of the sums expended during such quarter as found necessary by the Secretary for the proper and efficient administration of the State plan.

"(b) Payment of the amounts due a State under subsection (a) shall be made in advance thereof on the basis of estimates made by the Secretary, with such adjustments as may be necessary on account of overpayments or underpayments during prior quarters; and such payments may be made in such installments as the Secretary may determine. Adjustments under the preceding sentence shall include decreases in estimates equal to the pro rata share to which the United States is equitably entitled, as determined by the Secretary, of the net amount recovered by the State or any political subdivision thereof, with respect to benefits furnished under the State plan, whether as the result of being subrogated to the rights of the recipient of the benefits against another person, or as the result of recovery by the recipient from such other person, or because such benefits were incorrectly furnished, or for any other reason.

"(c) For purposes of subsection (a) expenditures under a State plan in any calendar year shall be included only to the extent they exceed the amount of the enrollment fees collected in such year under the State plan in accordance with the provisions of section 1602(a)(4).

"OPERATION OF STATE PLANS

"SEC. 1604. If the Secretary, after reasonable notice and opportunity for hearing to the State agency administering or supervising the administration of any State plan which has been approved under section 1602, finds—

"(1) that the plan has been so changed that it no longer complies with the provisions of section 1602; or

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

the Secretary shall notify such State agency that further payments will not be made to the State (or, in his discretion, that payments will be limited to parts of

the State plan not affected by such failure) until the Secretary is satisfied that there is no longer any such noncompliance. Until he is so satisfied, no further payments shall be made to such State (or payments shall be limited to parts of the State plan not affected by such failure).

"ELIGIBLE INDIVIDUALS

"SEC. 1605. (a) For the purposes of this title, the term 'eligible individual' means, with respect to any enrollment year for any individual, an individual who—

"(1) (A) is 65 years of age or over,

"(B) resides in the State and at the beginning of such year, and

"(C) meets, with respect to such year, the income requirements of subsection (b); or

"(2) (A) resides in the State at the beginning of such year, (B) was an eligible individual for the preceding enrollment year, and (C) paid enrollment fees under the plan for the preceding enrollment year, or had a major medical expense insurance policy and the State made payments under the State plan toward the cost of the premiums of the policy during such year, or was a recipient of public assistance for each month of such year.

"(b) For the purposes of this title, the income requirements of this subsection are met by any individual with respect to any enrollment year if, for his last taxable year (for purposes of the Federal income tax) ending before the beginning of such enrollment year,

"(1) he did not pay any income tax, or

"(2) (A) his income did not exceed $2,500 in the case of an individual who, at the beginning of such enrollment year, was unmarried or was not living with his spouse, or

"(B) the combined income of such individual and his spouse did not exceed $3,800 in the case of an individual who, at the beginning of such enrollment year, was married and living with his spouse.

"(c) The term 'income' as used in subsection (b) means the amount by which the gross income (within the meaning of the Internal Revenue Code of 1954) exceeds the deductions allowable in determining adjusted gross income under section 62 of such Code; except that the following items shall be included (as items of gross income):

"(1) monthly insurance benefits under title II of this Act,

"(2) monthly benefits under the Railroad Retirement Acts of 1935 and 1937, and

"(3) veterans' pensions.

Determinations under this section shall be made (in the manner prescribed by the Secretary by regulations) by or under the supervision of the State agency administering or supervising the administration of the plan approved under section 1602.

"(d) In the case of any individual who would not be an eligible individual with respect to an enrollment year but for the provisions of subparagraph (2) of subsection (a), the enrollment fee for such individual for such enrollment year shall be increased (over the $2 per month specified in sec. 1602 (a) (4)) by the amount appearing in column II of the following table on the line on which is included in column I A or column I B, whichever is applicable to him, the amount by which his income for his last taxable year exceeds the income specified for him in subsecttion (b) (2):

I			
A If the individual was at the beginning of his enrollment year unmarried or not living with his spouse and his income for his last taxable year exceeds the amount specified for him in subsection (b)(2)(A) by—	or	B If the individual was at the beginning of his enrollment year married and living with his spouse and the combined income of of such individual and his spouse for his last taxable year exceeds the amount specified for him in subsection (b)(2)(B) by—	II. The increase in monthly enrollment fee shall be—
1. Not more than $500		Not more than $750	None
2. More than $500, but not more than $1,000		More than $750, but not more than $1,500	$1.00
3. More than $1,000 but not more than $1,500		More than $1,500, but not more than $2,250	3.00
4. More than $1,500, but not more than $2,000		More than $2,250, but not more than $3,000	6.00
5. More than $2,000, but not more than $2,500		More than $3,000, but not more than $3,750	10.00
6. More than $2,500		More than $3,750	15.00

The applicable amount in column II of the above table for any individual shall be reduced to the extent that it, plus the enrollment fee specified in section 602(a)(4), exceeds for such State the average monthly cost of medical benefits per individual covered under the plan, as determined by the State agency (administering or supervising the administration of the plan approved under section 1602) in accordance with regulations of the Secretary.

"MEDICAL SERVICES

"SEC. 1606. Subject to regulations of the Secretary—

"(a) The term 'medical services' does not include—

"(1) services for any individual who is an inmate of a public institution (except as a patient in a medical institution) or any individual who is a patient in an institution for tuberculosis or mental diseases; or

"(2) services for any individual who is a patient in a medical institution as a result of a diagnosis of tuberculosis or psychosis, with respect to any period after the individual has been a patient in such an institution, as a result of such diagnosis, for forty-two days.

"(b) The term 'inpatient hospital services' means the following items furnished to an inpatient by a hospital:

"(1) Bed and board, at a rate not in excess of the rate for semiprivate accommodations);

"(2) Physicians' services, nursing services, and interns' services; and

"(3) Laboratory and X-ray services, ambulance services, and other services, drugs, and appliances related to his care and treatment (whether furnished directly by the hospital or, by arrangement, through other persons).

"(c) The term 'skilled nursing-home services' means the following items furnished to an inpatient in a nursing home:

"(1) Skilled nursing care provided by a registered professional nurse or a licensed practical nurse which is prescribed by, or performed under the general direction of, a physician;

"(2) Medical care and other services related to such skilled nursing care; and

"(3) Bed and board in connection with the furnishing of such skilled nursing care.

"(d) The term 'physician's services' means services provided in the exercise of his profession in any State by a physician licensed in such State; and the term 'physician' includes a physician within the meaning of section 1101(a)(7).

"(e) The term 'outpatient hospital services' means medical and surgical care furnished by a hospital to an individual as an outpatient.

"(f) The term 'organized home health care services' means (1) visiting nurse services and physician's services, and services related thereto, which are prescribed by a physician and are provided in a home through a public or private nonprofit agency operated in accordance with medical policies established by one or more physicians (who are responsible for supervising the execution of such policies) to govern such services; and (2) homemaker services of a nonmedical nature which are prescribed by a physician and are provided, through a public or private nonprofit agency, in the home to a person who is in need of and in receipt of other medical services.

"(g) The term 'private duty nursing services' means nursing care provided in the home by a registered professional nurse or licensed practical nurse, under the general direction of a physician, to a patient requiring nursing care on a full-time basis, or provided by such a nurse under such direction to a patient in a hospital who requires nursing care on a full-time basis.

"(h) The term 'physical restorative services' means services prescribed by a physician for the treatment of disease or injury by physical nonmedical means, including retraining for the loss of speech.

"(i) The term 'dental treatment' means services provided by a dentist, in the exercise of his profession, with respect to a condition of an individual's teeth, oral cavity, or associated parts which has affected, or may affect, his general health. As used in the preceding sentence, the term 'dentist' means a person licensed to practice dentistry or dental surgery in the State where the services are provided.

"(j) The term 'laboratory and X-ray services' includes only such services prescribed by a physician.

"(k) The term 'prescribed drugs' means medicines which are prescribed by a physician.

"(l) The term 'hospital' means a hospital (other than a mental or tuberculosis hospital) which is (1) a Federal hospital, (2) licensed as a hospital by the State in which it is located, or (3) in the case of a State hospital, approved by the licensing agency of the State.

"(m) The term 'nursing home' means a nursing home which is licensed as such by the State in which it is located, and which (1) is operated in connection with a hospital or (2) has medical policies established by one or more physicians (who are responsible for supervising the execution of such policies) to govern the skilled nursing care and related medical care and other services which it provides.

"MISCELLANEOUS DEFINITIONS

"SEC. 1607. For purposes of this title—

"Federal Share

"(a)(1) The 'Federal share' with respect to any State means 100 per centum less that percentage which bears the same ratio to 50 per centum as the per capita income of such State bears to the per capita income of the United States, except that (A) the Federal share shall in no case be less than 33⅓ per centum nor more than 66⅔ per centum, and (B) the Federal share with respect to Puerto Rico, the Virgin Islands, and Guam shall be 66⅔ per centum.

"(2) The Federal share for each State shall be promulgated by the Secretary between July 1 and August 31 of each even-numbered year, on the basis of the average per capita income of each State and of the United States for the three most recent calendar years for which satisfactory data are available from the Department of Commerce. Such promulgation shall be conclusive for each of the eight quarters in the period beginning July 1 next succeeding such promulgations.

"(3) The term 'United States' means the fifty States and the District of Columbia.

"(4) Promulgations made before satisfactory data are available from the Department of Commerce for a full year on the per capita income of Alaska shall prescribe a Federal percentage for Alaska of 50 per centum and, for purposes of such promulgations, Alaska shall not be included as part of the 'United States'. Promulgations made thereafter but before per capita income data for Alaska for a full three-year period are available from the Department of Commerce shall be based on satisfactory data available therefrom for Alaska for such one full year or, when such data are available for a two-year period, for such two years.

"Deductible Amount

"(b) The 'deductible amount' for any individual for any enrollment year means an amount equal to $250 of expenses for medical services (determined without regard to the limitations in clauses (i), (ix), and (x) of section 1602(a)(2)(A)) incurred in such year by or on behalf of such individual, whether he is married or single, except that, in the case of an individual who is married and living with his spouse at the beginning of his enrollment year, it shall be an amount equal to $400 of expenses for medical services (so determined) incurred in such year by or on behalf of such individual or his spouse for the care or treatment of either of them, but only if application of such $400 amount with respect to such individual and his spouse would result in payment under the plan of a larger share of the cost of their medical services incurred in such year.

"Enrollment Year

"(c) The term 'enrollment year' means, with respect to any individual, a period of twelve consecutive months as designated by the State agency for the purposes of this title in accordance with regulations prescribed by the Secretary. Subject to regulations prescribed by the Secretary, the State plan may permit the extension of an enrollment year in order to avoid hardship.

"Recipient of Public Assistance

"(d) The term 'recipient of public assistance' with respect to any month means an individual who—

"(1) receives old-age assistance, aid to dependent children, aid to the blind, or aid to the permanently and totally disabled for such month pursuant to a State plan approved under title I, IV, X, or XIV, as the case may be; or

"(2) would, upon application, receive old-age assistance for such month pursuant to a State plan approved until title I if an appropriate portion of the enrollment fees, the deductible amount, and the remainder of the cost of medical services (determined without regard to the limitations in clauses (i), (ix), and (x) of section 1602(a)(2)(A)) not met from expenditures under the State plan approved under this title were included in determining his need, and if such plan approved under title I contained no citizenship requirement and imposed no residence requirement which excluded any resident of the State.

"Major Medical Expense Insurance Policy

"(e) The term 'major medical expense insurance policy' means, with respect to any State, a policy offered by a private insurance organization licensed to do business in the State, which is approved by the State agency (administering or supervising the administration of the plan approved under section 1602), which is noncancelable except at the request of the insured individual or for failure to pay the premiums when due, which is available to all eligible individuals in the State, and which provides for payment of all or a portion of the costs, in excess of a deductible which is not less than $250 and not more than such amount as may be prescribed by the Secretary, of medical services and other health care (or such portion of such services and care as may be permitted in regulations of the Secretary).

"ADVISORY COUNCIL ON HEALTH INSURANCE

"SEC. 1608. (a) There shall be in the Department of Health, Education, and Welfare an Advisory Council on Medical Benefits for the Aged (hereinafter referred to as the 'Council') to advise the Secretary on matters relating to the general policies and administration of this title. The Secretary shall secure the advice of the Council before prescribing regulations under this title.

"(b) The Council shall consist of the Surgeon General of the Public Health Service and the Commissioner of Social Security, who shall be ex officio members (and one of whom shall from time to time be designated by the Secretary to serve as chairman), and twelve other persons, not otherwise in the employ of the United States, appointed by the Secretary without regard to the civil service laws. Four of the appointed members shall be selected from among representatives of various State or local government agencies concerned with the provision of health care or insurance against the costs thereof, four from among nongovernmental persons who are concerned with the provision of such care or with such insurance, and four from the general public, including consumers of health care.

"(c) Each member appointed by the Secretary shall hold office for a term of four years, except that (1) any member appointed to fill a vacancy occurring prior to the expiration of the term for which his predecessor was appointed shall be appointed for the remainder of such term, and (2) the terms of the members first taking office shall expire as follows: four shall expire two years after the date of the enactment of this title, four shall expire four years after such date, and four shall expire six years after such date, as designated by the Secretary at the time of appointment. None of the appointed members shall be eligible for reappointment within one year after the end of his preceding term.

"(d) Appointed members of the Council, while attending meetings or conferences of the Council, shall receive compensation at a rate fixed by the Secretary but not exceeding $50 a day, and while away from their homes or regular places of business they may be allowed travel expenses, including per diem in lieu of subsistence, as authorized by law (5 U.S.C. 73b–2) for persons in the Government service employed intermittently.

"(e)(1) Any appointed member of the Council is exempted, with respect to such appointment, from the operation of sections 281, 283, and 1914 of title 18 of the United States Code, and section 190 of the Revised Statutes (5 U.S.C. 99), except as otherwise specified in paragraph (2).

"(2) The exemption granted by paragraph (1) shall not extend—

"(A) to the receipt or payment of salary in connection with the appointee's Government service from any source other than the private employer of the appointee at the time of his appointment; or

"(B) during the period of such appointment, to the prosecution or participation in the prosecution, by any person so appointed, of any claim against the Government involving any matter with which such person, during such period, is or was directly connected by reason of such appointment."

PLANNING GRANTS TO STATES

SEC. 2. (a) For the purpose of assisting the States to make plans and initiate administrative arrangements preparatory to participation in the Federal-State program of medical benefits for the aged authorized by title XVI of the Social Security Act, there are hereby authorized to be appropriated for making grants to the States such sums as the Congress may determine.

(b) A grant under this section to any State shall be made only upon application therefor which is submitted by a State agency designated by the State to carry out the purpose of this section and is approved by the Secretary. Such grants for any State shall, subject to the provisions of subsection (c), be equal to 50 per centum of the cost of carrying out such purpose in accordance with such application.

(c) Payment of any grant under this section may be made in advance or by way of reimbursement, and in such installments, as the Secretary may determine. The aggregate amount paid to any State under this section shall not exceed $50,000.

(d) Appropriations pursuant to this section shall remain available for grants under this section only until the close of June 30, 1962; and any part of such a grant which has been paid to a State prior to the close of June 30, 1962, but has not been used or obligated by such State for carrying out the purpose of this section prior to the close of such date shall be returned to the United States.

MISCELLANEOUS AMENDMENTS

SEC. 3. (a) Effective with respect to payments for quarters beginning after June 30, 1961, paragraph (1) of section 1101(a) of the Social Security Act is amended by striking out "and XIV" and inserting in lieu thereof "XIV, and XVI".

(b) Section 6103(b) of the Internal Revenue Code of 1954 (relating to inspection of income tax returns by States) is amended by adding at the end thereof the following new paragraph:

"(3) STATE PLANS FOR MEDICAL BENEFITS FOR THE AGED.—All income returns filed with respect to the taxes imposed by chapters 1 and 2 (or copies thereof, if so prescribed by regulations made under this subsection) shall be open to inspection, by the State agency administering or supervising the administration of a State plan for medical benefits for the aged which has been approved under title XVI of the Social Security Act, if the inspection is for the purpose of administering such plan. The inspection shall be permitted only upon written request of the governor of such State, designating the representative of such State agency to make the inspection on behalf of such agency. The inspection shall be made in such manner, and at such times and places, as shall be prescribed by the Secretary or his delegate. Any information thus secured by any State agency may be used only for the administration of such State plan (whether by such State agency or by the agency or agencies which it supervises)."

SECRETARY

SEC. 4. As used in this Act and the amendments made thereby, the term "Secretary", unless the context otherwise requires, means the Secretary of Health, Education, and Welfare.

(NOTE.—This proposal was subsequently introduced in the Senate as bill S. 3784, by Senator Leverett Saltonstall.)

Senator SMATHERS. I wonder do you have a copy of this list of States, the costs for each State?

Secretary FLEMMING. Yes.

Senator SMATHERS. Do you have a copy for all members?

The CHAIRMAN. If you will read those figures, I want to know whether they include, the amount that must be raised under the House bill and the amount that must be raised under the administration bill on the part of the States.

Secretary FLEMMING. Mr. Chairman, as soon as a copy is put in front of you I will do so.

The CHAIRMAN. Has the administration requested that this legislation be introduced by a Senator or Congressman?

Secretary FLEMMING. Not as yet, because, Mr. Chairman, as you know—when this was presented to the Ways and Means Committee they were holding a series of executive sessions over a period of about 10 weeks, and we presented this to them for consideration along with other matters that they were considering.

The CHAIRMAN. It has not been introduced in either branch of the Congress?

Secretary FLEMMING. That is correct.

On table 2, you will notice at the head there it has got a projected total of a billion 229 million, and then first of all, the total amount that would be available for the present old-age assistance recipients because, of course, this would call for a step up in their benefits, of $436 million. And then others of $793 million. And then the source of funds, $602 million Federal, $627 million State and local, and enrollment fees $181,700,000.

Then we have taken that by State. For example, Mr. Chairman, the State of Virginia the total would be 10 million, and as you will note there, $100,000, and, $13,100,000, with $2,100,000 on the OAA recipients, $11 million on the others and then the $13 million divided $7,800,000 Federal fund, $5,500,000 State funds.

The CHAIRMAN. On table 2 is that first column the amount of new money that the States must raise?

Secretary FLEMMING. No, that is the total amount of money that would be involved in this program. It is column 5 which shows the amount of new State money. That is the source of the funds, $627 million would come from State and local fund.

And then that is broken down by States, Virginia, for example, that would be $5.5 million.

Senator ANDERSON. Can you tell us how you determined how much a State has to pay?

I see Virginia has to pay $5 million as against the Federal Government's $7 million.

New York has to pay $78 million as against the Government's $46 million. Virginia has a little of the best of it, which the chairman would appreciate, but the rest of us would like to know how you get to it?

Secretary FLEMMING. As I indicated in my opening statement, Senator Anderson, it is an equalization formula with a range of one-third-two-thirds. That is one-third for the States with the largest income, and then two-thirds on the part of the Federal Government in the States with the lowest income.

Senator ANDERSON. Therefore, this would indicate there are more poor people in Virginia, doesn't it? Is that what it means in simple terms?

Secretary FLEMMING. This formula is worked out in exactly the same way that you would, not exactly the same way but on the same principle as you work out the distribution of public assistance funds.

The CHAIRMAN. I wish to ask one more question. Could the States under the administration proposal set up fee schedules for doctors and hospitals and standards of treatment?

Secretary FLEMMING. Yes, the fact of the matter is under our proposal it would be the State that would administer the program, and it would be necessary for them——

The CHAIRMAN. They could set up the fee schedule for doctors, fixing how much they may charge and how much the hospitals may charge.

Secretary FLEMMING. Just as they do now under the public assistance program, under the vendor payment provision of the public assistance program, that is going on in virtually all of the States at the present time and it is my understanding, Mr. Chairman, that it has been worked out in a completely satisfactory manner.

The CHAIRMAN. Senator Frear?

Senator FREAR. No questions.

The CHAIRMAN. Senator Carlson?

Senator CARLSON. Mr. Secretary, Senator Anderson raised a question that I think we ought to have some figures on. Those of us who are familiar with this program realize that some of the rural States, of course, have great numbers of their population that were never under the OASI program, never covered, and therefore we have more substantial numbers on the old-age assistance rolls and also probably more people that get benefits from low paid OASI payments and in addition to that are also on the old age assistance rolls. I would like very much for the record to have a breakdown by States of the numbers of individuals who are covered by the OASI and those that are receiving old-age assistance, and those that receive both.

I think that enters into this picture. Could you supply that for the record?

Secretary FLEMMING. Yes, without any difficulty at all, Senator Carlson. I would be very happy to do so.

(The following was later received for the record:)

Numbers of persons aged 65 and over receiving old-age, survivors, and disability insurance, old-age assistance, and both types of payments, specified dates [1]

State	Estimated number of OASDI aged beneficiaries, Dec. 31, 1959 [2]	Number of OAA recipients, February 1960 [3]	Number receiving both OAA and OASDI, February 1960 [3]
Total	10,074,750	2,368,197	675,622
Alabama	131,389	98,679	21,255
Alaska	3,067	1,448	527
Arizona	48,958	13,904	4,195
Arkansas	101,640	55,267	8,645
California	808,217	256,614	122,873
Colorado	84,480	47,315	18,530
Connecticut	165,242	14,492	6,389
Delaware	22,833	1,334	352
District of Columbia	33,607	3,124	862
Florida	326,567	69,481	22,534
Georgia	137,287	97,289	16,011
Hawaii	17,973	1,463	314
Idaho	37,341	7,344	2,310
Illinois	607,547	75,039	19,765
Indiana	298,786	27,418	6,974
Iowa	198,054	34,541	9,333
Kansas	140,621	28,797	6,960
Kentucky	168,897	56,399	10,643
Louisiana	101,642	124,818	35,970
Maine	72,797	11,829	4,533
Maryland	130,265	9,456	2,198
Massachusetts	374,906	80,125	39,060
Michigan	436,222	62,322	20,708
Minnesota	211,910	46,567	12,948
Mississippi	93,238	80,135	19,908
Missouri	288,149	117,165	34,427
Montana	40,579	6,982	2,226
Nebraska	97,973	15,093	3,469
Nevada	10,142	2,639	1,385
New Hampshire	46,286	4,916	1,790
New Jersey	378,913	18,821	6,447
New Mexico	24,501	10,847	1,936
New York	1,102,293	83,325	28,416
North Carolina	182,186	49,016	7,562
North Dakota	34,792	7,217	1,535
Ohio	566,943	87,556	26,392
Oklahoma	119,347	90,244	21,684
Oregon	125,032	17,191	6,070
Pennsylvania	739,871	50,113	13,579
Puerto Rico	50,089	39,611	34
Rhode Island	63,594	6,788	2,865
South Carolina	78,739	32,848	2,161
South Dakota	42,905	9,021	2,042
Tennessee	163,439	55,231	6,125
Texas	364,726	222,061	52,394
Utah	36,446	7,985	2,029
Vermont	28,144	5,678	1,981
Virginia	165,425	14,835	1,416
Washington	179,076	49,856	19,954
West Virginia	108,449	19,832	1,933
Wisconsin	267,938	34,810	10,763
Wyoming	15,287	3,326	1,210

[1] Does not include Guam and the Virgin Islands; complete data not available.

[2] Number of persons receiving old-age, wife's, husband's, widow's, widower's, and parent's benefits adjusted to exclude (1) women beneficiaries aged 62-64, (2) wife beneficiaries under age 62 with child beneficiaries in their care, and (3) duplicate counts for beneficiaries receiving both old-age and wife's or husband's benefits.

[3] For some States data are for month early in 1960 other than February.

Source: U.S. Department of Health, Education, and Welfare, Social Security Administration, Bureau of Public Assistance, Division of Program Statistics and Analysis, July 1, 1960.

Senator CARLSON. Isn't that a fair assumption that that situation would prevail?

Secretary FLEMMING. That is right.

Senator CARLSON. Then under any program that was covered through a social security program would we not have more individuals in some of what I call the rural States that would not be eligible for benefits, than under the proposal that you have submitted?

Secretary FLEMMING. I will ask Commissioner Mitchell to respond to that specific question because he is very familiar with it.

Mr. MITCHELL. The situation to which you refer, Senator, I think has been to a large extent overcome by extensions of coverage during recent years to farmworkers. Now there are large numbers of farmers, both farm operators and farmworkers, who are covered and who are in a benefit status. It is true, however, that there are a substantial number of people who are receiving old-age and survivors insurance benefits who also receive public assistance because the OASI benefit may be only a minimum, not sufficient to maintain the person and his family.

Senator CURTIS. Senator Carlson, if you will yield for just a brief question on that point, now I think it would discriminate against rural areas. The number of people who were old and not in the employment market or possibilities before OASI was extended to their group will be greater than those segments of our population which OASI was available to from the beginning, sir, isn't that correct?

Secretary FLEMMING. That certainly is true.

Senator CURTIS. So a rural area that is made up of farmers, employees of farmers, and small unincorporated family run businesses would have a higher percentage of people left out of a program geared to OASI and the recipients thereof than other areas, isn't that correct?

Secretary FLEMMING. I think that is a fair evaluation.

Senator CURTIS. Thank you.

Senator CARLSON. That is all, Mr. Chairman.

The CHAIRMAN. Mr. Flemming, one other point here.

Table 2 only shows money to be raised by the States totaling $627 million.

Now both of these bills—the House bill, plus your proposal as I understand it, would compel the States to raise nearly a billion. Where is the balance?

Secretary FLEMMING. As indicated here the amount to be raised by the State and local governments is $627 million. Now under title 6 of the House bill, as you indicated earlier, the State's share would be about $165 million, so that gives you a total of $792 million to be raised by the States.

I do not have a breakdown by States of the $165 million——

The CHAIRMAN. I just want to point out that table 2 is misleading. It does not include the total amount. It says $627 million. I asked

you for the amount of money the States would have to put up under the combination you propose and it runs to nearly a billion dollars.

Secretary FLEMMING. No, $792 million together.

The CHAIRMAN. Well, let's go over it again because I don't understand it and I want to get this right.

You confirm the fact that the House bill will require the States to raise the $64 million.

Secretary FLEMMING. That is correct.

The CHAIRMAN. You further confirm the fact that your administration proposal would require about $800 million?

Secretary FLEMMING. No; $627 million.

The CHAIRMAN. Well you have got an additional cost for old-age assistance and that is $75 million?

Secretary FLEMMING. Just one minute. I am sure we can come to an understanding. We are awfully close here. I have got $792 million, you see, as I thought—a few minutes ago I see you mentioned the additional assistance costs under our plan. Actually so far as the State is concerned it would not step up. It would be the Federal Government.

The CHAIRMAN. The House bill is $164 million, and your proposal is $675 million. That includes the additional costs for old-age assistance, medical care for $250 deduction of $75 million.

Secretary FLEMMING. The only difficulty there, Mr. Chairman, is you have included that additional $55 million as a State cost.

That would be a Federal cost, because actually the State public assistance would be reduced by about $10 million. So that does bring us to a total additional State cost, if you want to round it out, of just about $800 million.

The CHAIRMAN. All right, now the point I am making is, that table 2 does not show that. There it only shows $627 million.

Secretary FLEMMING. Yes, table 2, Mr. Chairman, deals only with the additional program on which I testified. It does not give a State by State breakdown of the title 6 of the House bill.

The CHAIRMAN. Have you got a table that does show that?

Secretary FLEMMING. It is—do you have the House report in front of you?

The report of the Ways and Means Committee?

The CHAIRMAN. I think you ought to have a table to show the total cost.

Secretary FLEMMING. Yes; I agree with you that it would be a good thing to telescope these two tables and we would be very glad to do that and furnish it for the record.

The CHAIRMAN. Will you submit it for the record, because you are recommending both the House bill and the administration bill; are you not?

Secretary FLEMMING. Yes.

The CHAIRMAN. There ought to be a table that shows the total costs for the States.

(The following was later received for the record:)

Estimated annual Federal and State-local costs under (a) proposed medicare program for the aged, (b) program of medical services for the aged (title XVI of Social Security Act, as added by title VI of H.R. 12580 and (c) improvement in medical services under the old-age assistance program arising from combined effect of proposed medicare program, proposed title XVI of Social Security Act, and proposed increase in Federal matching for medical services under old-age assistance in H.R. 12580

[All figures in millions]

State	Medicare program for the aged		Proposed title XVI (assuming medicare program in effect)		Additional OAA medical costs arising from medicare program and H.R. 12580 combined		Total increased costs for medical services for aged persons under medicare program and H.R. 12580 combined	
	Federal cost	State and local cost	Federal cost	State and local cost	Federal cost	State and local cost	Federal cost	State and local cost
United States	$602.5	$627.2	$122.9	$116.8	$74.3	−$19.3	$799.7	$724.7
Alabama	15.6	7.9	(1)	(1)	7.2	3.1	22.8	11.0
Alaska	.3	.2	(1)	(1)	(1)	.3	.3	.5
Arizona	3.3	2.5	(1)	(1)	.4	2.0	3.7	4.5
Arkansas	9.6	4.8	(1)	(1)	3.2	1.4	12.8	6.2
California	46.9	78.3	8.0	8.0	1.4	26.9	56.3	113.2
Colorado	7.0	6.5	.5	.4	(1)	−.3	7.5	6.6
Connecticut	7.2	14.4	4.7	4.7	(1)	−4.3	11.9	14.8
Delaware	.8	1.6	(1)	(1)	.1	.1	.9	1.7
District of Columbia	1.4	2.3	.1	.1	(1)	.4	1.5	2.8
Florida	19.7	16.1	.4	.3	5.7	3.2	25.8	19.6
Georgia	15.7	8.8	(1)	(1)	10.2	4.4	25.9	13.2
Guam	(1)	(1)	(1)	(1)	(1)	(1)	(1)	(1)
Hawaii	.9	.8	.1	.1	(1)	.1	1.0	1.0
Idaho	2.5	1.8	(1)	(1)	.1	.8	2.6	2.6
Illinois	25.7	39.3	13.9	13.9	−2.4	−10.2	37.2	43.0
Indiana	14.1	14.3	5.8	5.8	−1.5	−1.5	18.4	18.6
Iowa	10.2	7.7	.2	.1	.1	2.4	10.5	10.2
Kansas	7.3	5.8	1.7	1.1	---	−2.1	9.0	4.8
Kentucky	14.5	7.4	(1)	(1)	6.4	2.7	20.9	10.1
Louisiana	14.4	8.6	.1	.1	.5	9.8	15.0	18.5
Maine	4.2	3.1	.5	.3	(1)	(1)	4.7	3.4
Maryland	5.7	6.5	1.2	1.2	.2	.2	7.1	7.9
Massachusetts	27.1	35.6	9.2	9.2	---	−27.5	36.3	17.3
Michigan	23.8	29.1	3.2	3.2	.2	3.5	27.2	35.8
Minnesota	17.3	14.5	4.5	2.1	−1.4	−13.7	20.4	2.9
Mississippi	10.8	5.3	(1)	(1)	8.1	3.4	18.9	8.7
Missouri	19.0	17.7	.6	.5	5.6	4.0	25.2	22.2
Montana	2.2	2.0	(1)	(1)	.2	.9	2.4	2.9
Nebraska	4.9	3.6	1.5	.8	−.7	−1.3	5.7	3.1
Nevada	.5	.8	.1	.1	(1)	.2	.6	1.1
New Hampshire	2.8	2.4	1.0	.8	−.3	−1.3	3.5	1.9
New Jersey	13.5	21.7	9.7	9.7	---	−4.2	23.2	27.2
New Mexico	2.2	1.4	(1)	(1)	(1)	.5	2.2	1.9
New York	46.8	78.5	30.7	30.7	---	−30.3	77.5	78.9
North Carolina	12.0	6.0	.1	.1	2.8	1.2	14.9	7.3
North Dakota	2.3	1.4	.3	.2	---	−1.7	2.6	.1
Ohio	28.1	35.2	5.5	5.5	.1	1.5	33.7	42.2
Oklahoma	12.0	8.1	.1	.1	.1	1.8	12.2	10.0
Oregon	7.5	7.1	2.5	2.4	---	−2.1	10.0	7.4
Pennsylvania	29.1	30.9	4.7	4.7	.1	1.2	33.9	36.8
Puerto Rico	4.0	2.0	(1)	(1)	---	3.9	4.0	5.9
Rhode Island	3.8	4.1	1.2	1.2	---	−.4	5.0	4.9
South Carolina	5.6	2.8	(1)	(1)	2.4	1.0	8.0	3.8
South Dakota	2.5	1.3	(1)	(1)	.4	1.0	2.9	2.3
Tennessee	12.9	6.6	(1)	(1)	5.2	2.2	18.1	8.8
Texas	36.2	28.3	.2	.1	20.9	10.5	57.3	38.9
Utah	2.4	1.7	(1)	(1)	.1	.7	2.5	2.4
Vermont	1.9	1.3	.1	(1)	.3	.2	2.3	1.5
Virgin Islands	.1	(1)	(1)	(1)	(1)	(1)	.1	(1)
Virginia	7.6	5.5	.7	.4	.4	.2	8.7	6.1
Washington	12.8	14.4	3.6	3.6	---	−5.6	16.4	12.4
West Virginia	6.5	3.7	.1	.1	.9	.3	7.5	4.1
Wisconsin	16.4	14.8	5.6	4.7	−2.7	−8.9	19.3	10.6
Wyoming	.9	.7	.1	.1	(1)	.1	1.0	.9

[1] Less than $50,000.

NOTE.—The above figures relate to what the experience might be in the 1st full year of operation if all States developed plans and put them in full effect. Because of the many variations possible in State plans and participation under title VI of H.R. 12580 and in the participation of individuals in the medicare plans, the above figures should not be considered to be as precise as they appear to be.

Secretary FLEMMING. Mr. Chairman, the kind of a table that you are asking for will bring this out, but could I ask Mr. Myers to comment on the overlap that there would be between title 6 of the House bill and our program for the aged?

Mr. MYERS. Mr. Chairman, on this point, if both programs, that is title VI in the House bill and this medicare for the aged plan were introduced, the cost estimates that have been given are not fully additive since each one must be considered separately. However, if they were both introduced simultaneously, you would, of course, have the individual getting benefits under one program or the other so that it would not be correct to add the two together to get the total costs of the combined program. In other words, many individuals who would be aided under the House bill, would instead come under the medicare program which is more of a paid up, what you might say, insurance-type approach than the assistance-type approach in the title VI of the House bill. We would be very glad to prepare for you this combined table the result of which would be somewhat lower than the sum of the two separate tables.

The CHAIRMAN. Yes, but this committee should have the information as to how much the States are required to put up in new money.

Secretary FLEMMING. That's right.

The CHAIRMAN. And the table you have submitted here is about, how short is it a couple of hundred million, is it not, 200 million short?

Secretary FLEMMING. Well, you see, as the heading on the table indicates——

The CHAIRMAN. I don't care what the heading indicates.

Secretary FLEMMING. It is just the medicare program.

The CHAIRMAN. You gave the impression to the committee, or rather to me, that the total costs would be $627 million divided by the States. You read out Virginia, for instance, that is not the total.

Secretary FLEMMING. Mr. Chairman, when I presented this I thought I made it clear that I was presenting a table on the medicare program and that is what it clearly says. In addition to that there is, of course, whatever expense is involved in title 6 of the House bill, but as Mr. Myers indicated there is quite an overlap between the two, and we will be glad to prepare a table which telescopes the two and give you the overall figure.

The CHAIRMAN. I think your testimony, sir, is very confusing. You stated that you favored the House bill and you favor this bill as a supplement to the House bill, and now you say they overlap and you don't show us where they overlap.

So I think you had better come to the committee meeting at another time prepared to answer the questions we know have to be answered.

Secretary FLEMMING. Well, Mr. Chairman, all I am stating is a fact that they do overlap.

The CHAIRMAN. But you say you endorse both of them—you said you endorsed the House bill; didn't you?

Secretary FLEMMING. Yes; I certainly did.

The CHAIRMAN. And you said your own bill should be added, and now you say they overlap.

Secretary FLEMMING. Yes.

The CHAIRMAN. Are you proposing that we enact overlapping legislation?

Senator BUTLER. If it costs more money that way. [Laughter.]

Secretary FLEMMING. They only overlap, Mr. Chairman, in the sense that some people would come under one program and if they came under one program they wouldn't come under the other. That is all, and they would be dealing with different people.

The CHAIRMAN. Here we have an administration bill that no Senator or no Congressman has ever introduced. I don't know that I have ever known that to have happened before in my experience.

Senator BUTLER. Mr. Chairman, may I make an observation? The last time I sat in this chair at a public hearing I think it was the Secretary of the Treasury who sat where the Secretary, Mr. Flemming, is now sitting.

He explained to us the precarious position of the dollar.

He told us how necessary it was that we retrench and be saving and that we display complete fiscal responsibility. Now you come up and you want to spend $1,225 million per annum as a starter for a program that is local in nature and should be taken care of by the people in their local communities.

Secretary FLEMMING. Senator Butler, if I may correct the record on that, our proposal is not that the Federal Government spend $1,200 million. Our proposal is that the Federal Government spend $600 million and that the States and local communities spend $600 million.

We agree with you there is a responsibility that should be shared by the State and local governments, but we also feel that it is a matter in which the Federal Government should be a partner.

Senator BUTLER. I say to you, Mr. Secretary, this is not a matter that should be shared by the Federal Government. This is a matter that can be taken care of by self-reliant people in their local communities, if given a chance to do so.

Secretary FLEMMING. Well——

Senator BUTLER. I say there is lack of coordination here. The Secretary of the Treasury—I can't believe he would endorse this bill. How could he endorse this bill after coming here and telling us that the balance of payments are going against us, the dollar is becoming more precarious every day of the week?

The CHAIRMAN. It is $876 million. [Laughter.]

Senator BUTLER. It doesn't seem to make any difference what it is, just so it is money. I have never seen such fiscal irresponsibility.

Secretary FLEMMING. Senator Butler, I would like to comment on your comment.

Senator BUTLER. You certainly may do it.

Secretary FLEMMING. Well, I would like to say this: That I see no conflict between fiscal responsibility and the Federal Government accepting some responsibility for taking care of what is a very serious problem in this country at the present time. There is no reason at all why, if a program of this kind were put into operation, it would still not be possible to operate under a balanced budget.

It will require hard choices, but where the welfare of human beings is involved to the extent that it is in this particular instance, it seems to me that the country can well afford to decide to do something about

taking care of this problem, and taking care of this need may mean giving up something else or even increasing taxes in order to do it.

Senator BUTLER. Is the Secretary now telling this committee that this problem has not existed as long as we have been a Nation.

What makes it so pressing now when the dollar is in such a precarious position?

We need to save all the money we can. We need all the thrift we can muster. We need all the self-reliance that the people of this great country can put forth or you are going to have a situation where you are not going to be able to pay anybody anything.

Secretary FLEMMING. Senator Butler, I don't know whether you had the opportunity of examining the facts that I presented to the committee, dealing with the situation as far as the aged are concerned or not, but I do not think that anybody can examine those facts and arrive at the conclusion that fiscal considerations should be placed above human considerations but in my judgment——

Senator BUTLER. Does that mean the Government of the United States should spend unheedingly?

Secretary FLEMMING. No.

Senator BUTLER. What does it mean? Your statements don't hang together. If you don't pay any attention to finances, what then is the ultimate result?

Secretary FLEMMING. Senator Butler, as I indicated earlier, this Government could become involved in this kind of a program and still have a balanced budget.

Senator BUTLER. Does the Secretary honestly believe and now wants to tell this committee that this is the end rather than just the beginning of this program?

Secretary FLEMMING. No, I wouldn't say that.

Senator BUTLER. It is just the beginning.

Secretary FLEMMING. I wouldn't allege it is the end.

Senator BUTLER. Now tell us, it is but a modest beginning?

Secretary FLEMMING. No, I don't regard it as a modest beginning. I regard it as a very substantial contribution to the problem of dealing with long-term illness.

The fact remains, Senator, that at the present time the aged do not have the opportunity of obtaining protection against the heavy costs of long-term illnesses, and everybody knows that many of the aged are called upon to suffer as a result of that and, in many instances, their families are called upon to suffer as a result of that.

Now, it seems to me that this country has the resources to identify a situation of this kind and move in and do something about it, and at the same time adhere to a policy of fiscal responsibility.

I can assure you that the President would not have approved the submission of this program if he thought that it was in conflict with a policy of fiscal responsibility. He feels that it can be handled and handled within the framework of fiscal responsibility.

Senator BUTLER. I don't want to cross over the lines of authority. I don't want to ask any question of you that you feel you should not answer under executive privilege. But does the Secretary of the Treasury approve this program?

Secretary FLEMMING. I am not going to talk for other people in the executive branch other than the President who cleared it.

Senator BUTLER. Does the Budget Director—has the Budget Director cleared it?

Secretary FLEMMING. You were not here when I had a discussion with Senator Byrd on that. I told Senator Byrd and I will repeat it again, that it is my understanding, although I was not here—it was in a closed session and I have not read the transcript—it is my understanding that the Budget Director appeared before the Ways and Means Committee, and supported this proposal.

Senator BUTLER. He is going to have a lot of explaining on some other things to do to me because I can't believe it.

The CHAIRMAN. He didn't hear him say it. Have you seen the record of his testimony?

Secretary FLEMMING. I have not.

The CHAIRMAN. You have not seen the record and Senator Butler, he had numerous conferences with the Budget Director and was unwilling to say whether the Budget Director approved it or did not approve it in these conferences.

I want to make a statement and if it is incorrect I want you to show where it is incorrect.

This legislation, if passed, as you recommend, will cost the Federal Government $876 million. It will cost the States $840 million in 1 year, that means $1,716 million. It makes no difference to a taxpayer whether it comes out of the Federal taxes or State taxes. It all comes out of the taxpayer's pocket so this bill is a $1,716 million bill if it is made operative by the States matching it. Is that correct, or do you question that?

Secretary FLEMMING. No, if all of the States do come into the picture, I would be perfectly willing to accept that figure except for the allowance of overlap but I won't make any point on that because that wouldn't affect the bill materially.

Senator BUTLER. Mr. Secretary, do the local communities, the city governments make any contributions?

Secretary FLEMMING. There would be a State contribution.

Senator BUTLER. State only?

Secretary FLEMMING. That is correct, Senator Butler.

The CHAIRMAN. I would like you to put in the record a breakdown of this overlapping.

Secretary FLEMMING. I would be very happy to.

(NOTE.—See table supplied in response to earlier request of the chairman.)

The CHAIRMAN. As I understand it you are recommending both bills and now you state they overlap.

Senator SMATHERS. Mr. Secretary, first may I say that I wish to commend you on your statement with respect to the interest that you have in the medical needs of elderly people. Do you expect this bill to be passed at this session of the Congress?

Secretary FLEMMING. Well, Senator Smathers, I think the people on the other side of the table are in a better position to make that evaluation than I am.

Senator SMATHERS. I understand that completely but I am asking you. I think I understand the job we have to do here.

Secretary FLEMMING. I am a little bit confused.

Senator SMATHERS. I am asking you, Do you want this bill passed at this session?

Secretary FLEMMING. Well, certainly. I mean we recommended it to the Ways and Means Committee and we are recommending it to the Finance Committee just what we recommended to the Ways and Means Committee.

I personally would be delighted to see it passed at this session but as to what is going to happen, I am frank to say I am just a little bit confused at the present time as to what may emerge from the Congress.

Senator SMATHERS. You are not alone in being confused as to what is going to happen here in the Congress. I am just trying to get at the facts of the sincerity that you have for this program. Why was it that we didn't get this program here until so late?

Secretary FLEMMING. Well, let's see, I presented the program to the Ways and Means Committee in May. I spent off and on about 10 weeks in the Ways and Means Committee as they discussed this problem. There isn't any doubt at all that we had various points of view within the executive branch as to the best way of dealing with this matter, and it was not until May that those points of view were resolved, and I was put in the position to come up and present an administration proposal on it.

Like you, I gather from your question, I am sorry that it has taken our Government as long, including the executive and legislative branches, to come to grips with what I consider to be a very real and a very pressing need.

But as you know, there are a lot of points of view on this, and it isn't easy to get them resolved and in support of one way of doing it.

Senator SMATHERS. So it was late in May that the administration, as I understand it, decided to make this kind of a proposal to the Congress.

Secretary FLEMMING. I think it was—it was May 4.

Senator SMATHERS. May 4?

Secretary FLEMMING. That is correct, and my testimony at that time was made public by the Ways and Means Committee.

Senator SMATHERS. Do you have anybody out at the Governors' conference presenting this type of program to the Governors so that you might get some indication from them of its merit? They would be interested since their respective States would have to participate in it.

Secretary FLEMMING. We were not, so far as I know, invited to present this program or this issue to the Governors' conference. The Under Secretary of the Department has been out there presenting our plans for the White House Conference on the Aging, but that is the only thing we were invited to present.

Senator SMATHERS. Do you believe that you could probably acquire some support for this type of a program inasmuch as it is a Federal-State participation program if you got the Governors for it?

Secretary FLEMMING. Well, I am sure that any Governor would be reluctant to face the problems involved of taking on an additional fiscal responsibility at this time. I appreciate the problems that they are up against.

On the other hand, I do feel that this is something that should be shared by the Federal and State Governments. As you know, we have the responsibility for a good many Federal-State programs in our Department.

Senator SMATHERS. I understand that completely, Mr. Secretary, and I think you are absolutely right that there would be great reluctance. I am just curious as to how serious you people have been pushing this legislation toward the end of the session.

Did you go out there? Did you write somebody out there and ask them could you appear? Have you asked the Governors for their cooperation? It would obviously take their cooperation to make this type of a program work.

Secretary FLEMMING. The answer is that we did not request to go or to have this put on the agenda of the Governors' conference, possibly we missed a bet there but——

Senator SMATHERS. I am curious as to whether or not this proposal which the administration has evolved has arisen subsequent to the great discussion about the Forand and McNamara bill and other bills on the subject.

Secretary FLEMMING. I will try to be perfectly fair and frank about it. Of course, the discussion that has taken place regarding this particular issue, I think, has helped all of us get attention focused on the problem, but I want to say that the program that we have presented does represent the conviction of the administration as to the best way in which to deal with the problem. There is a very deep-seated conviction that it should be a joint sharing of responsibility on the part of the Federal and State Governments just as we do in the public assistance areas at the present time.

I tried to say earlier, Senator Smathers——

Senator SMATHERS. Do you recall prior to May 4 when you made a statement as to the need in this area that you or anyone else in the administration had made such a statement with respect to the fact the Federal Government should do something in the field of helping the medical indigent other than those who were under OAS?

Secretary FLEMMING. Yes, statements were made prior to that time to that effect. I also was before the Ways and Means Committee some time before that and indicated that we felt there was a very real need, and that we should endeavor to work out something.

I was before the Ways and Means Committee last July in which I also indicated a recognition of a very real need, and a feeling that something should be worked out in an effort to deal with this need more adequately than it is being dealt with at the present time.

Senator SMATHERS. But was that when you were called before the Ways and Means Committee to testify with respect to the Forand bill and the other bills of that nature?

Secretary FLEMMING. I testified—the Ways and Means Committee last July held hearings on the Forand bill.

Senator SMATHERS. That is when you made that statement?

Secretary FLEMMING. I certainly did, that is correct.

Senator SMATHERS. Now, Mr. Secretary, what has been the reaction of the American Medical Association to this proposal?

Secretary FLEMMING. Well, by reading the newspapers, I gather they don't like it.

Senator SMATHERS. Do you have any other information other than that of reading the newspapers as to what their position is?

Secretary FLEMMING. They have not sent me an official communication to that effect but I don't have any reason to question the accuracy of the reports that I have read.

Senator SMATHERS. Now, Mr. Secretary, let me refer you to your statement for just a moment, where you talk about the administration plan. In point No. 2 you say it should make available a system of comprehensive health and medical benefits which provide adequate protection against the cost of long-term and other expensive illnesses. How does your particular proposal, in brief, do that?

Secretary FLEMMING. I think probably the best way I can answer that is to give you an example.

Senator SMATHERS. All right.

Secretary FLEMMING. Let's assume that this plan is in effect in a particular State and let's assume that we are dealing with a woman in her seventies who has suffered a stroke. Now this identification of the treatment that she would receive was prepared for me by the Public Health Service doctors. We will assume she was in the hospital for 30 days which would represent a cost of $900, about $30 a day. We will assume she was in a skilled nursing home for 22 months.

Senator SMATHERS. Could we also eliminate one other assumption? This elderly lady, of course, is not on old-age assistance. In other words, she is not getting public assistance.

Secretary FLEMMING. No, not getting public assistance, that is right. She may be on OASDI.

Senator SMATHERS. Yes. Is she in the category where she first has to pay $24 before this?

Secretary FLEMMING. Yes, I am assuming this; that is right.

Senator SMATHERS. She is also in the category of having to pay the first $50 of her medical expense.

Secretary FLEMMING. That is correct.

Senator SMATHERS. All right.

Secretary FLEMMING. Skilled nursing home for 22 months at a cost of $5,280, private duty nurse used for 5 days 24 hours, and then the doctors' expense, total of $325, and drugs $100, making a total expenditure of $6,925.

Now under the program that we have recommended, the program would pay $5,140 of the total expense of $6,925; she would have to pay $1,833. I am assuming this is a 2-year illness, as you will notice, so that she would pay the deductible twice, that is $250 each year, a total of $500, and then, of course, she would pay 20 percent of the total expenditures. She would pay the fee for 2 years of $24 a year, which would be $48. Altogether, she would pay $1,833. The plan would pay her $5,140.

Mr. Chairman, that illustrates what I tried to emphasize in my testimony, namely, that our plan is designed to deal with the long-term illness, because, take under the Forand bill, just as another illustration—with this same illness, under the Forand bill the plan, that is the Government, would pay $1,620, and she would have to pay $5,305.

Under the McNamara bill that is before this committee at the present time, the plan would pay $3,350, and she would pay $3,575.

Now the reason, of course, is that both the Forand bill and the McNamara bill tend to place the emphasis on the first dollar costs of an illness, whereas the plan that we have presented places the emphasis on the cost of a long-term illness. For that reason, where a person is involved in an illness of this kind, our plan, as you can

see, would be extremely helpful. It would mean that the individual would receive $5,140 as against $3,350 under the McNamara plan, and $1,620 under the Forand plan.

Senator SMATHERS. Where you say the emphasis of these other two bills is on the payment of the first dollar and yours is on the payment of the long term, what happens to these people who are not on old-age assistance, but actually who can't pay these first dollars.

They are not indigent to the point where they have to be on public assistance but they are medically indigent. How could they even qualify for this particular proposal, if they could not pay $247 a year to start with?

Secretary FLEMMING. Well, of course, our feeling is that in many instances, either they themselves or through their families, could take care of the initial cost. Of course, if there was no possibility of their taking care of the initial cost, they would go on the old-age assistance program.

But we do feel that there are some insurance policies that are not too expensive that you can get to take care of initial first dollar costs. The real problem for many families comes in dealing with the long-term illness.

Senator SMATHERS. Mr. Secretary, I don't want to take all your time, these other Senators want to ask you questions but I want to ask you one other question: You say on page 12 it should provide private insurers with the opportunity of expanding their programs of extending health protection to the over-65 age group. How does your particular proposal do that?

Secretary FLEMMING. Just one moment. You will notice that we did put in as an optional benefit the opportunity for a person to elect to purchase from a private group a major medical expense insurance policy with the understanding that 50 percent of the costs would be paid for him from Federal-State matching funds up to a maximum of $60. And then, of course, we definitely do leave open, as our previous discussion indicates, the possibility of the insurance company or other private groups taking care of the initial costs, that is the first $250 of an illness. In other words, we think that this is a program that would make it possible to build on the progress that has been made by commercial companies and by nonprofit groups in insuring people in this area. Our feeling is that they have not as yet certainly done an adequate job by any means in making available protection for long-term illness.

Senator SMATHERS. Before you came to that conclusion, did you consider granting private insurance companies tax credits for losses that might be sustained from writing health policies?

Secretary FLEMMING. As we worked on our various plans, I think it is fair to say that that idea was not presented to us, at least not to my recollection. It may have been, but not to my recollection.

Senator SMATHERS. All right, sir.

Secretary FLEMMING. Mr. Chairman, and Senator Smathers, could I in response to one of your earlier questions, just to keep the record straight, point out as far as the attitude of the administration toward this problem is concerned, in all fairness to one of my predecessors, Mrs. Hobby, I should call attention to the fact that in 1954 the administration submitted what was known as a reinsurance bill. That

bill was designed to deal with certain aspects of this particular proposal. Also, I think that I should also call attention to the fact that last July, prior to the hearings on the Forand bill, again at the request of the Ways and Means Committee we did submit to that body a very comprehensive study of this whole area.

We did not make recommendations but we certainly indicated that very clearly there is a problem here that the country cannot continue to ignore.

Senator SMATHERS. You had been studying the problem.

Secretary FLEMMING. That is correct, and as I say, earlier, the administration actually submitted a proposal. I think this found its way, part way through the Congress but not all the way.

Senator SMATHERS. On reinsurance.

Secretary FLEMMING. That is correct.

Senator SMATHERS. Yes.

The CHAIRMAN. Senator Curtis?

Senator CURTIS. Mr. Secretary, referring to your presentation, this portion deals with the proposals involving OASI other than this question of medical health for the aged. There you discuss the costs and in general state that the anticipated revenue from the social security taxes, and by that I mean title 2, will in the future take care of the anticipated expenditures.

In arriving at that conclusion, what allowance, if any, did you make for the fact that the Congress might in the future increase benefits?

Secretary FLEMMING. None whatever. I mean these figures are based on the law as it would be if the bill that has been passed by the House should be passed by the Senate and concurred in by the President.

Senator KERR. Without amendment?

Secretary FLEMMING. That is correct.

Senator CURTIS. But the Congress has increased benefits often, usually just prior to election; have they not? That is not a sin of the administration; you have enough to answer for.

But the Congress should take responsibility for that. They have; have they not?

Secretary FLEMMING. They certainly have since 1950. [Laughter.]

Senator CURTIS. Now, in predicting that this social security system is financed adequately to take care of the future, what, if any, allowance have you taken for the possibiilty that Congress might freeze taxes if in a given period a surplus does accumulate?

Secretary FLEMMING. That Congress might——

Senator CURTIS. Freeze the taxes and prevent——

Secretary FLEMMING. In other words, not move forward as the law now provides.

Senator CURTIS. Yes.

Secretary FLEMMING. We did not make any allowance for that. We assumed that those schedules would go into effect in accordance with the law.

Senator CURTIS. But Congress has done that during the years social security has been in existence.

Secretary FLEMMING. Mr. Myers tells me in the forties not so far—not during the 1950's but they did during the 1940's.

Senator CURTIS. What I am trying to point out is that we have a political system here, not an actuarial system.

One more question with regard to those figures. What allowance, if any, in saying that this tax would be adequate for the future, have you made for continual inflation?

Secretary FLEMMING. I think I should ask Mr. Myers to respond to that as the actuary, because he is the person who works on these figures, as you know.

Mr. MYERS. Senator Curtis, in this respect, the cost estimates are based both on the law staying the same, and also on existing economic conditions remaining the same—in other words, the general earnings level staying the same. If in the future, earnings levels went up and the law stayed the same, the system would actually be in better financial condition, because the income from taxes (or the contributions) would go up more rapidly than the benefit disbursements would. Of course, if earnings change in the future, it is possible that the system would be amended. Accordingly, we have made what we call static estimates; we assume the law stays the same, and we assume that economic conditions stay the same as they are now.

Senator CURTIS. Thank you.

Now, Mr. Secretary, you say:

> The program would permit States to pay for the medical expenses of low-income aged persons who were not so needy as to require old age assistance but whose income and resources after taking into account amounts needed for current expenses are insufficient to meet their medical bills.

Would the Federal Government have the authority to pass on the financial eligibility of an individual applicant?

Secretary FLEMMING. The answer is no.

Senator CURTIS. That would be left to the States?

Secretary FLEMMING. Under title VI of the House bill, that would be left to the States.

Senator CURTIS. I might ask, and I am sure that Mr. Myers can give us a reasonably accurate estimate: In our old-age assistance program we permit the States to determine who is needy. There has been a great variance among the States. Of every 100 people over 65 in the State of Louisiana how many of them have been determined as needy and therefore eligible to old-age assistance and incidentally, I might say the level of benefits are such that the Federal Government pays about six-sixths of it. How many out of every person over 65 are on old-age assistance, the best estimate?

Secretary FLEMMING. Nearly 60 percent.

Senator CURTIS. Nearly 60 percent. Now how many out of every 100 people over 65 in the State of our distinguished chairman, Virginia, are on old-age assistance?

The CHAIRMAN. Why do you pick on Virginia? [Laughter.]

Senator CURTIS. I think the answer will reveal it.

Senator KERR. He will eventually get around to Nebraska and I think that will be fine. [Laughter.]

Secretary FLEMMING. About 10 percent or possibly a little less.

Senator CURTIS. In other words, six times as many people out of every 100 are determined to be needy in Louisiana, a State with great wealth, oil production, and so on, as there are in Virginia. Do you

know how—Senator Kerr has a keen sense of anticipation, about what is the figure in Nebraska? [Laughter.]

Secretary FLEMMING. Mr. Chairman, Senator Curtis, I am sure you will give us a chance to correct these for the record.

Senator CURTIS. I just want your best estimate.

Secretary FLEMMING. But between 15 and 20 percent.

Senator CURTIS. I would guess closer to 15. [Laughter.]

In other words, here is Nebraska, a poor State, not very much industry, practically no tourist business, no valuable minerals, and we administer our law and reach into the Federal Treasury to pay old-age assistance under a system that another State extends it to 4 times as many people out of every 100.

Now, under the Ways and Means Committee bill for payments to people who are financially in need but not on old-age assistance, are you going to prevent that disparity between States?

Secretary FLEMMING. Well, I think my answer to the first question that you asked along that line really answered this one, does it not? I mean, title VI of the House bill makes it possible for the States, within very broad language that is incorporated in the bill, to determine their own standards.

For example, a State, if they wanted to use an income test, for example, to determine who was eligible, one State might use $2,500 and another State might use $4,000, or another State might use $1,500.

Senator CURTIS. Then, coupled with that, you have also a variable—I don't say you—the House has a variable matching formula, has it not?

Secretary FLEMMING. That is correct. They use the same variable matching formula that is used now for public assistance, 50 to 65. That is for the last payments on public assistance.

Senator CURTIS. But as to the individual it is not graduated against the Federal Government on the payment the individual receives such as old-age assistance?

Secretary FLEMMING. That's right.

Senator CURTIS. That's all, Mr. Chairman.

Secretary FLEMMING. Mr. Chairman, just to—we now have what I think are firmer figures on your question.

Nebraska 10 percent, Louisiana 60 percent, Virginia 6 percent.

Senator CURTIS. You mean Louisiana is six times more adroit and effective in getting money out of the Federal Treasury than we poor people in Nebraska? I withdraw the question.

Secretary FLEMMING. OK.

Senator BUTLER. Mr. Chairman, a moment ago I sought to show that these programs start very modestly and then have a tendency to become very large.

An excellent example of that is provided by expenditures for public assistance programs.

At the time the Congress liberalized the old-age and survivors insurance program in 1950, we contemplated that expenditures for public assistance would ultimately decline.

The intent of the Congress is clearly revealed in the Report No. 1669 of this very committee dated May 16, 1950, which discussed

the amendments embodied in H.R. 6000, 81st Congress. It stated, and I quote:

> The committee-approved bill is designed to have the insurance program become the basic method for strengthening of old-age and survivors insurance will reduce the need for public assistance expenditures. The broad extension of coverage, the increase in benefits, and the liberalized eligibility requirements of the insurance program will decrease the number of people who will have to depend on the assistance programs.

That closes the quote from the report of this committee. This statement was made, as I have said in 1951, when budget expenditures for the total public assistance program totaled a billion 39 million dollars.

The 1961 budget estimate for this program submitted by President Eisenhower on January 18, 1960, proposed an expenditure of $2,087 million. In other words, although coverage has been extended, a program which was destined to decrease in importance doubled in size in a single decade. Now, Mr. Secretary, I say this should be a caution to this committee and maybe to yourself and the administration, that these programs may be very worthy, but when you embark upon them, even at a very modest way, before you know it, they will consume you.

Secretary FLEMMING. Senator Butler, I think the key observation in the report that you read was the observation that there was an expectation that the number of persons on old-age assistance would decline.

Senator BUTLER. That's right.

Secretary FLEMMING. Since I have been in office, I have noted with interest that the curve has been going down as far as the number of persons on old-age assistance is concerned. Now it is true that expenditures have risen, because the Congress has changed the payments structure from time to time, and of course, there is the factor of an expanding population when we look back over a period of 10 years.

But your increase in terms of numbers of persons on the assistance rolls has not come from old-age assistance. It has come from the aid to dependent children.

That figure has been moving up, but the number of persons on old-age assistance rolls has been moving down, and the reason it has been moving down, I think, very clearly is that the OASDI benefits have been extended to more and more persons, coverage has been extended and in addition, of course, the benefit schedule has been improved.

Senator BUTLER. But, Mr. Secretary, the point I make is this: Whenever you enter a new field, that field is always broadened, the requirements to become a member of the class included within the field are made easier, and the benefits are always increased. I call that to your attention.

Secretary FLEMMING. Senator Butler, I wouldn't deny that at all and I think as you consider the various approaches to this problem this has got to be taken into consideration.

I would like to say, however, that at that point, I am not a complete pessimist. As a result of my experience in Government, I do have confidence in our system of checks and balances. I know the cost curve is apt to be up, but when you consider the checks between the legisla-

tive branch itself, I don't think we have to assume it is going to get out from under control if we are dealing with a situation that is designed to meet a real need.

Senator BUTLER. But it has been my experience that those checks sometimes fail to materialize, people who were against this program 6 months ago are now for it. I don't understand that.

Secretary FLEMMING. But on balance, I still have confidence in the way in which our form of government operates in dealing with matters of this kind.

The CHAIRMAN. Senator Kerr.

Senator KERR. Mr. Secretary, I have a number of questions but I am going to yield the time to Senator Anderson who is next on our side here, if I may be permitted to address my questions to you in a communication and then you can answer them.

Secretary FLEMMING. I would be very happy to, Senator Kerr.

Senator KERR. Thank you.

(The letter which Senator Kerr subsequently wrote Secretary Flemming, and the reply made by Secretary Flemming, follow:)

JUNE 30, 1960.

Hon. ARTHUR S. FLEMMING,
Secretary, Department of Health, Education, and Welfare,
Washington, D.C.

MY DEAR MR. SECRETARY: May I first express my appreciation for your very informative statement before the committee on Wednesday, June 29, in connection with the proposed amendments to the Social Security Act now under consideration.

As I stated at the hearings, a few questions have arisen in my mind in connection with your remarks and I would appreciate it if you will supply me with the answers.

(1) On page 6 of the mimeographed copy of your remarks you state that the bill of the Committee on Ways and Means, in providing increased Federal participation to improve the old-age assistance medical programs, is pursuing a desirable objective and although "there is some question whether the provision in the bill would produce the intended result, it is probably worth trying." Why is there question as to whether the result will be so attained and what could be done to strengthen this provision?

(2) On page 9 of your statement you mention that about 4 million of the 16 million people now in our aged population are not covered by social security. How many of this 4 million are not covered by other Government pension or retirement programs—civil service, railroad retirement, veterans programs, State and local retirement systems, and the like? How many are on public assistance? Of the group not covered under any of these programs, how many are in need of health-care protection?

(3) Of the 12 million people you say would be eligible under the administration proposal, how many are under the social security (OASDI) system?

(4) What percent of payroll cost would be involved in providing the broad scope of benefits described in the administration's medicare program under the social security mechanism?

(5) On page 12 you state that all persons 65 and over would be eligible to participate if, in the preceding year, they did not pay an income tax or had, in the preceding year, adjusted gross income which did not exceed $2,500 ($3,000 for a couple). What provision is made for the individual in his first year of retirement?

(6) Will all services under the administration's proposal have to be determined as medically necessary by a physician?

Thanking you for this courtesy, and with best wishes, I am,

Sincerely yours,

ROBERT S. KERR.

THE SECRETARY OF HEALTH, EDUCATION, AND WELFARE,
Washington, July 11, 1960.

Hon. ROBERT S. KERR,
U.S. Senate, Washington, D.C.

DEAR SENATOR KERR: I am very happy to answer the questions stated in your letter of June 30. Briefly, my reply to each of them would be as follows:

Answer to question No. 1

The Ways and Means Committee apparently concluded that the only way to meet their concern that medical care programs under old-age assistance be improved in those States that are doing little or nothing in this area was to increase the rate of Federal participation in payments for this purpose. However, they were also concerned and we share their concern fully that the Federal share of public assistance payments not be made unduly high. They accordingly adopted a provision which would increase the Federal share by 5 percent in new expenditures of up to $5 a month for medical care. Thus, up to 25 cents of additional Federal funds per recipient over and above the normal Federal share would be provided. We are not sure that this amount represents a sufficient inducement to result in appreciable improvement in many of the States where such improvement is needed most. We do not, however, favor increasing the Federal share in public assistance payments and accordingly would not recommend that the provision in the House bill be increased.

Answer to question No. 2

Of the 4.3 million persons aged 65 and over not eligible for OASDI at the beginning of this year, more than one-third are protected by another public retirement program.

There are approximately 1.1 million persons aged 65 and over not eligible for OASDI who are receiving benefits under the Railroad Retirement Act, under the provisions of the Federal Civil Service Act, other programs for retired civilian and military personnel of the Federal Government, or retirement programs for State and local government employees.

Close to half a million other persons aged 65 and over are on the Veterans' Administration rolls receiving compensation or pension payments and not receiving payments under the OASDI, railroad retirement, or public employee retirement programs.

About 1.7 million are primarily dependent on public assistance.

There remain about 1 million aged persons with no protection under any public program. The great majority are widows 72 years of age or over. Some have considerable private resources, but many are supported by children with family responsibilities that would make it difficult for them to cover heavy medical bills for parents. As a whole, these persons would be in particular need of health protection through public means.

Answer to question No. 3

On the basis of such data as we have relating to the income of OASDI beneficiaries, we would guess that about 10 million of the 11.4 million persons aged 65 and over and eligible for OASDI would be eligible under the administration plan because they either pay no income tax or have adjusted gross incomes plus social security, railroad retirement, and veterans' benefits amounting to less than $2,500 ($3,800 for a couple) a year.

We do not have the detailed information with regard to amounts of income from different sources and for those eligible but not drawing benefits that would be required to make a precise estimate.

Answer to question No. 4

The estimated level premium cost, on an intermediate cost basis, of providing the benefits included in the administration's proposed program to persons eligible for OASDI benefits who are aged 65 and over is 1.09 percent of taxable payroll ($4,800 tax base).

Answer to question No. 5

The proposal which was discussed with your committee does not make any special provision for individuals in the year of retirement. It is reasonable to believe that up to the point of retirement employed persons will, in most instances, have both the resources and opportunity to secure health protection which would

carry over into retirement. While this is certainly not true in all cases, the advantages of an administratively simple test of eligibility, in our judgment, outweigh those of a more complex type of provision which would be necessitated if the year of retirement was given some kind of special treatment. Moreover, those whose income was less than $2,500 ($3,800 for a couple) would be eligible to participate in the program.

Answer to question No. 6

Benefits under the proposal would be available "for the following services * * * to the extent determined by the attending physician to be medically necessary."

If we can be of further help to you, please let me know.

Sincerely yours,

ARTHUR S. FLEMMING, *Secretary.*

Senator KERR. I want to say I am among those who feel that the suggestion you have brought to the committee, while I am not in the position to say to you as of this moment I am either for it or against it, I am one of those who is glad that you have brought it because it evidences great awakening generally everywhere of a need to recognize and meet a problem and certainly in my judgment, it contributes to the sum total of the knowledge that will be before the Congress and will be of help in assisting the Congress to evaluate the various suggestions which are before it in its sincere effort to find a proper solution to an actual and pressing problem.

Secretary FLEMMING. Thank you very much.

Senator KERR. I will now yield to the Senator from New Mexico.

Senator ANDERSON. Mr. Secretary, the table 2 which you presented indicates there is quite a difference in the way States contribute. Do you think the same factors which you have used to alter a little bit the amounts which States contribute in public assistance funds apply in this field properly?

For example, the State of New York will contribute $78 million against the Government's $46 million. The State of California will contribute $78.3 million against the Government's $46 million.

Those two States will put up a fourth, it comes out mathematically exactly one-fourth of the $627.2 millions.

Do you believe the burden is one-fourth in those two States?

Secretary FLEMMING. Well, Senator Anderson, I appreciate that this question of an equalization formula is certainly a debatable one and one on which good arguments could be advanced on both sides. This committee, of course, has given it very careful consideration in connection with public assistance.

Then just recently the Senate has passed a bill in the area of Federal assistance to education, and you included there an equalization formula that is really a 3 to 1 formula rather than a 2 to 1 formula. Certainly there has been a trend on the part of the Congress as we deal with these Federal-State programs to work into them the equalization formula.

Now personally I don't have certainly a dogmatic feeling relative to the exact nature of the formula and also relative to the various factors that should be taken into consideration. It has been suggested that in developing an equalization formula in this area you might very well take into consideration the percentage of aged in a State in relation to the total population of that State.

Senator ANDERSON. Precisely. I think that is what Senator Curtis was trying to get to.

That the equalization formula which you used in public assistance might be completely out of line in this field.

Secretary FLEMMING. I think that this is something that should be explored carefully and I think you can probably identify a series of factors that would be very relevant to this area, and that would probably make it work out better.

Senator ANDERSON. I assume from your testimony that the administration is opposed to any program which would be financed by payroll taxes.

Secretary FLEMMING. That is correct.

Senator ANDERSON. I ask that question because I hope to present to this committee at some stage of its deliberations a program based upon payroll taxes and it is the position of the administration that they are opposed to that.

Secretary FLEMMING. That is correct.

Senator ANDERSON. You suggest in your testimony that your program is better because it is determined by an income test as against a means test.

Do your people who are familiar with social work believe in this field an income test is preferable to a means test or a means test is preferable to an income test? How do they come on to this decision not to use a means test?

You recognize that a man who owns his home, and has $100 a month is given the same program as a man who has to pay rent, hasn't got a penny in the world, and who only has $100 a month. You put them on a parity where the burden of medical care is completely different from a man who has his own small investment in a home as compared to a man who has to rent.

Secretary FLEMMING. Senator Anderson, I would be the first one to agree that when you use an income test no matter how you try to refine it you do not do complete equity as between the persons who may be involved in a program.

But what we did was to balance over against that the problem of the administration of the program, the ease of administration, and also the possibility of a person being able to participate in a health insurance program without too much probing going on as to his actual resources.

In other words, we feel—we recognize that the cutoff point we have suggested, which is $2,500—$3,800 for a couple—based on an income test, is probably rough, but we felt that what you would gain administratively in terms of ease, speed of administration, would offset some of these other factors that you have identified.

I know, as you indicate, that you cannot do a completely equitable job except as you go to a means test and, of course, even then you don't do a completely equitable job but you come closer to it than under an income test. But considering that this is an insurance program, I think we are justified in using the income cutoff with the definition that we have suggested.

I am sure there will be differences on it within our own Department, and I am sure there are differences outside.

As you know, there have been strenuous objections to the application of a detailed means test in this area, and I am frank to say I am somewhat sympathetic with those objections.

Senator ANDERSON. Precisely, and that is why in the suggestion I hope to make to the committee I use a payroll test where neither a means nor income test is necessary.

I can only say that after some years as a relief administrator, WPA, NYA, and a few other things, I found that means tests and income tests are equally confusing.

Secretary FLEMMING. They are both problems. Our feeling is that it is not wise to abandon the concept completely as I indicated in my testimony.

Senator ANDERSON. Well, you allow social security payments to be made without a means test.

Secretary FLEMMING. That's right.

Senator ANDERSON. If you sought to abandon them completely for this other program, why not abandon it completely there?

Secretary FLEMMING. Well, we feel that the social security program as it is at the present time, is a wage related program in which the benefits are directly related to wages, whereas in a health care program for the first time you would be moving over into the service benefits area.

Senator ANDERSON. Would an expenditure of this $978 million, if the chairman's figures are correct and I have found him pretty accurate when it comes to counting dollars on expenditures, would that have a tendency to unbalance the budget?

Secretary FLEMMING. In my judgment, Senator Anderson, considering the size of our budget it would be possible to build an expenditure of that kind into the budget without throwing it out of balance. Of course, as you realize, it will take a few years before you would get up to an expenditure of $800 million. All States would have to be participating and be participating to the maximum.

But I think as a Nation we could certainly afford an expenditure ultimately of that amount of money in order to deal with this very pressing human problem.

Senator ANDERSON. Aren't all the State budgets becoming tighter and tighter with the years?

Secretary FLEMMING. I recognize that the State governments are finding it difficult to handle their fiscal situation. Of course, we recognize that it varies somewhat from State to State.

But our philosophy there, Senator Anderson, has been that here is a pressing human need, and we believe if the Federal Government puts up the kind of an attractive package that is incorporated in our program, that the States should be responsive to this need, and will come in and work out ways and means of matching. We think, as you consider governmental expenditures generally, that this kind of an expenditure is entitled to a high priority in the thinking of a State legislature as well as in the thinking of the Federal Government.

Senator ANDERSON. Well, there are many high priorities in these States now. The State of Michigan had some budget troubles a short time ago, as I recall. This would add $30 million a year to the State's budget. Could that be lightly taken by a State legislature?

Secretary FLEMMING. Not lightly by any means, but I do feel that——

Senator ANDERSON. $78 million to the State of California, that is why I am asking you why you have abandoned the payroll tax ap-

proach which does not involve the existing budgets of the already hard-pressed States?

Secretary FLEMMING. Well, I tried to indicate in my testimony our feeling that we certainly should give very careful consideration before we put the benefits that are now provided under the social security system into competition with the kind of benefits that would be incorporated in this kind of a program. It is altogether possible that we would find that the possibilities under the payroll tax are not limitless, and we felt that on balance, considering the fact that these are service benefits, that it is fairer to finance them out of general revenues. Certainly as far as the Federal Government is concerned it means that they would be financed by relying to a very large degree on the progressive income tax. We think that that is a fairer thing to do than it is to throw half of the burden on earnings of $4,800 or less.

I have just responded to a line of questioning as to whether or not there are apt to be increases in the benefits that are provided today for retirement, disability, and survivors under the present OASDI. I think probably all of us would agree that there will be such improvements in that benefit structure.

Now, if we build into it a health insurance program, I know it is not going to stop at whatever point we start. Of course we will improve the benefits and of course we will probably adjust the age requirements as time goes on.

If you put these into competition with one another, it seems one of two things happen. Either you get your payroll tax up so high that you get a revolt and get it frozen to a certain extent. Or, in order to take care of improving your health benefits you don't do what you feel should be done on the retirement, the disability or the survivors benefits. It is our feeling it is better to take care of this out of the general revenues, where I think you have got a fairer tax structure, when you are considering service benefits of this kind. You place more of a burden on those in the upper income brackets than you do on those in the lower income brackets, whereas under social security you put a very heavy burden on the lower income bracket.

Senator ANDERSON. I would only challenge your feeling that it is easier to get money by increasing the already high accelerated income taxes than it is to get it by a payroll tax. I don't try to pit my experience in this field against yours, but I would suggest that in 1936 we were having discussions of social security and how it might be set up. There were many predictions then and many predictions on the floor of Congress that these payroll taxes were way too high as initially established. Now they are far beyond it, and there is less argument about it now than there was in 1936.

And therefore I feel if you are going to try to have any type of medical care program, it is going to be easier to finance out of a payroll tax than it is out of another burden on the already overburdened States and the already difficult situation with the Federal budget. The chairman of this committee knows that there was quite a little sentiment in the Senate of the United States to get rid of some of the taxes we now have, telegraph, telephone, transportation, and to put some additional burdens on such as repeal of the dividend credit. There was a great plea made that these people who are already so

heavily taxed had to have the dividend credit in order to live and you feel that an increase in that income tax would be easy to accomplish. I couldn't agree with you less.

Secretary FLEMMING. Senator, I think you and I would agree on this, I am sure, that our Nation is wealthy enough and has enough resources to assure adequate medical care for its aging. Then comes the question of how we finance it.

Now I think that we can't overlook the fact that the payroll tax is also a tax on the economy. If the payroll tax is increased for this particular purpose, it will take revenue out of every State in the country, and this, in turn, will have some effect certainly on what the State is able to do with its own tax structure, what it is able to take out of its people in addition.

So that it seems to me that we agree that as a Nation we can afford to take care of these problems that confront us at the present time.

Then comes the question, What is the best way of doing it? Either way we are taking it out of people. I mean it is an additional tax burden on people.

I just have the feeling it is a little bit fairer to use the progressive income tax than it is to throw so much of the burden on these low earnings of $4,800 or less or if it goes up to $5,400 or $6,000.

Senator ANDERSON. Mr. Chairman, I don't wish to continue if you wish to go to the joint session. I can only say to you that there are many people who feel that the payroll tax method permits expansion which the income tax method does not. You are right up against a pretty difficult ceiling and you are going to see more pressure rather than less to reduce it.

Hasn't the Treasury taken the position that it wants to see a gradual reduction of the income tax and reduction gradually in some of these excise taxes? They admitted they couldn't do it this year.

Secretary FLEMMING. I am sure they have taken that position.

Senator ANDERSON. So there seems to be an effort to try to reduce these individual income taxes.

Secretary FLEMMING. Again it seems to me as the payroll tax increases the burden will be recognized and there will also be the feeling either that the payroll tax shouldn't be increased further or that benefits should not be extended.

In other words, we feel this tax burden, no matter what kind of a method is used for the purpose of collecting taxes. I don't want to concede—I might have to ultimately—but I wouldn't want to concede that it would be absolutely necessary to raise the income tax in order for the Federal Government to take its share of this problem. Maybe I am wrong there.

Senator ANDERSON. If you face a deficit?

Secretary FLEMMING. If you face it then you have got to do it.

Senator ANDERSON. If you face deficit spending I judge the administration is not in favor of it.

I judge Senator Butler was not in favor of it.

Secretary FLEMMING. Right.

Senator ANDERSON. And $800 is substantial. It is true people walk in and say if you just raised the postal rates you could get $500 million to balance the budget but nobody has found a way to compel the Congress to raise that.

Secretary FLEMMING. That is right.

The CHAIRMAN. And then another $800 million comes from States and localities.

Senator ANDERSON. I wish we had time, Mr. Secretary, to go through this list of States and pick out the ones that are in desperate financial need. In 1934, back so many years, I prefer to forget, I became the first administrator of an emergency school tax in my State. Nobody wanted to put it on, but they put it on for the narrow emergency of the next few months. You don't have to have me assure you whether the tax is still there or not.

Secretary FLEMMING. No.

Senator ANDERSON. These burdens are becoming greater and greater and greater and the States are looking for revenue.

The able Senators from New York introduced an amendment the other day which provided if the Government drops the telephone tax New York would be glad to pick it up and turn it back into its own coffers. They need so much money, and yet you are going to take $78.5 million out of New York per year when this becomes fully effective. I say I think you picked out a difficult method of financing.

Secretary FLEMMING. Mr. Chairman, if I might just say on the point, take the McNamara bill, for example, just as one illustration, I think the estimated cost there is around a billion-three something like that. Of course, if we use the payroll tax, then that has got to be raised and it has got to come from the wage earners in addition to the employers.

The CHAIRMAN. Senator Douglas?

Senator DOUGLAS. Mr. Flemming, in view of the fact that the State contributions under your plan would amount to approximately $800 million a year, do you believe that all of the States would voluntarily accept the plan which you propose?

Secretary FLEMMING. Senator Douglas, I don't think they would do it immediately, but, based on the experience that the Federal Government has had with Federal-State programs, particularly in the health and welfare area, I think that within a reasonably short period of time they would come in.

Now, the reason I feel that is that I believe it is an attractive program that is being offered. I think that there is a very deep-seated feeling on the part of the citizens of this Nation that something ought to be done, and I believe that the citizens of the various States would indicate that in a rather convincing way to their State legislatures. I know you are interested in the whole Federal-State area. I had a little study made of the various Federal-State programs that our Department administers, and it is very interesting to note the number of States that have come into those programs, sometimes within the first years. Sometimes it has taken a period of 3 years, and in some instances they haven't come into it adequately. I would be the first to admit, for example, that there are seven or eight States that haven't taken advantage of the vendor payment part of public assistance in the way in which I had hoped they would have taken advantage of it. So it is a problem.

I wouldn't deny it.

Senator DOUGLAS. Would there not be States which for a considerable period of time would not accept the program and whose aged

citizens would therefore be excluded from the benefits of the plan which you propose?

Secretary FLEMMING. Well, of course, this is speculating. I don't know whether I would agree that it would take a considerable period of time because, again, I feel that the interest of the citizens within the States in seeing this problem dealt with in a more adequate manner would express itself to the State legislatures and that they would come in. Certainly for as long a period as they didn't, you are right. I mean the citizens in those States would not get the kind of assistance that I think probably both of us agree they should have.

Senator DOUGLAS. Do I understand your plan to be that for those who are not under old-age assistance that an enrollment fee of $24 a year is required from each individual before they will be entitled to the benefits of the plan?

Secretary FLEMMING. That is correct.

Senator DOUGLAS. Now, in other words, it would require individual acceptance?

Secretary FLEMMING. That is right.

Senator DOUGLAS. Of the plan, and payment of the $24 a year?

Secretary FLEMMING. Right.

Senator DOUGLAS. Individuals would be free not to make the payments?

Secretary FLEMMING. That is correct.

Senator DOUGLAS. Now, then, what percentage of the aged persons do you think would accept the plan, what percentage would refuse the plan, and what basis do you have for any estimate which you make?

Secretary FLEMMING. Well, the cost figures that are reflected in the tables that I have presented to the Chairman and to the members of the committee rest back on the assumption that 75 percent of those (not on old-age assistance) that would be eligible to participate would participate. I think you will recall that under our plan, of course, the 4 million who are paying income tax would not be eligible but that leaves about 12 million, and then about 2½ million of those are under public assistance and then the remainder would be eligible for this program.

We estimated 75 percent of this latter group would participate.

Now, that is subjective judgment, very frankly. However, it rests back on the fact we are dealing with a low-income group who certainly increasingly recognize the seriousness of this problem, and we feel if they were given this opportunity at least 75 percent would probably take advantage of it.

Senator DOUGLAS. Let me make this point, if I may. For those who because of reasons of pride or otherwise are not on old-age assistance, but who are very close to the margin themselves, isn't this requirement of $24 a year one which would cause them to refuse to come under the plan?

Secretary FLEMMING. Well, we felt that putting it at that low figure that it would not have that effect, but that is a matter of judgment and as I indicated in my presentation we are not wedded to the details. We are certainly perfectly willing to think through a problem of that kind with the committee.

I think your point is a point that should be weighed carefully. We did weigh it, and we came out at the $24 point, but here, again, we conceivably could be wrong on that.

Senator DOUGLAS. According to your figures 20 percent of those who do not pay income tax, whose incomes therefore are low, would not choose to come under the plan, and therefore would be excluded from its benefits.

Secretary FLEMMING. That is the assumption on which we built our cost figure.

Senator DOUGLAS. Mr. Flemming, you made a very interesting statement that the Federal share of the costs would largely be met from the income tax, which is arithmetically progressive, or the corporate income tax which is also arithmetically progressive, whereas the payroll tax would be proportional at least for the incomes covered in the act. But I hope you are aware of the fact, and I am sure you are, that so far as State revenues are concerned, that approximately 60 percent of State revenues are derived from the sales taxes. These sales taxes are arithmetically regressive, that is, those in the lower incomes pay a larger proportion of their income in sales taxes than those in the upper income brackets. So that so far as the State's share is concerned, it would be financed in an arithmetically regressive fashion, although the Federal share would be financed in an arithmetically progressive fashion.

In practice, does that vary very much from the proportional system under social security?

Secretary FLEMMING. Well, I certainly think your statement is a very fair one. Your observation is a very fair one.

My only hope would be that to the extent that the States had to raise additional revenue in order to deal with this that they would rely more on a progressive income tax and less on a sales tax, because I think we would probably both agree that in many instances the States probably are not taking full advantage of the possibilities under the income tax.

I know I think it is about 37 States that make some use of it but in some instances very little use of it. So that I think both of us would much prefer to see the revenue raised by a reliance on a progressive approach such as the income tax rather than throwing too heavy a load on the low-income level.

Senator DOUGLAS. I would like to ask a question about the insuring unit. As I understand it, each individual could select a private insuring company or agency.

Secretary FLEMMING. If he chooses.

Senator DOUGLAS. That is right. How many companies are there now which write some form of hospital, medical, surgical benefits for the aged?

Secretary FLEMMING. As I indicated, in testimony and in response to questions, I don't think the record is too good at the present time, but I do think we have to recognize a trend. I have some figures here, and I could put the whole exhibit in the record, but let me just give you some illustrations.

Mutual of Omaha does offer a catastrophic insurance policy which may be taken out through age 63, guaranteed renewable for life. The benefit——

Senator DOUGLAS. You will forgive me, Mr. Secretary, I think that is material that would be inserted in the record. What I am trying to get at is how many of these private companies now have one plan or another?

Secretary FLEMMING. We have identified four.

(*Note.*—The Secretary's reply refers to the four major medical expense policies available as of May 1960 on an individual basis to persons 65 and over. These are sold by two insurance companies. Additionally, a large and increasing number of insurance companies and Blue Cross-Blue Shield plans offer ordinary health insurance or prepayment protection to aged individuals.)

Senator DOUGLAS. Four?

Secretary FLEMMING. And some of the plans are more liberal than others. I mean they vary, as you would appreciate, in terms of the premium. They vary in terms of the deductible, and so on.

Senator DOUGLAS. Is it not probable that with the Federal Government meeting the residual costs and more or less underwriting the plans that there would be a big increase in the number of private companies which would write such policies?

Secretary FLEMMING. Well, there might be. As you know, our suggestion was that, through the Federal-State fund, we agree to take care of 50 percent up to a total dollar figure of $60. We would pay 50 percent but not to exceed $60. There are in existence now some plans that have——

Senator DOUGLAS. You mean on premiums?

Secretary FLEMMING. Yes. Some policies have a premium ranging from $100 to $130. There are some that have premiums that are lower than that, but then, of course, the benefits are not as much.

Now, our feeling is that the plan that we present, that is the Federal-State plan, is an attractive package. I think the people who might exercise this insurance purchase option as contrasted with going under the plan are people who will just say, I don't want to have anything to do with the Government in dealing with this particular matter. Those people might exercise this option.

Senator DOUGLAS. Well, do you foresee any difficult administrative problems when there are 50 States dealing with X numbers of insurance companies in any given State?

Secretary FLEMMING. Well, the State wouldn't be dealing with the company, I mean the individual would buy the policy.

Senator DOUGLAS. Yes, but what about the supervision?

Secretary FLEMMING. Well, the supervision of it would be the responsibility of the State and that could——

Senator DOUGLAS. And reimbursement, supervision over reimbursement, isn't that true?

Secretary FLEMMING. And, of course I don't think the character of the supervision would be much different than it is now, because as we know the States do supervise the insurance companies at the present time. They would add this as an activity that they would be called upon to supervise.

Senator DOUGLAS. They would really have to supervise very closely, would they not, because it would be State funds which would be expended whereas at present it is purely a private contract between the individual and the insurance company, isn't that true?

Secretary FLEMMING. I think it might very well lead to a type——

Senator DOUGLAS. Wouldn't this involve State authorities checking hospital bills and nursing home bills, and I believe you provide for physician's care, too, do you not?

Secretary FLEMMING. Well, we do in our package of benefits.

Senator DOUGLAS. Yes.

Secretary FLEMMING. But it seems to me, Senator Douglas, that if the individual bought a policy from one of these companies, the only thing that the State would be required to do would be to make sure of the fact that it is a policy dealing with catastrophic illnesses, and that the matter of how much is paid to hospital, and how much is paid the doctor and so on would be a matter that would be entirely in the hands of the insurance company.

Senator DOUGLAS. Even though the Federal Government and the State governments were underwriting the costs?

Secretary FLEMMING. Well, at least the way we contemplated it, if the State government approves the basic policy, what the Government is underwriting is 50 percent of the premium but not beyond $60. In other words, it puts a ceiling in as to how far it is willing to go, and that is the only thing that it underwrites. Of course it is underwriting indirectly these other costs.

Now, the thing that the State and the Federal Government would be interested in would be to make sure of the fact that the person buying such a policy was getting a policy designed to deal with catastrophic illnesses. But the actual expenditure of funds to cover the hospital and the doctor and so on would be by the insurance company.

Senator DOUGLAS. The Federal and State Governments would provide premiums and then——

Secretary FLEMMING. Up to 50 percent.

Senator DOUGLAS. And would allow the benefits to be determined between the insurance company and the individual?

Secretary FLEMMING. That is correct.

Senator DOUGLAS. And give a hunting license to the hospitals and other groups to make such charges as the insurance companies would approve, is that right?

Secretary FLEMMING. As far as this option is concerned, that is right. But there is a kind of a built-in control there, isn't there, when the Government says that it will underwrite only up to 50 percent and not to exceed $60? Now, there has been some confusion on this point.

Senator DOUGLAS. You mean combined Federal-State contribution would only be 50 percent?

Secretary FLEMMING. Only 50 percent and not to exceed $60.

Senator DOUGLAS. That is not to exceed a total of $60 or $30?

Secretary FLEMMING. No, no, a total of $60.

Senator DOUGLAS. In other words, $30 would then be the combined Federal-State contribution for the premium?

Secretary FLEMMING. The combined would be $60, that is the State $30, Federal $30 in a State having 50–50 matching.

Senator DOUGLAS. I cannot quite understand this. But why is it superior to the McNamara plan, for instance, which covers not only those under social security but also those not fully employed in the upper age groups outside social security?

Secretary FLEMMING. Well, certainly the McNamara bill corrects what I would regard as one of the weaknesses in the Forand bill. The Forand bill, of course, ignores the 4 million people who are not

covered by social security. The McNamara plan makes provision for those, and, on the other hand, of course, as long as you use the social security approach, there would be some people covered under the McNamara bill, who, I think, we would all probably agree would not need this kind of protection. But that is inherent in a social security approach.

I think, also, it is fair to say this, Senator Douglas, that our package of benefits that would be available under the program would do a still better job of taking care of long-term illnesses than would the McNamara bill. So, to that extent, it is superior.

What we have done is recognize the same need that many others recognize. We recognize that the time has come for government, and we think both Federal and State Governments, to become partners in dealing with this particular need, but we do not feel that it is wise to use the social security method for dealing with it, but rather this other type of approach.

Senator DOUGLAS. There is one technical question that I am going to ask, and then I am going to ask another question which may be somewhat unfair and which if it is unfair you should feel free to refuse to answer.

The technical question that I am going to ask is this: Is it not important to provide for nursing care in the home by practical nurses, if necessary. Is there not danger in any plan providing primarily for meeting hospital costs that we load the hospitals up with people who are in stages of senility, so that the hospitals really become not restorative agencies but warehouses for the senile aged? But a very large portion of the aged need someone who will come in during the day, will fix them up, and so forth, and get them on their way?

Secretary FLEMMING. Senator Douglas, I couldn't agree with you more, and I think that however we work this out as a government, this is something we must keep in mind. This would be one of my principal objections, for example, to the Forand bill, because the emphasis is entirely on hospital care and surgical costs.

Senator DOUGLAS. May I interrupt you a moment to say this is not a defect in the McNamara bill because the McNamara bill provides for 90 days of hospital care or 180 days of nursing home care, or 240 days of nursing in the home, and the unused portions of the hospital care can be shifted to the home nursing.

Secretary FLEMMING. The McNamara bill, in my judgment, on that particular point certainly moves in the right direction, but I might also say that the package of benefits that we have presented goes even further in that particular direction.

Senator DOUGLAS. The package of benefits which you present includes physicians care, isn't that true?

Secretary FLEMMING. That is correct.

Senator DOUGLAS. The McNamara bill is confined really to nursing care.

Secretary FLEMMING. That is right.

Senator DOUGLAS. Now what about the American Medical Association being enthusiastic on meeting physicians costs by this group system?

Secretary FLEMMING. Well, I think, as I stated in response to an earlier question, I know they are not enthusiastic about our program.

They have so indicated. But, Senator Douglas, I think that as the Federal Government moves into this area, we have got to be very careful not to make a mistake on this point, because there are many people who can be taken care of adequately in the home.

Senator DOUGLAS. Yes.

Secretary FLEMMING. And to say to those people, "The only way you can get assistance in covering the cost of illness is to go to a hospital or even a nursing home" just doesn't make good sense. What we are going to do it overburden our hospitals, and of course, our nursing homes, which we haven't got enough of anyhow. You and I are in complete agreement there, that whatever package of benefits is made available under whatever method, it should place just as much emphasis on home care as it does on institutional care.

Senator DOUGLAS. I am very glad to hear you say that, Mr. Flemming. I personally would be willing to accept a reduction in the number of days of hospital care provided under the McNamara bill and an increase in the number of days of home nursing, but there is another question I wanted to ask to follow this up. If you make this matter one simply of contract between the insurance companies and individual, can you be certain that you will get proper emphasis on home nursing? Wouldn't the tendency be to play up hospital care? Blue Cross has been a great boon to the hospitals of this country. Now if you have still further extension of this, isn't that going to throw the emphasis upon the hospital care which can be supervised by an insuring agency to some degree, rather than on home nursing which is more difficult to supervise and administer and get more needy?

Secretary FLEMMING. Senator Douglas, I am glad you have asked that question because I was afraid a little while ago that possibly one important aspect of our plan is not clear.

Our major plan, that is, the Federal-State plan which would provide all of these benefits that I have been talking about, is not a plan that would be administered by insurance companies. That plan would be administered by the State governments. Now, the State government could, of course, as some have in the public assistance area, contract with the Blue Cross or somebody else to carry out the plan, but it wouldn't be the Blue Cross or the insurance companies plan. It would be the plan provided for in the law as we would contemplate it.

Now the only point at which the insurance company would come into the picture is if an individual, instead of coming under this plan which would provide this comprehensive system of benefits, decided that he would rather operate under a private policy, either a Blue Shield or private commercial company policy. He could exercise that as an option and then he would only get the benefits that were provided for by that particular policy. On the basis of presently available policies, my assumption would be that the benefits that would be available to him under that policy would be much less than the benefits that are incorporated in our plan. As far as our plan is concerned which we assume would attract a great many of the persons participating, the State would administer it under a Federal law which would make it very clear that if the State plan was going to be approved, it would have to include a schedule of benefits such as that set forth in my testimony.

Senator DOUGLAS. Well, wouldn't it be simpler if you want to lay down Federal standards throwing the emphasis on home nursing, to have it done in Federal law through social security rather than to depend upon a maze of administrative rulings by the Federal Government, the State governments, and of agreements between individuals and insurance companies?

We could write a statute on the social security basis very simply. But when you get caught in this 50 State, Federal Government, X numbers of insurance companies, X numbers of persons voluntarily acepting the plan, frankly I think you get into a perfect administrative maze.

Secretary FLEMMING. Well, Senator Douglas, let me again say that, as far as our basic plan is concerned, we don't have to deal with the insurance companies at all. They are out of the picture. We do have to deal with the 50 States. But the 50 States——

Senator DOUGLAS. The 50 States will have to deal with the insurance company.

Secretary FLEMMING. No, they don't have to deal with any. I am not getting through on this.

Senator DOUGLAS. You are going to have it done by insurance companies, the Federal Government doesn't deal with the insurance company, the States don't deal with the insurance companies, who does deal with them, are they suspended in the air without any visible means of support?

Secretary FLEMMING. I know there have been stories written about our plan which suggest that it is a plan which is to be administered by the insurance companies; but it is not. It is a Federal-State program to be administered by the State governments, and the State governments have got to submit to the Federal Government a plan which would conform with the provisions of the law. Once that plan is approved, then the State governments go ahead and administer them. There are no insurance companies in the picture at all as far as this package of benefits is concerned.

Senator DOUGLAS. Has anyone introduced your plan?

Secretary FLEMMING. No; we had discussion on that, but I have given the committee a bill which does incorporate it.

Senator DOUGLAS. You have not yet found a legislative father?

Secretary FLEMMING. It will be introduced, I can assure you of that.

Senator DOUGLAS. It will be introduced?

Secretary FLEMMING. I can assure you of that. Senator Douglas, I appreciate, from what the chairman said, this does not probably put me in too strong a position on this point, but actually this, as you know, this evolved out of about 10 weeks' sessions with the Ways and Means Committee, and they were in executive session all the way along the line, and we presented the outline of the plan just as we have presented it to you. It is perfectly clear from the House bill that they did not accept this plan nor did they accept the Forand bill, so it was not necessary to introduce a bill in the House.

The CHAIRMAN. Was a vote taken on it in the committee, do you know?

Secretary FLEMMING. The only things they voted on were one or two modifications of the Forand bill and what came out of the committee.

I hope, Senator Douglas, for the sake of keeping the record straight, that I have made the point clear that under our plan you would write into the law itself this benefit package. Then you would say to a State: "If you are going to participate in a plan, if you are going to get Federal funds, you have got to present a plan which incorporates this schedule of benefits which would be available to any person who pays $24." The only point at which the insurance company comes in is indicated in my statement. There it says that each State would provide that an aged person eligible for participation in the program could elect—that is in lieu of paying his $24 fee and getting the benefits that are listed—

could elect to purchase from a private group a major medical expense insurance policy with the understanding that 50 percent of the costs would be paid for him from Federal-State matching funds up to a maximum of $60. The States would be responsible for establishing the minimum specification for such policy in accordance with broad standards established by the Federal Government.

But the person who wants to come in and pay this $24 is the person who would get from the State the kind of benefits that I have listed on page 13 and I think you can see that they are worked out in such a way as to achieve the objective you and I talked about. They include, hospital care up to a limit of 180 days. Then they include skilled nursing homes, physicians, outpatient hospital services, organized home care, private duty nursing services, physical restorative services and dental treatment. There are limits on laboratory and X-rays, not to exceed $200 and prescribed drugs not in excess of $350. Now that package is developed in such a way as to be of maximum help to the person who is involved in a 1-year, 2-year, 3-year, long-term illness. Of all of the plans that are before the Congress at the present time, this one would go further in taking care of that situation than any of the others.

I admit that the others would do more in dealing with first dollar costs.

Senator DOUGLAS. Now, Mr. Flemming, this may not be a question that you want to answer, but it is a question I would like to ask.

Suppose we could have a plan providing substantially the same package of benefits that you propose, based primarily, however, upon social security with supplemental payments by the Federal Government or Federal Government and States, for those outside of social security, not fully employed, how bitter would be your opposition to that alternative? [Laughter.]

Secretary FLEMMING. Well, I think the President has made clear in his public statements, and I tried to make clear in my presentation to the committee, that we are opposed to traveling the social security route.

The CHAIRMAN. You are opposed to the Forand bill?

Secretary FLEMMING. Yes, sir.

Senator DOUGLAS. You would be opposed—I think you have answered the question. In other words you are opposed to any use of the social security approach?

Secretary FLEMMING. That is correct. There is another bill pending before this committee. I think it was introduced yesterday by Senator Javits and seven or eight of his colleagues. Now that ap-

proach is somewhat similar to our approach. It does not agree at all points but philosophically——

Senator DOUGLAS. I thought there had been some process of capillary exchange of information between Senator Javits and the Department of Health, Education, and Welfare when he introduced that bill?

Secretary FLEMMING. Well, let me put it this way: I don't think it would be difficult for us to reach an agreement with Senator Javits and those who are sponsoring his bill.

Senator DOUGLAS. But let me make one final point.

In other words, your basic objection to the McNamara bill is not inadequacy of benefits or the fact that it meets the first dollar costs and does not confine itself to the later dollar costs, but to the fact that it chooses the social security approach, and even if we were to accept all of these other suggestions of yours, but were to operate primarily through social security, plus some Federal or State funds for those outside social security, you would still be compelled—and I use the word "compelled"—to oppose it.

Secretary FLEMMING. We would oppose it. Senator Douglas, I think I should say this also in response to your question: We believe very firmly in this concept of a deductible in this picture, and then in the concept of some cost sharing, because with those two in for the same amount of money, you can go much further in dealing with the long-term illness. We feel that the real problem here is the long-term illness.

Senator DOUGLAS. Mr. Chairman, I thank you. And I thank you.

The CHAIRMAN. Mr. Flemming, I think Senator Anderson asked you whether you thought this would be a deficit and I understood you to say that you did not.

I would like to call attention to the fact that this morning there was a statement made by the Treasury of an anticipated surplus of $300 million or more and had this bill, costing $876 million been in operation, there would then be a deficit of about $500 million.

Secretary FLEMMING. Well, Senator Byrd, in responding to the question in that way, I assumed that if we were faced with the necessity of working an item of this kind into the budget that we undoubtedly would have to make some other hard decisions, on things that we would not finance and would not support, in order to support this kind of a program.

That is what I meant by saying that I believed that you could——

The CHAIRMAN. In other words, you think this would bring about an increase in taxes?

Secretary FLEMMING. Well, it could, but it might bring about a reduction in some other expenditures, too.

The CHAIRMAN. What other expenditures?

Secretary FLEMMING. Well, I mean it is just possible that——

The CHAIRMAN. I haven't seen any expenditures reduced around here for a long time.

Secretary FLEMMING. I realized when I made that statement on the basis of your experience and observation you would greet it with some skepticism.

The CHAIRMAN. Yes.

Secretary FLEMMING. Nevertheless, in the development of a budget it is conceivable they might be able to do it.

The CHAIRMAN. You realize there is a tremendous resistance to increased taxes; taxes already are nearly confiscatory.

I think you indicated you wanted taxes increased in the higher brackets. A man who has an income now of $80,000 or more pays 92 percent above the $80,000.

That destroys the incentive to invest in enterprises, and so forth.

Secretary FLEMMING. Well, Senator Byrd, the point I was trying to make is that I would rather, in order to obtain additional revenue to deal with a problem of this kind, I would rather rely on the progressive income tax than I would rely on the payroll tax under social security. That was my point.

The CHAIRMAN. The income tax is a very severe tax as it is now collected.

Secretary FLEMMING. That is correct.

The CHAIRMAN. It starts at 18 to 20 percent in the very low brackets, and the middle-group people, the middle $10,000 and $15,000 and $20,000 people, they pay a terrific tax because their brackets are so close together.

Secretary FLEMMING. Right.

The CHAIRMAN. When you get up around to $40,000 or $50,000, you pay 60 percent; when you get above $80,000, as I have just said, you pay 92 percent; and if you increase those taxes much more, you are going to destroy the incentive so necessary to the business enterprise system.

Secretary FLEMMING. Senator, the point I was trying to make with Senator Anderson is that you don't relieve people of a tax burden by stepping up the payroll tax. That still is a substantial burden also. It is a burden on our economy and that has got to be taken into consideration when we face a problem of this kind.

In other words, there seems to be a feeling in some quarters that if we don't take this out of general revenue but get the revenue by a payroll tax that we are relieving ourselves of a tax burden. That I don't see at all.

I mean it seems to me that is also a heavy tax burden.

The CHAIRMAN. Now, if you can't answer this immediately put it in the record, this $876 million of new expenditures, which would be brought about by your proposal, what increase is that percentagewise on the present expenditures for this purpose?

Secretary FLEMMING. Well, of course, as far as the health insurance program is concerned, we don't have any comparable expenditures at all at the present time. Title VI, its additional expenditures of $375 million would be related, I assume to the $2 billion that is now appropriated for the public assistance programs generally. But the health insurance program would be a brandnew type of expenditure and it would be a little hard to relate that with something else.

The CHAIRMAN. Could you give it percentagewise, is it 100-percent increase or what is it? Are we going into a completely new field?

Secretary FLEMMING. It is a new area really. That is why I find it a little difficult to relate it to something you see. The $375 million you can relate very accurately to the $2 billion.

The CHAIRMAN. There are some expenditures in some of these categories.

Secretary FLEMMING. That would be about 19, 20 percent there.

The CHAIRMAN. But the administration recommendations are in a new field; are they not?

Secretary FLEMMING. Yes.

The CHAIRMAN. That would be 100-percent increase in those fields.

Secretary FLEMMING. That is right.

The CHAIRMAN. Senator Hartke?

Senator HARTKE. Mr. Chairman, I want to thank you for giving me a chance.

Maybe you can hear me all right; can you?

Secretary FLEMMING. Yes.

Senator HARTKE. I think you are to be commended for doing such a fine job in your statement of outlining the basic need of these people, and I think that you are to be commended for reiterating the fact that there is a present need and a human need here.

What I wondered about is when did the Department of Health, Education, and Welfare and this administration become so acutely aware of this present human need?

Secretary FLEMMING. Well, the first time that the Department of Health, Education, and Welfare made a recommendation in this area was in 1954, a recommendation that was reported out by the House Interstate and Foreign Commerce Committee——

The CHAIRMAN. Senator Hartke——

Secretary FLEMMING. And it was turned down by the House. The Senate Labor and Public Welfare Committee also reported it out, but as I understand it no action was taken on the floor of the Senate.

The CHAIRMAN. Senator Hartke, we now find we have to call the Secretary back at 2:30 because there are several Senators who desire to question him. I am compelled to leave for a very important engagement in my office. Would you prefer to continue your questions now or this afternoon?

Senator HARTKE. I have no desire.

The CHAIRMAN. Is it entirely satisfactory if you will excuse me?

Senator HARTKE. Whatever the chairman desires.

Secretary FLEMMING. Would you like me back at 2:30?

The CHAIRMAN. Yes.

(Whereupon, at 1:15 p.m., the hearing was recessed to reconvene at 2:30 p.m. of the same day.)

AFTERNOON SESSION

The CHAIRMAN. The meeting will come to order. I submit for the record the report received from the U.S. Department of Labor commenting on the pending bill.

(The report referred to follows:)

U.S. DEPARTMENT OF LABOR,
OFFICE OF THE SECRETARY,
Washington, July 1, 1960.

HON. HARRY F. BYRD,
Chairman, Committee on Finance,
U.S. Senate, Washington, D.C.

DEAR SENATOR BYRD: This is in further reply to your request for our comments on H.R. 12580, the "Social Security Amendments of 1960," which was approved by the House on June 23. This bill is an omnibus bill which makes

numerous changes in the social security and employment security systems, and which adds provisions for health care for the aged.

The Department of Labor concurs in general with the objectives of this bill. Our responsibility lies particularly with the title V provisions dealing with the employment security system which is administered by this Department. We note with approval that this title makes a number of desirable changes. These include the Department's recommendations with respect to earmarking the Federal unemployment tax; building up the Federal unemployment account to $550 million or 0.4 percent of aggregate State taxable payrolls, whichever is larger; building up an administration account of $250 million; tightening up the conditions for advances to States and repayment of such advances; making Puerto Rico a part of the Federal-State unemployment compensation system; and several minor extensions of coverage. The bill does not adopt the Department's recommendations that employers be covered regardless of size, that nonprofit employers be covered, and that the tax base be increased to $4,200. Instead, the bill increases the Federal unemployment tax by 0.1 percent, the entire increase to be collected by the Federal Government.

There is one provision of title V over which this Department is deeply concerned. This is the provision which imposes a $350 million ceiling on appropriations for employment security administration by State agencies. Since expenditures are now very close to the proposed ceiling, in all probability the inevitable increase in costs would make an amendment of the Social Security Act necessary in the near future. Little room would be left for inevitable increases in the costs of operations caused by the constantly expanding number of workers and employers, or for temporary increases in costs due to changes in employment levels.

The Department of Labor concurs in the objective of title VI of H.R. 12580 which amends the Social Security Act to provide for a Federal-State voluntary system of medical services for certain needy aged. We defer, however, to the Department of Health, Education, and Welfare as to the technical aspects of these provisions.

We also concur in general with the objective of the amendments of the Social Security Act provided by H.R. 12580 but again defer to the Department of Health, Education, and Welfare on the particular provisions.

The Bureau of the Budget advises that it has no objection to the submission of this report.

Sincerely yours,

JAMES P. MITCHELL,
Secretary of Labor.

The CHAIRMAN. We are honored today in having the Senator from Michigan, Senator McNamara, the first witness; will you take a seat, Senator, and proceed?

STATEMENT OF HON. PAT McNAMARA, U.S. SENATOR FROM THE STATE OF MICHIGAN

Senator McNAMARA. Mr. Chairman, I understand you are ready to proceed.

The CHAIRMAN. Go ahead, Senator.

Senator McNAMARA. I have with me Mr. Sidney Spector, who is staff director of the Subcommittee on Problems of the Aged and Aging of the Labor and Public Welfare Committee.

Mr. Chairman, yesterday, in response to what was then the plan of your committee, I submitted a brief written statement, in behalf of my medical insurance proposal, which has been submitted as amendment 6-24-60—C to H.R. 12580.

(Copy of this amendment, with analysis and departmental report thereon, appears on p. 451.)

Senator McNAMARA. Now, however, since you have called hearings on the bill, I will take this opportunity to present some additional remarks.

I would ask that my previous statement be made part of the hearing record, since it complements the remarks I am making today.

(The brief written statement referred to follows:)

STATEMENT OF SENATOR PAT MCNAMARA TO THE SENATE FINANCE COMMITTEE ON H.R. 12580

Mr. Chairman, the Committee on Finance has before it an amendment (6-24-60-C) to H.R. 12580, submitted by myself and 23 other Senators. The contents of this amendment are essentially the same as S. 3503, pending before the committee since May 6.

I will not, in this brief statement, attempt to provide a full explanation of the proposed amendment. A lengthy address I made before the Senate when S. 3503 (identical with amendment 6-24-60-C) was introduced is attached, along with comparisons, analyses and other material.

In short, however, the amendment proposes a system of medical insurance for America's elderly retired citizens. It would provide coverage for approximately 14.8 million persons.

Benefits would include hospitalization, nursing home care, home health, and diagnostic services and assistance in payment for very expensive drugs. It would not include the fees charged by an individual's doctor.

Financing of the plan for the great majority of the beneficiaries would be through a payroll deduction of one-fourth of 1 percent each for the employee and employer and three-eighths of 1 percent for self-employed persons. These funds would be placed in a special "medical insurance trust fund." Protection for the remainder would be financed by payments from the general fund into the trust fund. It is estimated that this portion would cost $350 million a year, of which approximately $132 million would be "new" expenditures not now made under existing public assistance or veterans programs. It is expected that this figure would be reduced as the number of persons outside the OASI system declines in years ahead.

So much for a brief description of the provisions. I would like to emphasize to your committee that this is not a hastily drawn proposal, submitted at the last moment for effect. While we make no claims of perfection, we can look with genuine satisfaction to the vast amount of effort which has gone into this proposal.

It is the result of more than a year's work by the Senate Subcommittee on Problems of the Aged and Aging. It reflects the thinking of many experts in this field, and we feel the benefit schedule is a balanced one and financing methods are sound and workable.

Above all, however, we are convinced that our proposal answers the need. That the need exists is no longer challengeable, in our estimation. The files and transcripts of the Subcommittee on Problems of the Aged and Aging are full of overpowering evidence of the kind of health problems affecting the elderly, and of their inability to adequately finance their own medical care.

It is encouraging that the need for health protection for the elderly is so well established that the only real argument remaining is over the form the protection should take. In the past year, a number of proposals have been offered. Some of these stress the "voluntary" approach, subsidization of private insurance programs, Federal-State plans or additional assistance in charity cases only.

These proposals have one or more serious flaws. They are either inefficient, unacceptable in too many States, deficient in benefits, or they offer their protection only to those who are "fortunate" enough to prove they are paupers.

We firmly believe that health protection for the elderly must be established on an insurance basis so that it is an earned right of the American citizen. We are convinced that the vast majority of the American people are perfectly willing to finance their future health care at a time when they can afford to do so—while they are employed. The most logical and efficient way to accomplish this is through a payroll deduction plan.

To apply a means test, to require the surrendering of dignity and wordly possessions to become a charity patient, is repugnant to the American concept and desire for an abundant and secure retirement for its elderly citizens.

It is, I believe, completely evident to the Congress and to the Nation that the next major piece of social legislation enacted will be health insurance for the elderly. It will take its place with the original Social Security Act, the wage and hours law, and the Employment Act of 1946 as keystones of America's internal greatness and its willingness to meet domestic responsibilities.

Those who protest the establishment of a health insurance program are, at best, fighting only a delaying action. They will not be able to prevent the adoption of a program. The major questions remaining are: When will adoption come and what will the program contain?

Although presumably only a few more days remain of the 86th Congress, we have the opportunity and the time to pass a proper medical-care program. The hearings and the studies held by both Houses of Congress should contain the answers to any questions of detail or content.

I respectfully urge the Committee on Finance to heed the tremendous popular demand and the factual need for a health insurance program for the elderly. But, just as important, I urge that the program we adopt be broad enough to do the job that must be done. We are confident that our amendment contains such a program.

Senator McNamara, I would like, in these brief comments, to enumerate some of the defects of the title VI of H.R. 12580, the medical care section, and to point out that, standing alone, it does not begin to fill the need.

First, it ignores altogether the basic idea behind social insurance, that payments should be made before, and not during, retirement.

Under H.R. 12580, those aged who are not covered by the bill would be paying Federal, State, and local taxes, for the health care of the remaining aged citizens coming under the bill, receiving nothing themselves.

Second, the House bill rests on the undependable formula of State matching funds, on a year to year basis, with absolutely no assurance of full participation by each and every State.

Objective study by the American Public Welfare Association reveals that only 15–20 States now can provide average medical care, for recipients of old-age assistance.

Third, the proposal contains a primitive throwback—to the outmoded philosophy of the means test. This would penalize those aged who have been provident enough to accumulate some savings and property of their own.

To make matters worse, each State would be allowed to set up its own separate criteria of who could be eligible.

As another unhappy consequence, millions of elderly citizens would be omitted from protection, despite their inability to afford premium costs for really adequate private insurance.

Fourth, it can only aggravate the problem of having to pay for the aged's medical care costs through relief and assistance programs.

It means adding to the burdens of the general revenues of the Federal, State, and local governments.

Fifth, no standards of benefits are established, and each State can offer as little as it cares to provide in health benefits to its medical indigents.

Benefits would not be determined by the needs of the elderly, but by the coffers of and values of the State. This would not be true if we adopted the social insurance method.

Sixth, few States, if any, would appropriate enough out of their limited resources to finance a program of preventive and restorative health services.

Elderly men and women, now and in the future, will delay and avoid proper medical attention because of their well-founded worries about the heavy expenses of adequate medical care.

These are six major reasons why I firmly believe we cannot permit title VI of the bill to be adopted as the answer of the 86th Congress to the health needs of the elderly.

The provisions of the House bill would assist only a fraction of those who need help, and even that assistance is extremely limited and loaded with fishhooks.

Naturally, I am proud of the medical care program which 23 of my colleagues and I have pending before this committee—as S. 3503 and as an amendment to H.R. 12580.

We believe that this program answers the need, and does so in the best possible way, through the social insurance approach.

However, we are not blinded by any pride of authorship. We recognize that there are other proposals which adopt the same basic principles.

The important issue before this committee, and before the Senate and the Congress, is the adoption of a genuine medical insurance program that will benefit the majority of our elderly citizens.

This is a challenge to all of us, and one which I do not think we can afford to fail.

Mr. Chairman, I have prepared or had prepared a brief analysis of our bill, and I would like to submit it at this time for the record.

(The analyses referred to follow:)

MEMORANDUM BY SENATOR PAT MCNAMARA, CHAIRMAN, SENATE SUBCOMMITTEE ON PROBLEMS OF THE AGED AND AGING

ANALYSIS: RETIRED PERSONS MEDICAL INSURANCE ACT

Major provisions

1. Cover under a system of prepaid health insurance all "retired aged" (men
3. One hundred and eighty days care in a skilled nursing home, or
2. Provide for 90 days of hospital care per year, or
3. One hundred and eighty days in a skilled nursing home, or
4. Two hundred and forty days of care at home in a supervised home health program.
5. Provide diagnostic outpatient services for such items as laboratory tests and X-rays.
6. Pay for a portion of the cost of very expensive drugs.
7. Provide for research and demonstration programs to improve quality and efficiency of health care.

Relevant data bearing on the above provisions follow

1. We estimate that this bill will cover 14.8 million men and women as follows:

11.3 million OASI beneficiaries.
1.7 million who are receiving old-age assistance and no OASI.
1.8 million other retired aged—men over 65 and women over 62.

The act would exclude from its coverage all men and women and their spouses who are working full time. In the ordinary case, these men and women will be covered by a group health insurance policy. The bill is thus limited to the retired aged.

2. Estimates of cost for the above provisions

Total cost, computed as conservatively as possible, is estimated at $1,578 million or $106 per capita (i.e., per retired person).

11.3 million OASI beneficiaries would be financed by a one-quarter percent increase in the social security tax on the employee and employer.

1.7 million old-age assistance recipients would cost $180 million to come from general revenue fund.

1.8 million other persons would cost $190 million; to come from general revenue fund.

3. Hospitalization

This bill provides for 90 days hospitalization for the aged but aims at reducing excessive use of hospitals through the following features:

Provision is made for diagnostic services as a preventive program.

An incentive is provided to use nursing homes and home health services instead of hospitals when not needed.

4. Skilled nursing home care

For each day of unused hospital care, the bill provides 2 days of care in a skilled nursing home following a physician's certification. Total days authorized, 180.

5. Home health services

For each day of unused hospital care, the bill provides 2⅔ days of home health services by a community-sponsored agency. Total days authorized, 240.

6. Outpatient diagnostic services

The bill provides for preventive services through early diagnosis of incipient illness by means of X-ray and other laboratory tests.

7. Very expensive drugs

A portion of the cost of very expensive drugs prescribed by a physician using generic names is included in the insurance program. The amount and kind of coverage is to be determined by the Secretary after a year's study.

8. Effective date

The bill would provide for phasing the effective dates of the various benefits so as to provide an opportunity to build up the financing fund, conduct adequate planing, and develop the necessary facilities:

Hospitalization effective July 1, 1961, and not later than January 1, 1962.

Nursing homes, January 1, 1963, and not later than July 1, 1963.

Home health services, January 1, 1962, and not later than July 1, 1962.

Diagnostic outpatient services, July 1, 1961, and not later than January 1, 1962.

Very expensive medicines, July 1, 1962, and not later than January 1, 1963.

The Secretary of HEW would be authorized to designate the dates within these periods when the act would be effective.

9. Summary of costs

The one-fourth percent increase on the OASDI tax on employer and employee and three-eighths percent on the self-employed would be sufficient to finance the medical benefits for the retired OASI beneficiaries.

Three hundred and seventy million dollars from the general fund would finance the medical benefits for those not eligible for OASI benefits.

Partially offsetting this $370 million appropriation are current Federal expenditures for—

	Million
Medical care under old-age assistance	$153
Medical care for other groups who would be covered	85

Thus, it is estimated that net additional costs to the Federal Government would be approximately $132 million.

10. Research and demonstration

The bill would direct the Secretary of HEW to conduct research on the health care of older persons and on improvements in the quality and efficiency of health services.

The Secretary is also authorized to conduct appropriate demonstration programs on how to meet the health needs of older persons as effectively and efficiently as possible in their communities.

11. Other important provisions

Persons receiving social security benefits or old-age assistance payments are automatically eligible for benefits. Other individuals who have not earned in the preceding month more than the amount set in the retirement test under OASI will be covered.

The Secretary is to publish annually a listing of hospitals, nursing homes, and home health agencies which are included for payments under the act. It is expected that for hospitals, the Secretary may use the AHA accrediting service; and that for nursing homes, only those will be included which meet adequate standards for care and rehabilitation.

State health agencies can be given authority to inspect whether standards are being met and whether professional services are adequate.

The bill authorizes the Secretary of HEW to administer the act with a national health service advisory council.

The Secretary may use the services of private nonprofit organizations in administering the program.

Railroad Retirement and Federal employee pensioners could come under the program at any time such legislation is enacted.

RETIRED PERSONS MEDICAL INSURANCE ACT

(Introduced by Senator Pat McNamara, May 6, 1960)

TITLE I—AMENDMENTS TO TITLE II OF THE SOCIAL SECURITY ACT

This bill is an amendment to title II of the Social Security Act to provide medical insurance benefits to aged beneficiaries under the OASDI program.

Section 101(a) of the bill provides for a new section in the Social Security Act under which provision is made for the payment of medical insurance benefits to aged beneficiaries under the OASDI program.

MEDICAL INSURANCE BENEFITS

Sec. 226(a)(1)—Eligibility for benefits

Retired persons eligible to OASI benefits would be eligible for medical insurance benefits under this bill if they have reached the age of 62 for women and 65 for men.

A spouse who receives more than one-half support from his or her eligible spouse for a year which began no earlier than the calendar year preceding the dependent spouse's attainment of age 62 for women, age 65 for men, would be eligible for medical insurance benefits.

An application for payment must be filed in the form and manner, and by such person as shall be prescribed by the Secretary of HEW.

Sec. 226(a)(2)—Kinds of benefits

Medical insurance benefits are to include hospital services, nursing home services, home health services, diagostic outpatient services, and very expensive drugs.

Sec. 226(a)(3)—Definition of retirement

The bill defines a retired OASI beneficiary as (*a*) anyone who had total earnings of less than $2,000 in a calendar year preceding illness, or (*b*) anyone in the above ages who did not earn more than $100 in wages and was not self-employed in 3 months in a calendar year preceding his illness, or (*c*) had attained age 72. The calendar year could not be earlier than the calendar year preceding attainment of age 62 for women and 65 for men.

For purposes of the definition of retirement under this section an individual shall be deemed not to have engaged in self-employment in any month in which he renders services in his business in less than 8 days during that month.

Sec. 226(a)(4)—Amount of benefits

Hospital services: 90 days in any calendar year.

Nursing home services: 180 days.

Home health services: 240 days.

Diagnostic services to the extent established by regulation of the Secretary of HEW after study and consultation with the Advisory Council.

Very expensive drugs only to the extent set by the Secretary in regulations after study of the subject and consultation with the Advisory Council.

This paragraph also defines one unit of service as (*a*) 1 hospital day or (*b*) 2 days of nursing home service or (*c*) 2⅔ days of home health services. No person can receive more than 90 units of services of any combination of hospital, nursing home, or home health services in any calendar year.

Sec. 226(a)(5)—Referral and recertification by physician

To be eligible for benefits an individual must be referred to the hospital, nursing home, or home health service agency by a physician who certifies that such services are required for the individual's medical treatment. Periodic recertification at specific intervals—to be established by the Secretary—would be required as a condition of continuing eligibility during the period of illness. Referral would not be necessary in emergency cases.

Sec. 226(a)(6)—Applications for payment

Applications for the payment of medical insurance benefits, except for very expensive drugs, may be filed no earlier than 3 months before or no later than 12 months after the beginning of a period in which covered health services were furnished. With respect to very expensive drugs, application would have to be filed within such time as the Secretary of HEW would by regulation prescribe.

Sec. 226(b)—Determinations of eligibility

The Secretary would have authority to make and review determinations of eligibility for medical insurance benefits. Payment of monthly OASI benefits other than disability insurance benefits would be conclusive evidence of the attainment of retirement age.

Sec. 226 (c)—Definitions

(1) *Hospital services.*—These are inpatient services including all of the regular services provided by a hospital. Provides for semiprivate accommodations, unless other accommodations are required for medical reasons, medical service, nursing and such other services customarily provided by hospitals. Does not include services provided in connection with cosmetic or plastic surgery for beautification.

(2) *Nursing home services.*—This includes skilled nursing care, related medical and personal services and bed and board furnished an individual as an inpatient.

(3) *Home health services.*—These are visiting nurse and allied services provided by a nonprofit home health service agency in the patient's home. They include various kinds of therapies, medical social services, and homemaker services.

(4) *Diagnostic outpatient services.*—These are X-ray, laboratory, and other diagnostic services provided by a hospital on an outpatient basis as prescribed by a physician.

(5) *Very expensive drugs.*—These refer to drugs prescribed by a physician using generic names and the cost of which is in excess of an amount fixed by the Secretary. Drugs prescribed by brand names would be included if the physician's prescription states that no substitution may be made.

Sec. 226(d)(1)—Agreements with providers of health services

This paragraph provides that the Secretary shall publish lists of hospitals, nursing homes, and home health service agencies, licensed pursuant to State law, which meet standards prescribed by him. Such institutions are eligible for payment under this section if an agreement to make no charge to eligible individuals for covered services is filed with the Secretary. This paragraph provides that the Secretary may take account of standards set by nationally recognized accrediting bodies. He may also delegate responsibility to appropriate State agencies to assist in determining whether standards are being met.

Agreements may be terminated by providers or by the Secretary under regulations to be established.

Services furnished by mental and tuberculosis hospitals are excluded.

(*d*)(2)—Payments may be made to hospitals not listed by the Secretary for emergency services furnished to eligible persons.

(*d*)(3)—Payments to hospitals for hospital service and outpatient diagnostic service would be equal to the cost of rendering the service, and the method of determining such cost shall be prescribed by regulations after consultation with the Advisory Council.

(*d*) (*4*)—No payments can be made for hospital services where the patient is entitled to hospitalization under workmen's compensation legislation, except in special situations where entitlement under workmen's compensation has not been finally determined and arrangements have been made for reimbursement of the trust fund if the claim under workmen's compensation law is sustained. No payment can be made for hospital services if the hospital is obligated by law or by contract with a political entity to furnish service at public expense and without employing a means test.

(*d*) (*5*)—Payment to nursing homes and for home health services shall be based on the reasonable cost of rendering service.

(*d*) (*6*)—This paragraph provides for the payment of only that part of the cost of very expensive drugs which exceeds the amount fixed by the Secretary. Payment is to be based on reasonable cost of the drugs, plus such percentage as may be determined by the Secretary after consultation with the Advisory Council to provide adequate compensation to the pharmacy for its services in furnishing the drugs. Payment may be made to any licensed retail pharmacy which has entered into an agreement with the Secretary.

(*d*) (*7*)-(*9*). *No interference in administration*

This is a definite statement—that no supervision or control over the administration or operation of any agency which has entered into an agreement with the Secretary under this section is permissible.

(*d*) (*10*)—Payment for covered services would be made from the Federal medical insurance trust fund.

Sec. 226(c)—Free choice by patient

This subsection asserts the absolute free choice of an individual to secure hospital services, nursing home services, home health services, or diagnostic services, from any facility which he selects and which is listed by the Secretary as eligible to provide the class of services. It also asserts that he may obtain very expensive drugs from any pharmacy which has entered into an agreement with the Secretary.

Sec. 226(f) (1)—Creation of National Medical Insurance Benefits Advisory Council

This section provides for the creation of the National Medical Insurance Benefits Advisory Council composed of the Commissioner of Social Security and the Surgeon General of the Public Health Service as cochairmen, and 12 members appointed by the Secretary, 4 of whom would be representatives of the general public, and the remaining members outstanding people in the hospital and health field. Each is to have a term of 4 years on a staggered basis. The Advisory Council is authorized to appoint special committees for particular purposes and will meet as necessary, but not less than once a year.

(*f*) (*2*)—The Advisory Council or a technical committee appointed by the Council would have the duty of studying the operation of this section of the act.

Sec. 226(g) (1)—Use of private, nonprofit organizations

It is within the discretion of the Secretary to use the services of private, nonprofit organizations in the administration of this section of the act.

(*g*) (*2*)—*Method of payment for health services*

Payments to participating private, nonprofit organizations for costs incurred in the administration of the program, and as reimbursement for amounts paid to providers of service, would be made from the Federal medical insurance trust fund.

Sec. 101(b) of the bill—Creation of Federal medical insurance trust fund

This section creates the Federal medical insurance trust fund in addition to the OASI trust fund and the disability trust fund. It provides for the allocation of a specified portion of social security taxes to this new trust fund. The section authorizes for fiscal year ending June 30, 1961, to December 31, 1971, appropriations to the medical trust fund of revenue derived from one-half of 1 percent increase in the OASI tax, three-fourths of 1 percent beginning January 1, 1972. On self-employed the tax would be three-eighths of 1 percent until January 1, 1972, and nine-sixteenths of 1 percent thereafter.

Section 101(c) of the bill sets forth the phasing schedule with respect to the effective dates of the various benefits.

Hospital services: Not earlier than July 1, 1961, or later than January 1, 1962.

Nursing home services: Not earlier than January 1, 1963, or later than July 1, 1963.

Home health services: Not earlier than January 1, 1962, or later than July 1, 1962.

Diagnostic outpatient services: Not earlier than July 1, 1961, or later than January 1, 1962.

Very expensive drugs: Not earlier than July 1, 1962, or later than January 1, 1963.

TITLE II—MEDICAL BENEFITS FOR RETIRED AGED NOT ELIGIBLE FOR SUCH BENEFITS UNDER TITLE I OF THIS ACT

This title creates a new title XVI in the Social Security Act to provide medical benefits for those aged persons not eligible for benefits under the OASI program.

Section 201(a) of the bill amends the Social Security Act by adding a new title.

Section 1601 (a)

Provides that persons not eligible for OASI benefits may be eligible for medical insurance benefits if they are residents of the United States, have attained retirement age, and meet the retirement test as provided in section 226 of title II of the act. The amount and kind of benefits payable and the conditions under which they would be paid are the same as provided in section 226 of the act. Benefits would be payable for 90 days of hospital services, 100 days of nursing-home services, and 240 days of home health services.

Section 1602

This section authorizes appropriations to the Federal medical insurance trust fund necessary to meet payments for persons eligible to receive benefits under this section—i.e., retired persons not eligible for OASI benefits. Appropriations would come out of general revenues.

Section 1603

Payments made under this title would be made from the Federal medical insurance trust fund.

Section 1604

This section excludes all those eligible to an annuity or pension under the Railroad Retirement Act, or eligible to receive an annuity under the Civil Service Retirement Act, and their spouses. However, title IV of the bill is a declaration of policy which states that it is the intent of the Congress to make available, as soon as possible, to those receiving railroad retirement and civil service retirement annuities the same type of services made available by this act to those receiving OASI benefits.

TITLE III

Amends appropriate sections of the Internal Revenue Code of 1954 so that the total social security tax can include the additional tax authorized in title I of this bill.

TITLE IV

Section 401

This section is a declaration of policy by the Congress to include, as soon as possible, persons receiving annuities under Railroad Retirement Act and Civil Service Retirement Act.

Section 402—Research and demonstration on health needs

This section directs the Secretary to conduct a continuing study and investigation of the health needs of older individuals and the means for meeting these needs most effectively and efficiently. It also authorizes appropriate demonstration programs in this field.

Senator McNAMARA. I would further like to ask that the remarks that I made in connection with the presentation of our bill in the Senate, of which I have a copy here, be published at this point in the record.

The CHAIRMAN. Without objection, those insertions will be made in the record.

Senator McNAMARA. Thank you.

(The statement referred to follows:)

[Congressional Record, Thursday, June 2, 1960]

THE RETIRED PERSONS MEDICAL INSURANCE ACT

Mr. McNAMARA. Mr. President, the Senate Subcommittee on Problems of the Aged and Aging has completed another series of hearings—the first of its activities of the 2d session of the 86th Congress—as authorized by Senate Resolution 266.

These hearings dealt with a topic which the majority of the subcommittee stated, in a report on the first year of its investigation, to be the No. 1 priority item for action by the Congress in the field of aging.

I refer to the topic of adequate health services for the aged, and the problems they and their families face, in finding an effective means of financing such health services.

Detailed analysis and statistical documentation of the need for action in this area of social legislation are set forth in the report of the subcommittee and in the 6 days of hearings in April.

THE SPECIAL HEALTH PROBLEMS OF THE AGED

From a narrow point of view, it might be said that there are no unique health problems of the aged, that many children have had diseases that many old persons have had, and vice versa.

But this is really quibbling. The aged do have special health problems.

For example:

First. In 1957, nearly 8 out of 10 noninstitutionalized aged persons, over 11 million, that is, had one or more chronic ailments.

A large part of such ailments consisted of heart trouble, arthritis, diabetes, and kidney disease.

Putting chronic ailments in terms of all ages, only 4 out of 10 are so afflicted. Compare this with the 8 out of 10 among the aged.

Second. Of the 10 million cases of heart disease—including high blood pressure—4 million, or 40 percent, are among people 65 years of age and older.

In other words, the aged make up less than 9 percent of the total population but 40 percent of all cases with heart trouble.

More than one-fourth of all the aged have such conditions.

Third. More than half of the aged with chronic conditions are limited in their activity.

Fourth. While only 3 percent of the total population have limitations in mobility, 19 percent of the aged—six times greater than the general population—find it difficult to get around. And I am referring only to the noninstitutionalized aged.

Fifth. The aged suffer mostly from long-term chronic conditions, not from short-term acute ones, a point frequently neglected in most health insurance programs today.

As a result, they stay in hospitals two to three times longer than the younger age groups.

Sixth. Ironically, many of the aged have handicaps which could have been prevented—if the disease or injury had been treated properly from the beginning.

Mr. President, I ask unanimous consent to include at the end of my remarks tables which indicate, in detail, the extent to which the aged do have special health problems of their own.

The PRESIDING OFFICER. Without objection, it is so ordered.

(See exhibit 1.)

THE FINANCIAL PLIGHT OF THE AGED

Mr. MCNAMARA. I believe that organized medicine is doing a disservice by manipulating the data on the financial status of the aged in such a way as to give the impression that our retired Americans are financially able to meet their medical bills and pay for insurance premiums without any legislation along the lines I am about to propose today.

According to some publications of medical organizations, one would almost believe that our aged fellow citizens are really the wealthiest people in America. But let me set the record straight. If we look at our senior citizens as individuals, a method developed by that most reliable agency, the Census Bureau, we find that in 1958, among men 65 and over the median income was $1,488.

Taking men and women together, about 80 percent of them have less than $2,000 annual income, and about 60 percent have less than $1,000 income.

Keeping in mind that the Secretary of Health, Education, and Welfare has indicated that, on the basis of a very low-cost food budget, an income of less than $2,560 for an elderly couple is "uncomfortably low," we find the following:

In 1958 about 3 million families headed by individuals over 65 received less than $2,500 in income. This makes at least 6 million men and women with such income or less.

Then we have to add at least 2 million unrelated aged individuals who received less than $1,500, a figure which is considered quite low in terms of adequacy.

In other words, at least 8 million aged citizens living in what, at today's prices, can only be poverty.

Opponents of health insurance legislation try in desperation to cloud the issue by claiming that income is not the best, or only way, to measure the financial ability of the aged; that even though their income is low they have plenty of assets.

It is claimed that in the past several years their asset status has been better than that of all other age groups. Again, let us get the record straight. The economists for the AMA might be getting a pat on the back from their employers, but I can assure Senators that their professional reputation among fellow economists has not been improved.

To begin with, people with low incomes happen also to have low liquid assets, by and large.

For example, in the Federal Reserve Board's Consumer Finance Survey for early 1959, among spending units with aged heads who had incomes of less than $3,000, 56 percent had liquid assets of less than $500. But among those units with incomes of $3,000 to $5,000, only 30 percent had liquid assets of less than $500.

Second. In the 10 years since 1949, there has been no important progress in the proportions of aged heads of spending units with no liquid assets at all.

In 1949, the percentage was 32 percent. In 1959, the percentage was 29 percent

In absolute figures, of course, there was actually a retrogression. In 1949, at least 3.0 million spending units with aged heads had no liquid assets. But by 1959, 10 years later, there were at least 4.6 million of such spending units with no liquid assets at all. An additional 3 million had liquid assets of less than $500.

In other words, at least 7.6 million elderly persons had liquid assets of less than $500.

I have used the term "at least" because, in reality, the Survey of Consumer Finances does not get to those aged with the definitely lowest financial status. The survey, therefore, excludes the less favorably situated older Americans in its tables.

In other words, there are more than 7.6 million aged spending units with liquid assets between zero and $500.

Furthermore, the statistics of the Survey of Consumer Finances do not take into account the changes in the purchasing power of these assets—nor the increase in medical costs for the aged—since 1949.

Now what about income from assets? The best material we have on this is from the 1957 social security beneficiary survey, which reported that 41 percent of the married couples had no income from assets, and that the median for those married couples with some asset income was the grand sum of $180 for the entire year of 1957.

Among single retired workers, 55 percent had no asset incomes, while the median for those with some income from assets was $102 for 1957.

For widows receiving OASI benefits, 48 percent had no asset incomes, and those with any asset income had a median of $149.

For that same year only one out of every six couples had asset incomes of $600 or more. One out of every 8 aged widows and 1 out of every 14 single retired workers received the same amount or more.

Let me repeat the point made earlier, that people with low incomes generally have low liquid assets. We cannot ignore this fact. This fact tends to be neglected by those who say that even if the aged have low incomes they have other means of financing their medical care, that they have savings, that they have equities in their homes, that they have cash values in their life insurance policies.

But even the Health Information Foundation, sponsored by the drug companies of the country has reported recently that among the aged interview by their pollsters, no more than slightly over one-half had more than one source of asset income to help meet an expensive medical bill. The remainder, about 47 percent, had only one such source, or none at all.

The research director of the Health Information Foundation, Dr. Odin Anderson, in speaking 5 years ago about the use of assets to pay for medical bills of all ages had this to say:

"A very crucial assumption—and also self-evident—is that adequate services for the care of long-term illness cannot be wholly financed from savings such as liquid assets, personal property, and other personal effects and assets which are regarded as the normal birthright of a hard-working and provident American. (From paper presented at 1955 meeting of American Public Health Association.)

If it is self-evident for the general population, how much more obvious and self-evident it is that the care of long-term illness for the aged cannot be financed from such sources.

If we do not agree with this proposition, then the logical alternative is to require that senior citizens sell or borrow on their homes.

We would also have to require the aged to use up their savings, sell their modest amount of bonds, and cash in their life insurance.

The AMA has publicized a survey which asked older persons how they would pay a $500 medical bill, and then explained the answers to mean that only 9.6 percent could not pay such a bill.

However, the research director of the survey, Dr. Ethel Shanas, has stated: "Almost half of all people could not manage a medical bill as large as $500" (in Public Welfare, April 1960).

The real meaning of the AMA's own interpretation is that they apparently would expect the other 90-plus percent of older Americans to finance such bills through using up their assets.

This amounts to about 12 million men and women over the age of 65 who would be expected to finance all or part of their medical bills by using up such assets.

Mr. President, am I wrong in stating this great and wealthy Nation had declared, by passing the Social Security Act a quarter of a century ago, that the means test was a degrading and reprehensible concept in providing for the general welfare?

If we follow the implied advice of the AMA, are we not going back, not a quarter of a century, but rather three whole centuries, to the poor laws of medieval England?

That is what we would be doing if we follow such backward counsel: after the aged dry up their assets for one illness, they would then have to apply for charity medical care, if they are not too proud to subject themselves to such a humiliating process.

If all our aged fellow Americans were willing to do this, then and only then could it truly be said, as the AMA does say, that no aged person needs to go without medical attention—regardless of financial ability.

Must I elaborate on the glaring defects in such a philosophy of medical care in the 20th century? On the quality of charity medical care? On its omission of any preventive approach? On the greater burden that would be placed on the physicians now already giving free and reduced-fee services? On the hospitals, the local communities, and the States, all of which can hardly be expected to meet the health needs of an ever-increasing population of aged men and women?

Mr. President, at this point I should like to refer to some of the findings of the University of Michigan's study of hospital and medical economies bearing on income, assets, insurance coverage, medical expenses, and so forth, of different age groups and families of varying sizes.

"There is good reason to believe," quoting from the testimony, "that the relationships shown between age, income, need for medical services, and resources available to meet these needs are probably applicable to the balance of the country without significant deviation."

Here are some of the basic findings in this highly refined analysis of the problem:

First. Income is the overwhelming determinant of the ability to get needed medical care.

Second. Income is inversely correlated with age. The older the person, the less his income.

Third. This significant correlation holds true even when an allowance is made for the smaller family size of aged households.

Nearly three-fifths of the low-income aged individuals in Michigan have no health insurance, as compared with less than one-third of the low-income younger individuals.

Even among the higher income aged individuals, more than two-fifths have no insurance, which is double the figure for all individuals, regardless of age.

Let me give another type of contrast. Keeping in mind that a higher proportion of the younger age groups than of the 65-and-over population is better off when it comes to income, even when allowing for larger family size, the following is highly pertinent:

First. For high income individuals aged 45 to 64, only 16 percent would have zero to one-half of their hospital medical bills paid for by insurance.

Second. In sharp contrast, 66 percent of the low-income aged individuals would have no more than one-half of their hospital medical bills paid for by insurance.

The two figures to compare are the 16 percent and the 66 percent—quite a gap. And these statistics do not even take into account that the average per capita hospital bill for the low income aged in Michigan was two to three times the bill for the 45 to 64 year olds.

In other words, their hospital bills are higher, but they have less protection against such bills through hospital insurance.

Taking into account the smaller size of the families with aged heads, two-fifths of such families in Michigan had incomes under $1,050, but less than one-fifth of younger families had such low incomes.

For low-income aged individuals, less than one-third have available any home care in case of sickness, whereas for low-income younger individuals, one-half to three-fifths would be able to have home care, that is, another able member of the family not regularly working outside the home.

THE ROLE OF VOLUNTARY HEALTH INSURANCE

The University of Michigan study leads me naturally to another basic point involved in the controversy over the financing of medical care for the aged; namely, the role of voluntary health insurance in meeting the problem.

Here, perhaps, we come to the heart of the matter. And in discussing this aspect of the controversy, I want to concentrate on four crucial questions:

First. The estimates of how many aged persons now have protection through hospital insurance.

Second. The adequacy of such coverage.

Third. The projections of how many aged will be covered in the future.

Fourth. The potential effect of Federal legislation on the private health insurance companies.

1. CURRENT COVERAGE

First of all, let me emphasize that despite all efforts on the part of the subcommittee staff we have not been provided with reliable information from the insurance companies on how many aged persons they now have on their rolls.

Even under direct questioning during our hearings, the insurance companies who testified declined to give the subcommittee any precise data.

In the questionnaires mailed to the companies scanty information was provided, even though the subcommittee promised to keep the names of the companies confidential.

The significance of such lack of figures is that there is no basis, therefore, for the widely advertised claims of the companies that they are meeting the problem today, or that they will have almost completely solved the problem at some date in the distant future.

Nevertheless, the Secretary of Health, Education, and Welfare has provided us with some estimates as to how many are covered as of 1960.

I emphasize the word "estimates." They are based on the assumption that the increases in older persons covered by insurance have continued at the same rate as prevailed between 1951 and 1957.

Let me repeat: the current estimates are based on an assumption. It is just as plausible to reason that a plateau may have been reached by 1957 and that the number with such insurance is decreasing because of the increasing cost of the premiums.

But even accepting the assumption of the Secretary of HEW, there are now perhaps 6½ million elderly Americans who have some type of health insurance coverage.

Mr. Flemming testified during our hearings to this effect. This means that about 9½ to 10 million persons over 65 still do not have any insurance.

This figure includes about 2½ million persons on old-age assistance, some of whom are eligible for varying amounts and qualities of medical care.

2. ADEQUACY OF CURRENT COVERAGE

This brings me to the next point, for the estimated 6½ million persons now covered, just how good is the protection they have? There are several ways of measuring the adequacy of coverage.

For example, the social security survey of beneficiaries in 1957 reported that among hospitalized insured couples, 73 percent had zero to one-half of their medical costs met by insurance.

Only 27 percent had more than one-half of costs met by insurance.

In the same survey, only 14 percent of all beneficiary couples had some of their medical costs covered by insurance.

In other words, as of 1957 insurance policies met very little of the medical costs of the social security beneficiaries, and these beneficiaries are better situated, financially, than other retired Americans.

A second way of measuring adequacy is to examine the premium costs relative to the benefits provided by such premiums.

For example, an individual would have to pay 80 percent more in premiums, often 100 or even 300 percent more, when converting a group policy after retirement for a policy with the same benefits as before retirement.

In other words, the retiree would be required to pay more in dollars for the same benefits.

Other examples involve not only slightly higher premiums, but a sharp decrease in benefits.

This is a crucial point to the retiree, because he suffers a sharp decrease in income when he leaves employment, only to find himself faced with an increase in the cost of his hospital insurance—and his risks of illness are increased as he gets older.

A third way of measuring adequacy is to inquire into what kinds of benefits he would get, for example, through a typical $6.50 per month policy.

To cite an example, one important company in this field provides for $6.50 for an individual per month the following benefits: Up to $10 per day for 31 days; up to $200 for surgery in or out of the hospital; up to $100 for miscellaneous hospital expenses.

There is, we should note, a 6-month waiting period for protection against any illness or accident previously experienced by the policyholder.

The company guarantees against cancellation of the policy, or raising the premium, unless it does the same for all policies in the individual's State as a group.

One of the basic weaknesses, if not the basic weakness of such policies, is that they are not based on a philosophy of preventive medicine.

A truly balanced approach to the health problems of the aged must include provisions for diagnosis, followup, and restorative medicine.

Furthermore, these policies are not geared enough to the chronic illness problem of the aged.

More specifically, we should note that "up to $10 a day" is far short of the typical $25-to-$30-a-day charge by hospitals around the country.

Also the 6-month waiting period for protection against preexisting medical conditions is a great obstacle to meaningful protection.

Furthermore, the guarantee against cancellation is not universal for all policies, and "cancellation" is not the same as nonrenewal. Actual cancellation can

occur at the end of the period for which the policy covers the insured person, except the word "cancellation" is not used in such cases. They call it, instead, nonrenewal.

In this connection let me cite the testimony of Frank van Dyke, a professor of administrative medicine of Columbia University, based on his study for the New York State Department of Insurance:

"An infinitesimal fraction of nongroup policies were lifetime, noncancelable, guaranteed renewable, and a small fraction were noncancelable, guaranteed renewable, up to a specified age limit.

"In the course of 1 year several thousand policies were canceled, restricted by rider, rescinded, or compromised by cash settlements upon agreement of the policyholder to terminate the policy."

The other findings of this study of New York insurance practices were that most group policies ended with the individual's retirement from a job, and that most of those group policies which did not end with retirement provided only reduced benefits to the policyholder.

Less than one-fourth of group policyholders had the right, in 1958, to convert their policies. And of this small percentage, four out of five had to take reduced benefits.

That is, less than 5 percent of all group policyholders could convert with no reduced benefits.

Six dollars and fifty cents a month, of $156 a year for an aged couple, is, furthermore, quite a burden for millions of aged Americans.

There is a contrast between the nature of the medical needs of the aged, such as diagnoses and long-term illness and the emphasis in current insurance programs on short-term illness and acute emergencies.

Mr. President, in this analysis of the private insurance approach to the problem, it is not my intention to criticize the motives of the insurance industry, nor their willingness to solve the problem.

My fundamental point is that I have very strong doubts about their ability to solve the problem.

Why is that the case? It comes down to the undeniable fact cited by Business Week magazine in its recent article on the subject:

"The problem basically is that the aged are high-cost, high-risk, low-income customers. Their health needs can be met only by themselves when they are younger or by other younger people who are still working. The only way to handle their health problem, therefore, is to spread the risks and costs widely. And that can best be done through the social security system to which employers and employees contribute regularly."

In other words, the essential weakness of the private insurance approach is that it must necessarily be based on experience rating.

That is, it discriminates against high-risk groups of men and women, even in the case of converted group policies.

One footnote should be added to this analysis of private insurance:

While the insurance companies have advertised and testified as to the great progress they are making, and to the wide variety of benefits they are just beginning to make available, it is also true that many of these companies do not operate in certain States; that many of the policies are available for only a specified, limited time of application, in only certain States.

3. PROJECTIONS OF COVERAGE IN THE FUTURE

Let us assume for the moment that the weaknesses I have outlined do not prevail, that existing and proposed benefits continue in the field of private, or so-called "voluntary" health insurance, that such insurance is adequate for those who have it.

Under these conditions, just how many aged Americans can we expect to have health insurance in the future?

Secretary Flemming's excellent staff of technicians have projected a figure of 56 percent—that 56 percent of our aged citizens might have coverage by 1965.

Even if this estimated 56 percent had adequate coverage, which is stretching it a bit, we would still have, as of 1965, 8 million senior Americans without any type of insurance.

This is far too many human beings who would be left out in the cold, dismal area of basic human needs.

Let us remember, the 56 percent figure is only a projection based on many optimistic assumptions such as those I mentioned earlier.

Mr. President, the Constitution charges Congress with providing for the general welfare.

The traditional and authorized purpose of government is, to quote Lincoln, "to do for a community of people whatever they need to have done but cannot do at all, or cannot do so well for themselves, in their separate and individual capacities."

The aged of America cannot do at all, or cannot do very well, for themselves, when compelled to meet the increasing costs of medical care—in their separate and individual capacities.

The so-called compulsory feature of our proposal is no more onerous than social security deductions. Federal deposit insurance, or taxes to pay firemen and policemen.

The Federal Government, by collecting a modest amount from each member of the younger working population and his employer against the costs of hospitalization and other medical services in retirement, will be meeting its legitimate purpose and duty.

"No democratic government," writes Business Week, "can refuse to grapple with a problem of such demonstrated urgency and importance. The issue cannot be evaded and, before it becomes a political football, the politicians of both parties should accept responsibility for finding the best possible answer in the shortest possible time."

In the same article the editors of Business Week conclude, after studying last year's report of the Secretary of HEW, that the social security approach is the best way of facing up to this urgent problem.

What the early advocates of the social security approach have been saying for the past several months has now been accepted by this leading publication in the business world.

And why not? This is not a matter of ideology. It is a case of just plain commonsense—and dollars and cents.

I ask unanimous consent that the text of the Business Week editorial, and a similar one from Life magazine, be printed in the Record at the conclusion of my remarks.

The PRESIDING OFFICER. Without objection it is so ordered.

(See exhibit 2.)

Mr. MCNAMARA. Mr. President, given the need, given the income status of the aged, given the limited potential of private health and hospital insurance, given the proven practicality of the tried-and-true social security mechanism for providing basic retirement income and disability benefits, there is simply no other alternative but the one we are espousing here.

In just a short 2 to 5 years after this program is in operation, I am sure we will be listening to speeches from our friends in the American Medical Association, the American Hospital Association, and even the Indiana Funeral Directors Association, proclaiming how life is so much better in America as a result of this and similar legislation. Until them, however, we will hear the usual arguments against social progress.

Many of the insurance companies, along with the AMA, have been using the argument that this legislative proposal would constitute a permanent solution to a temporary problem.

Just how long is temporary, anyway? Are they aware of the fact, for example, that a 65-year-old American today can expect, on the average, to live another 14 or more years?

Are they, therefore, suggesting that we wait 1½ decades before considering such legislation?

Call it political motivation if you will, but I see it as responding to a need for a practical solution to this human problem now.

Now, and not in 1975, or even 1961.

4. THE EFFECT OF FEDERAL LEGISLATION

The charge has been made that this legislation would adversely affect the financial standing of insurance companies and nonprofit plans offering policies for old-age health protection.

I doubt very much that the insurance industry would wither on the vine, no more than it has withered as a result of our old-age benefit program under social security.

In fact, private pension insurance has grown tremendously in the last 25 years.

I think the charge should be turned around and put in the form of a more important question: What will be the effect on current health insurance programs if there is no Federal legislation?

Certainly, in the case of the nonprofit insurance plans, the ones that currently insure the majority of the aged who are covered, such as Blue Cross, such legislation would be their salvation.

Let me cite one example. The Arkansas Blue Cross-Blue Shield plan, as of the end of 1959 had only a little more than 5,000 persons 65 and over covered by its policies.

But even with this small number of aged subscribers, the Arkansas plan was forced to absorb a loss of over $83,000 in 1959 to pay for their hospital and surgical expenditures.

This amounts to slightly more than $16 loss beyond income from premiums for each of its aged policyholders.

Is anyone suggesting that the Arkansas Blue Cross-Blue Shield plan add to its rolls all of the 187,000 elderly citizens of Arkansas?

At the rate of loss the plan is now enjoying, that would put the Arkansas Blue Cross-Blue Shield only $3 million in the red.

Is it really so horrible that Federal legislation would prevent such results?

I could cite other examples in detail. Let me, however, merely call attention to the fact that in 1959 the Texas Blue Cross-Blue Shield plan in Dallas, with nearly 44,000 aged enrollees, experienced a $1,600,000 loss as a result of insuring the elderly.

In 1958, the New Jersey Blue Cross-Blue Shield, with over 72,000 aged subscribers, had a loss of $1.9 million as a result of insuring the elderly.

As a result, in 1959, New Jersey Blue Cross was forced to raise drastically the premiums on their policies.

The examples I have cited of Blue Cross experience are not exceptions, I assure the Senate. These experiences should immediately raise the question: If the private nonprofit insurance plans, which are the cheapest and the best and which cover the largest portion of insured aged, like Blue Cross, if they continue to suffer such deficits, how can the commercial companies provide adequate coverage at a decent cost for the aged and still make a profit?

The answer is that they cannot. If they are going to stay in business and still insure the aged, they must raise the premium and reduce the benefits.

Therefore, if we continue the Blue Cross approach we will encourage greater and greater deficits.

If we continue the commercial policy approach we will have to tolerate fewer benefits at a higher cost.

The result of either approach is chaos, along with a limit to the number of aged covered by voluntary insurance.

I do not think, either, that a Federal-State subsidization of the voluntary insurance plans is the answer. This suggestion does not meet the test of practicality, to cite Business Week.

We would not get all of the States to participate adequately, and even if we could it would take too long for all of the States to finally get around to legislating such participation.

Furthermore, there is no guarantee of adequate benefits under one of the most recent proposals along these lines.

Prof. J. Douglas Brown, an economist and dean of the faculty at Princeton University, has put the criticism more bluntly:

"At best a clumsy, hybrid arrangement, involving overwhelming administrative difficulties and excessive costs. For the Government and the beneficiary, the economies and convenience of a large and uniform system of protection would be lost.

"The Government would pay more, the beneficiaries would get less, and the private carriers would trade freedom for little profit and thankless regulation."

Under the program which would provide Federal-State subsidization of private insurance carriers—there would also be a means test—although the advocates of the proposal insist on calling it an income test. Despite the name, it is still degrading.

Finally, I do not see why the Federal and State Governments should have to subsidize premiums of which a large part is lost for the consumer of medical services because of the relatively low loss ratios experienced by private carriers. Under the social security approach, the provision of health services could be obtained for no more than 5 percent of the total amounts received by the system; in other words, a 95-percent loss ratio.

But today, under individual policies sold by the commercial carriers, the loss ratios are no more than 50 percent; under group policies, about 80 to 85 percent.

We need and want, instead, a program in which the people would get the maximum amount of their contributions returned in the form of actual health benefits.

Only under social security is this possible; only under social security.

I want to stress another point that has been lost in the shuffle: An adequate Federal old-age health insurance plan actually can be a stimulus for a positive contribution by voluntary health insurance plans.

I say this in the face of arguments by the insurance companies, to the contrary. I say this because, for one thing, such legislation would make possible a reduction in private group insurance premiums for those labor-management policies which now include retired workers.

In addition, for many nongroup policyholders below 65, premium reductions or benefit increases would thus be possible.

Finally, even for our aged covered by the legislation, many of them would then be able to purchase, through voluntary insurance, additional benefits. To cite one example provided the subcommittee by Professor van Dyke of Columbia University, the Rochester, N.Y., Blue Cross plan would be able, under a 60-day Federal benefit program, to reduce the nongroup premium to no more than 10 percent higher than the group premium for the under-65 population.

Such legislation would also allow Blue Cross to provide supplementary benefits to the over-65 population for about $1 per month.

Thus, as a result of the type of legislation being proposed here, commercial health insurance could offer reduced-premium plans to those groups now paying for high-risk older men and women, and also supplementary benefits plans for those already retired but protected basically through OASI health insurance.

Nonprofit plans like Blue Cross would thus be saved from the deficit-creating burden of insuring the high-risk, high-cost aged and also, like the commercial plans, they could offer better and supplementary programs for employees and retired persons.

These comments concerning the impact upon insurance companies, especially Blue Cross plans, apply with even greater weight to the effects on hospitals.

The deficits in the budgets of hospitals around the country are too well known for me to document here.

But I wonder how many of my colleagues are aware of the fact that the operating deficits of the hospitals are, in large part, due to the financial inability of their aged patients to pay their bills?

In Boston, for example, the Massachusetts General Hospital reports that in just a 6-month period in 1958 one-third of all the ward admissions were 65 and over and that they were responsible for about $500,000 of that hospital's operating deficit, actually more than one-third of the total deficit.

Let me present the breakdown on the total payments of the nearly 2,000 elderly patients involved in this particular hospital's experience:

First. The total hospital bill was more than $800,000.

Second. The hospital provided free service amounting to $150,000, or over 18 percent of the total amount.

Third. Public assistance paid for nearly $240,000, or nearly 30 percent of the total amount.

Fourth. There was an unpaid balance of $135,000, or nearly 17 percent of the total amount.

Fifth. Insurance plans paid for nearly $108,000, or only 13 percent of the total amount.

Sixth. And the elderly patients themselves paid directly $173,000, only 21.5 percent of the total amount.

The lessons to be drawn from this example should be clear first, that through insurance and direct payments the aged were able to pay the hospital only 35 percent of the total hospital bill they incurred altogether; second, for nearly three-fourths of the remaining hospital bill public assistance and the hospital itself footed the expenses.

Of course, there is a strong possibility that the unpaid balance—or a large part of it—might remain unpaid with the hospital having to absorb the debt.

The Massachusetts General Hospital story is not unusual. It is, furthermore, a reflection of the inability not only of the aged and their families to pay for such medical costs but also of the local communities and the States to meet this growing problem.

One of our distinguished witnesses, Dr. James P. Dixon, formerly commissioner of the Philadelphia Public Health Department, and now president of Antioch College, has put the problem in a nutshell:

"The experience of the hospital field in dealing with local and State governments to obtain sufficient funds to underwrite the care of economically disadvantaged groups has not been an entirely happy one even for the care of clearly indigent persons.

"It seems necessary to turn to the Federal Government in order to find a broad enough base of tax support, and at sufficiently generalized definition of eligibility, to be successful in meeting the needs of our highly mobile older population.

"There is a growing feeling among hospital people that neither Blue Cross nor commercial insurance now meets, or can meet, the financial needs of older people with respect to hospital care. There is an increasing conviction that Federal participation will be necessary.

"There is lack of agreement as to the form that Federal participation should take—although there is a tendency at this time to favor an OASI mechanism" (from "Medical Care for the Aged: The Hospital's Viewpoint," American Journal of Public Health, February 1959).

To repeat, the legislation we are considering now will go a long way toward improving the financial status of insurance plans in the business of protecting the employed population of our country and toward helping the Nation's hospitals to reduce the back-breaking deficits they are now forced to assume.

PROVISIONS OF AN ADEQUATEE HEALTH INSURANCE PROGRAM FOR RETIRED AMERICANS

Mr. President, in my opinion, the time has long passed beyond the point of establishing the need for Federal action on the problem of financing the basic health care of our aged through the social security system.

The real issue is to make sure that in deciding these benefits we alert ourselves to the wisest counsel of authorities in the fields of medicine, hospital care, public health, and medical economics.

The real issue is to assure the Nation that the philosophy of modern medicine will be applied in meeting the health needs of our senior Americans.

In the bill I am presenting there are included the following provisions:

First of all, the group of citizens covered by the bill consists of retired aged persons, 65 and over for men, 62 and over for women.

These are retired persons only. It is this group among all the aged who have an undeniable need for such protection.

The numbers involved amount to about 14.8 million people: 11.3 million men and women now receiving OASI benefits, 1.7 million now receiving old-age assistance and nothing from OASI, and 1.8 million other retired persons. The bill provides for a definition of "retirement."

I consider this feature of the proposed legislation one of the most important. It puts to rest the criticism of such bills as the Forand bill that it excludes too many of our aged citizens now eligible for benefits under social security.

Here is the opportunity for the opponents of such legislation, including the Vice President, to show exactly how sincere they really are in objecting to the omission of such persons as the 2 million old-age assistance recipients. The Retired Persons Medical Insurance Act would include these and other non-OASI retired men and women.

If the charge by the opponents of the Forand bill has been leveled in a truly sincere effort and in the spirit of constructive criticism, they should be pleased to learn that we have accepted their criticism at face value and thus have proposed the inclusion of the aged men and women for whom all of us, even the opposition, have a deep concern.

The primary source of financing is through the social security system increasing the present tax one-fourth of 1 percent from employees and one-fourth of 1 percent from employers.

For those retired aged not now eligible for OASI benefits, a contribution from the general revenue will be necessary.

Not all of such a contribution would be new costs, however, since the Federal Government is already paying large sums in the form of grants to the States, payments to the Veterans' Administration, and so forth, for the aged's medical care.

While the proposed legislation would provide up to 90 days a year of hospital care, I am firmly convinced that hospitalization also needs to be accompanied

by alternative possibilities and followup facilities such as skilled nursing home care and supervised home medical care.

The bill therefore provides for direct admission into skilled nursing homes and direct use of home medical services without having to first enter into a hospital.

The number of days of such services would depend on the number of unused hospital days, but the maximum number of skilled nursing home days would be 180, and for home visits 240 in a year.

Modern medicine basically aims at keeping people out of hospitals; and, therefore, the bill includes the very important provision of outpatient diagnostic services such as laboratory tests and X-rays.

These basic provisions—hospitalization, skilled nursing home service, home health services backed up by diagnostic services—constitute, in the expert opinion of authorities in the health field, the basic package of any truly adequate health services program for the aged.

Hospitalization by itself is not the answer. For one thing, after basic treatment in a hospital the aged patient often needs only skilled nursing care in a qualified nursing home.

Or once recovered from a stroke, he remains in need of physical therapy which can be applied in his home.

Without these alternatives and followthrough possibilities, hospitalization by itself can lead to overusage of beds and, more important, to disappointments among the aged who stand in need of restorative medicine.

Such alternatives also can amount to a 10- to 15-percent reduction in hospital care.

Hospitalization by itself is only a link in the chain of medical attention which can restore many aged men and women to a more active life.

It requires other links such as diagnostic services and home care.

Another section of this bill is an attempt to provide another necessary link in an adequate foundation for the health care of our retired aged Americans.

The data of the Health Information Foundation, sponsored by the drug firms in our country, show that the aged have had a greater increase than the general population in expenditures for drugs and medicines.

They spend a higher portion of their medical dollar on drugs and medicines than the general population, and they amount they spend is more than twice the amount spent by people of all ages.

Old age brings with it a greater, and a constant rather than an intermittent, use of drugs and medicines.

Time after time the subcommittee heard of cases of older persons putting off going to a doctor, not so much because of the cost of physicians' services, but, rather, because of their fear of the cost of that prescription which automatically goes with a doctor's diagnosis.

The bill, therefore, provides for payment of a portion of very expensive drugs prescribed by a doctor using generic names, with the amounts and kinds of drugs to be determined by the Secretary of Health, Education, and Welfare, after a year's study.

The opponents of such legislation naturally will raise the cry of "how much will it cost?" First, let me make the general reply that the costs are geared to the human needs for an adequate health program for the retired aged citizens of the United States, a nation which boasts of its wealth and its great genius in solving social problems.

In a society like ours the issue is not: can we pay for progress in health? The issue is: do we want to pay for such progress? The decision we have to make, therefore, is a moral one.

The public opinion polls indicate that most Americans are willing to accept such an approach.

Once having made the moral decision, the problem is then to decide on the most practical, reasonable manner in which to carry out the decision.

This, too, has been pretty well determined through the machinery of the social security system, basically.

Given these particular conclusions, of course, there is the question of how much do we want to spend on a program of basic medical care for the retired aged.

There is widespread agreement that any program now will have to be confined to the income gained through a one-fourth of 1 percent tax by the employer and by the employee on the first $4,800 of wages.

And an increase, three-eighths of a percent for the self-employed.

On an individual basis, this comes to a maximum of $1 a month or about 24 cents a week from the employer and from the employee.

The benefits I have outlined do not all become available all at once.

In the bill I am introducing, hospitalization diagnostic services become available as of July 1, 1961, or not later than January 1, 1962, if the Secretary of HEW deems it necessary.

Nursing home care and expensive drug costs would be phased in over a period of 1 to 1½ years.

Nursing homes, for example, need to be brought up to standards before we start paying for their services.

Therefore, payments for nursing home care would start on January 1, 1963, and not later than July 1 of the same year.

Home health services would start on January 1, 1962, or not later than July 1 in the same year.

Partial payments for very expensive drugs would start on July 1, 1962, and not later than July 1 of the following year.

The Secretary of HEW would be authorized to designate the dates within these periods, when these benefits would be available.

Thus, keeping in mind the practical aspects of introducing what is considered to be an adequate health program for the retired aged, we have thus allowed for a gradual introduction of such a program. This also, again being realistic, means a lower cost at the outset.

The two first provisions—hospitalization and diagnostic services—would cost $1.1 billion.

By the end of the entire waiting period, with all the services made available, including nursing homes, home medical care, and expensive drugs, the total cost would be $1.5 billion a year. About $1.1 billion would come from the social security payroll deduction, the remainder from general revenue. I repeat the point made earlier, that the Federal Government is already contributing the bulk of such a remainder.

I must, at this point, make clear again that very little of these amounts can be said truthfully to constitute costs to the Government.

Remembering that the basic financing comes through the payroll tax of the employed population, this can hardly be called Government costs.

Furthermore, as I said before, a large part of the expenditures on the non-OASDI retired aged under this bill is already being met through the Treasury.

The Federal share of vendor payments for medical care under old-age assistance, for example, is about $153 million, not to mention large amounts already being expended on hospitalization and related services for other groups, about $85 million.

These, then, are the major provisions of the legislation. Its passage will be an accomplishment of which the entire Nation would be proud.

A few other aspects of the bill should be briefly mentioned:

While the benefits included do not provide payment for surgical care by physicians, they do include payments for all other hospitalization expenses associated with surgery, such as the use of the operating room, anesthetics, and so forth.

The Secretary of HEW may use the accrediting service of the American Hospital Association for assuring quality of care.

Only those nursing homes will be included which meet truly adequate standards for care and rehabilitation.

An Advisory Council, consisting of the Commissioner of Social Security, the Surgeon General of the Public Health Service, and representatives of the general public and of the hospital and health fields, shall advise and assist the Secretary of HEW in the formulation of policy.

If the Secretary deems it advisable, he may use the services of nonprofit organizations skilled in dealing with hospitalization of patients in the whole or any part of the United States.

Although the provisions do not apply to retirees under the Railroad Retirement Act, or to retirees of the Federal Government, they could come under the program by their funds "buying into" the act's medical insurance trust fund at a later date.

Finally, as a way of deliberating, seeking to improve the health status of our aged citizens, the act calls for research and demonstration programs by the Department of HEW on how to improve health services.

Mr. President, the passage of the Retired Persons Medical Insurance Act—S. 3503—would be a major accomplishment of which the entire Nation, and the Congress, will be proud.

A brief study of the history of related legislation will show that a few years after its passage even the opponents of this current proposal will be praising its beneficial effects upon the millions of Americans directly involved, and upon the larger millions of other Americans indirectly affected by the problem of financing adequate health care of the aged.

Mr. President, in conclusion I ask unanimous consent that the names of Senator McCarthy, Senator Engle, Senator Green, Senator Bartlett, and Senator Mansfield be added as cosponsors of S. 3503.

For the record I should like to say that Senator McCarthy was an original cosponsor but his name was left off the bill through inadvertence.

The PRESIDING OFFICER. Without objection, it is so ordered.

EXHIBIT 1

Cardiovascular conditions, by age groups [1]

Under 25	536,000
25 to 44	1,451,000
45 to 54	1,666,000
55 to 64	2,416,000
65	4,048,000
Total under 65 (3.8 percent of age group)	6,069,000
Total 65 and over (26 percent of age group)	4,048,000
Total in all age groups (5.77 percent)	10,117,000

[1] From testimony of Deputy Surgeon General Porterfield.

Number of patients discharged, number per 1,000 persons per year, and percent distribution; number of hospital days, number per 1,000 persons per year, and percent distribution, and average length of stay of patients discharged, excluding deliveries, by sex and age: Short-stay hospitals, United States, July 1957–June 1958

Sex and age	Discharges (excluding deliveries)			Hospital days (excluding deliveries)			Average length of stay (in days)
	Number (in thousands)	Number per 1,000 persons	Percent	Number (in thousands)	Number per 1,000 persons	Percent	
BOTH SEXES							
All ages	13,231	78.6	100.0	127,437	756.9	100.0	9.6
Under 15	2,796	53.1	21.1	15,515	294.8	12.2	5.5
15 to 24	1,508	71.5	11.4	12,974	615.1	10.2	8.6
25 to 44	3,775	82.7	28.5	32,229	705.9	25.3	8.5
45 to 64	3,397	98.5	25.7	40,910	1,186.8	32.1	12.0
65 to 74	1,148	119.2	8.7	16,363	1,699.7	12.8	14.3
75+	606	124.0	4.6	9,446	1,933.3	7.4	15.6
MALE							
All ages	6,090	74.4	100.0	66,743	814.9	100.0	11.0
Under 15	1,591	59.3	26.1	8,456	315.1	12.7	5.3
15 to 24	610	62.2	10.0	7,310	745.8	11.0	12.0
25 to 44	1,408	64.3	23.1	15,291	698.7	22.9	10.9
45 to 64	1,670	99.8	27.4	22,877	1,366.7	34.3	13.7
65 to 74	547	121.3	9.0	8,663	1,920.4	13.0	15.8
75+	263	123.4	4.3	4,145	1,945.1	6.2	15.8
FEMALE							
All ages	7,141	82.6	100.0	60,694	702.0	100.0	8.5
Under 15	1,205	46.7	16.9	7,059	273.6	11.6	5.9
15 to 24	898	79.5	12.6	5,664	501.6	9.3	6.3
25 to 44	2,367	99.6	33.1	16,937	712.5	27.9	7.2
45 to 64	1,727	97.4	24.2	18,033	1,017.0	29.7	10.4
65 to 74	601	117.5	8.4	7,699	1,504.9	12.7	12.8
75+	343	124.5	4.8	5,301	1,924.1	8.7	15.5

Source of this and following tables from National Health Survey, U.S. Public Health Service.

Number of patients discharged, number per 1,000 persons per year, and average length of stay by sex, age, and race: Short-stay hospitals, United States, July 1957–June 1958

Sex and age	Number of discharges in thousands			Number per 1,000 persons			Average length of stay in days		
	Total	White	Non-white	Total	White	Non-white	Total	White	Non-white
BOTH SEXES									
All ages	16,738	15,473	1,205	99.4	103.3	68.2	8.6	8.4	10.2
Under 15	2,801	2,580	221	53.2	56.5	31.6	5.5	5.2	10.0
15 to 24	2,901	2,624	278	137.5	142.3	104.7	6.5	6.5	6.8
25 to 44	5,868	5,377	492	128.5	131.6	102.8	7.2	6.9	10.4
45 to 64	3,413	3,195	218	99.0	101.9	70.0	12.0	11.9	13.9
65+	1,754	1,698	56	120.9	125.7	55.9	14.7	14.8	12.2
MALE									
All ages	6,090	5,677	413	74.4	77.8	46.4	11.0	10.6	16.5
Under 15	1,591	1,483	109	59.3	63.6	31.1	5.3	5.0	9.6
15 to 24	610	570	40	62.2	66.5	32.4	12.0	11.7	15.4
25 to 44	1,408	1,286	122	64.3	65.3	55.8	10.9	9.8	22.5
45 to 64	1,670	1,558	112	99.8	102.2	74.6	13.7	13.4	18.2
65+	810	780	30	122.0	126.5	62.9	15.8	15.9	12.4
FEMALE									
All ages	10,648	9,797	852	123.2	127.5	88.3	7.2	7.2	7.2
Under 15	1,210	1,097	113	46.9	49.2	32.4	5.8	5.4	10.4
15 to 24	2,291	2,054	237	202.9	208.1	166.8	5.1	5.0	5.3
25 to 44	4,460	4,091	369	187.6	193.3	141.8	6.0	6.0	6.4
45 to 64	1,743	1,637	106	98.3	101.6	65.8	10.4	10.5	9.3
65+	944	919	26	119.9	125.1	49.5	13.8	13.8	12.0

Percent distribution of patients discharged: by length-of-stay intervals according to sex and age: short-stay hospitals, United States, July 1957–June 1958

Sex and age	Length-of-stay intervals in days						
	Total	1	2 to 7	8 to 14	15 to 30	31+	Unknown
BOTH SEXES							
All ages	100.0	10.4	60.0	18.0	7.9	3.5	0.2
Under 15	100.0	28.0	54.7	10.0	5.2	1.9	.2
15 to 24	100.0	9.7	76.0	8.9	2.8	2.1	.5
25 to 44	100.0	6.7	70.3	16.1	4.8	2.0	.1
45 to 64	100.0	6.0	44.5	29.6	14.2	5.5	.2
65+	100.0	3.8	37.4	29.7	18.7	9.8	.6
MALE							
All ages	100.0	13.7	48.2	20.8	11.4	5.6	.3
Under 15	100.0	28.4	55.9	8.6	4.8	1.9	.3
15 to 24	100.0	14.9	57.0	15.2	4.9	7.2	.7
25 to 44	100.0	9.9	53.8	22.0	8.7	5.5	.1
45 to 64	100.0	6.9	40.8	28.3	17.5	6.5	.1
65+	100.0	4.2	31.7	31.6	21.6	10.0	.9
FEMALE							
All ages	100.0	8.5	66.8	16.4	5.9	2.3	.2
Under 15	100.0	27.5	53.2	11.7	5.8	1.7	----------
15 to 24	100.0	8.4	81.1	7.2	2.2	.7	.4
25 to 44	100.0	5.7	75.6	14.2	3.6	.9	.0
45 to 64	100.0	5.2	48.0	30.9	11.1	4.6	.3
65+	100.0	3.5	42.3	28.1	16.2	9.6	.4

Percent distribution of hospital days by length-of-stay intervals according to sex and age: Patients discharged from short-stay hospitals, United States, July 1957–June 1958

Sex and age	Length-of-stay intervals in days					
	Total	1	2 to 7	8 to 14	15 to 30	31+
BOTH SEXES						
All ages	100.0	1.2	29.7	22.5	19.5	27.1
Under 15	100.0	5.1	37.6	19.4	20.5	17.4
15 to 24	100.0	1.5	47.1	14.3	9.1	27.9
25 to 44	100.0	.9	42.7	23.0	13.9	19.5
45 to 64	100.0	.5	16.7	27.2	24.7	31.0
65+	100.0	.3	11.6	22.0	27.4	38.8
MALE						
All ages	100.0	1.2	18.9	20.8	22.4	36.7
Under 15	100.0	5.3	40.3	17.5	19.9	17.0
15 to 24	100.0	1.2	19.3	14.0	8.3	57.2
25 to 44	100.0	.9	22.5	21.3	17.1	38.2
45 to 64	100.0	.5	13.6	23.1	27.1	35.7
65+	100.0	.3	9.5	22.0	30.1	38.0
FEMALE						
All ages	100.0	1.2	39.1	23.9	17.0	18.8
Under 15	100.0	4.7	34.5	21.6	21.4	17.9
15 to 24	100.0	1.7	64.6	14.5	9.7	9.5
25 to 44	100.0	1.0	54.2	23.9	12.1	8.8
45 to 64	100.0	.5	20.5	32.3	21.6	25.0
65+	100.0	.3	13.6	22.0	24.6	39.5

Percent distribution of persons by limitation of activity due to chronic conditions according to sex and age: United States, August 1957

Limitation of activity	Age					
	All ages	Under 15	15 to 24	25 to 44	45 to 64	65+
BOTH SEXES						
All persons	100.0	100.0	100.0	100.0	100.0	100.0
With no chronic conditions	58.6	83.1	69.2	50.8	39.9	24.0
With 1+ chronic conditions	41.4	16.9	30.8	49.2	60.1	76.0
Not limited in activities	31.3	15.5	26.8	41.5	43.3	33.7
Not limited in major activity but otherwise limited	3.0	.6	2.0	2.7	5.2	9.0
Limited in amount or kind of major activity	4.9	.6	1.7	4.2	8.8	18.2
Unable to carry on major activity	2.2	.1	.4	.8	2.8	15.1
MALE						
All persons	100.0	100.0	100.0	100.0	100.0	100.0
With no chronic conditions	61.5	81.6	74.1	55.7	43.9	25.6
With 1+ chronic conditions	38.5	18.4	25.9	44.3	56.1	74.4
Not limited in activities	28.8	16.8	22.5	36.6	40.5	31.6
Not limited in major activity but otherwise limited	2.4	.8	1.6	2.3	3.6	7.3
Limited in amount or kind of major activity	4.5	.6	1.5	4.4	8.0	15.8
Unable to carry on major activity	2.8	.2	.3	1.0	3.9	19.7
FEMALE						
All persons	100.0	100.0	100.0	100.0	100.0	100.0
With no chronic conditions	55.9	84.8	65.0	46.2	36.0	22.7
With 1+ chronic conditions	44.1	15.2	35.0	53.8	64.0	77.3
Not limited in activities	33.6	14.3	30.5	46.0	46.0	35.5
Not limited in major activity but otherwise limited	3.6	.4	2.3	3.1	6.8	10.3
Limited in amount or kind of major activity	5.3	.5	1.8	4.1	9.4	20.2
Unable to carry on major activity	1.6	.1	.5	.6	1.8	11.3

Percent distribution of persons by limitation of mobility due to chronic conditions according to sex and age: United States, August 1957

Limitation of mobility	All ages	Under 45	45 to 64	65+
BOTH SEXES				
All persons	100.0	100.0	100.0	100.0
With no chronic conditions	58.6	68.2	39.9	24.0
With 1+ chronic conditions	41.4	31.8	60.1	76.0
Not limited in mobility	38.1	31.0	55.7	55.4
Has trouble getting around alone	1.9	.5	2.7	11.5
Cannot get around alone	.6	.1	.6	4.1
Confined to house	.8	.2	1.1	4.9
MALE				
All persons	100.0	100.0	100.0	100.0
With no chronic conditions	61.5	70.6	43.9	25.6
With 1+ chronic conditions	38.5	29.4	56.1	74.4
Not limited in mobility	35.6	28.5	52.0	56.4
Has trouble getting around alone	1.9	.5	2.7	11.6
Cannot get around alone	.3	.1	.3	1.9
Confined to house	.8	.3	1.1	4.5
FEMALE				
All persons	100.0	100.0	100.0	100.0
With no chronic conditions	55.9	66.0	36.0	22.7
With 1+ chronic conditions	44.1	34.0	64.0	77.3
Not limited in mobility	40.5	33.3	59.1	54.6
Has trouble getting around alone	1.9	.5	2.8	11.4
Cannot get around alone	.8	.1	.9	5.9
Confined to house	.8	.1	1.1	5.3

Number of days and number of days per person per year of restricted activity and bed disability by sex and age: United States, July 1957–June 1958

Sex and age	Number of days in millions		Number of days per person per year	
	Restricted-activity days	Bed-disability days	Restricted-activity days	Bed-disability days
BOTH SEXES				
All ages	3,369.6	1,309.9	20.0	7.8
Under 5	255.8	111.8	13.2	5.8
5 to 24	829.8	393.9	15.3	7.2
25 to 64	1,597.4	567.0	19.9	7.1
65+	686.7	237.2	47.3	16.3
MALE				
All ages	1,452.5	561.3	17.7	6.9
Under 5	126.2	51.0	12.8	5.2
5 to 24	377.3	177.9	14.1	6.6
25 to 64	648.6	225.8	16.8	5.8
65+	300.4	106.5	45.2	16.0
FEMALE				
All ages	1,917.1	748.6	22.2	8.7
Under 5	129.6	60.7	13.7	6.4
5 to 24	452.5	216.0	16.4	7.8
25 to 64	948.8	341.2	22.9	8.2
65+	386.3	130.7	49.1	16.6

EXHIBIT 2

[From Business Week, Apr. 16, 1960]

A CHALLENGE THAT CAN'T BE DUCKED

Health insurance for the aged is fast becoming the No. 1 issue facing Congress this year. And there's political dynamite in it: Any candidate suspected by

the millions of old people (and those concerned about their health problems) of taking a cold or know-nothing attitude toward the issue is likely to be in serious trouble this election year.

One thing about the issue is clear: Although plenty of politicians may see it as a vote-catching device, there is nothing synthetic or phony about the problem. Everyone who has seriously studied the situation has concluded that the provision of better health care for the aged is a serious and growing problem. Thanks to medical progress, the number of aged is increasing rapidly. In 1930, there were 6 million people over 65 in the United States; today there are 16 million.

For far too many of these, long life has meant shrunken incomes, increased sickness, loneliness, and the shame of being a candidate for a handout from society. Health, Education, and Welfare Secretary Flemming, in his thorough report to the House Ways and Means Committee last year, concluded that three out of every four aged persons would be able to "prove need in relation to hospital costs." That is to say, they would be able to prove that they simply could not afford to pay for the care they needed when taken seriously ill.

The issue, then, is not whether there is a problem but rather how to meet the problem.

TWO APPROACHES

Representative Aime Forand, Democrat, of Rhode Island, has proposed to deal with it through a system of compulsory Federal insurance within the framework of the Social Security Act. The Forand bill would provide insurance covering 60 days of hospital care, or 120 days of combined hospital and nursing home care, together with surgical services, to all those eligible for old-age insurance benefits. It would be financed, initially, by boosting social security payroll taxes one-half of 1 percent, divided equally between employees and employers.

The Forand bill has been attacked for a number of reasons by various groups, especially the American Medical Association, which sees it as the camel's nose of socialized medicine coming under the tent.

But the main weakness of the Forand bill, as specialists in the health field see it, is not that it does too much but too little. They condemn it as too narrow and as an encouragement to "hospitalitis"—the tendency, inherent in many of our present voluntary insurance programs, to put the sick into hospitals because there are no provisions for covering treatment at home or in doctors' offices.

The bill sponsored by Senator Javits, Republican, of New York, strikes at this weakness. As Javits points out, though hospitalization costs comprise a large part of an aged person's annual medical bill, the average older couple spends $140 a year on health costs unrelated to hospitaliaztion. "One out of every six persons 65 years and older," says Javits, "pays over $500 in medical bills annually." Yet 60 percent of the old people have annual incomes under $1,000 and can't afford home or office care that might cut down the length of hospitalization or eliminate it altogether.

Javits would deal with the problem by a voluntary program that would combine Federal and State subsidies, contributions sealed to income by the aged themselves, and both commercial and nonprofit insurance companies such as Blue Cross and Blue Shield. The program would not become operative in any State until the State put up the money, arranged with the insurance carriers, and agreed to certain standards for the program.

Although the Javits bill makes a hard effort to provide a voluntary (and heavily subsidized) program, it does not appear to meet the test of practicality. The program would take a very long time to negotiate with 50 individual State governments and with the insurance carriers—assuming that it would be possible at all to get them involved in a program whose costs are unpredictable.

Indeed, after studying Flemming's able report, and the arguments on all sides of this issue, we are forced to conclude that the voluntary approach simply will not do the job.

The problem basically is that the aged are high-cost, high-risk, low-income customers. Their health needs can be met only by themselves when they are young or by other younger people who are still working. The only way to handle their health problem, therefore, is to spread the risks and costs widely. And that can best be done through the social security system to which employers and employees contribute regularly. By comparison with the heavily subsidized schemes, this approach has the advantage of keeping old people from feeling that they are beggars living off society's handouts.

We do not pretend to know all the answers to the problem of enlarging the social security system to include a health insurance program for the aged. Even a modest study of the problem immediately convinces anyone of its difficulty and complexity. At this point, we don't think that the complete answer to it has emerged.

Nevertheless, no democratic government can refuse to grapple with a problem of such demonstrated urgency and importance. The issue cannot be evaded and, before it becomes a political football, the politicians of both parties should accept responsibility for finding the best possible answer in the shortest possible time.

[From Life magazine, Apr. 25, 1960]

AGE, HEALTH, AND POLITICS

The hottest political potato so far in this election year is this question: Are Americans over 65 entitled to Federal help to meet their hospital and doctor bills?

The Forand bill, which would raise $1 billion for such care by a one-half of 1 percent boost in the social security tax, has produced floods of favorable mail and given the Democrats an unexpected issue. Republicans, while granting the need for aid, are trying to find a more private, voluntary alternative. Since the issue is important, let's try to separate its social realities from its politics and facts from principles.

Unquestionably, many older Americans (15.8 million are over 65) are in real need. The average $72 a month they draw from social security scarcely provides food and shelter, much less for the medical expenses which increase with age. Few are in a position to meet the cost of chronic illness from which many suffer. Yet even to get charity care—itself inadequate in quantity and often inferior in quality—they must suffer the indignity of a pauper's oath.

Can their need for medical aid be provided by private, voluntary Blue Cross-type plans? These are expanding, but can never meet the whole need. Premiums for the aged as a separate group are prohibitively high. The least burdensome method of insurance is for the whole society to spread the costs over the whole working life cycle. The cheapest and most logical way of doing this, whether by the Forand bill or a better one, is by extending the existing system of social security.

To provide this aid need not be socialized medicine, as opponents claim, since payments could be made through private channels and patients select their own doctors and hospitals as before.

The first question of principle is whether this form of aid will undermine the private duty of providing for one's own old age through old-fashioned virtues like foresight and thrift. Being a floor, not a ceiling, it need not do so. Individuals will still have plenty of incentive to save for the future, though less fear of it.

Another question of principle is whether it is the proper function of a free government to offer special help to its older citizens. That principle was accepted when social security itself became effective in 1937. The presumption against any extension of Federal activity and expenditure, though Jeffersonian in origin, is now championed, though weakly, by the Republicans, who don't want to be tagged as enemies of the aged. But an extension of an established system like social security is not a violation of principle. But there is also an issue of cost.

Not even the Democrats can extend the welfare state without reference to the price tag. Enough spending bills were introduced in Congress last year to add $50 to $60 billion to our existing $78.4 billion budget if passed. Priorities, therefore, have to be determined. Health aid to the aged can be provided, but it may mean fewer schools, highways, or other needs which may also be urgent. A related question is whether aid to the aged can be done without renewed inflation. The aged, on small and fixed incomes have been the chief sufferers from inflation, and this is a good reason for giving social security a high priority. By the same token, any aid program that feeds inflation would defeat its own purposes and fool its beneficiaries. So the costs of any plan adopted must be carefully limited and controlled.

Doubtless the Forand bill can be improved. Some $200 million could be saved simply by raising the eligible age from 65 to 68. Moreover, many oldsters

able and eager to work could better provide for their own security if the $1,200 limitation were raised on the income they may earn without forfeiting social security pensions.

But in principle, such aid is proper public business. The issue is therefore inevitably and properly a political one. It should be decided according to the Nation's sense of justice, urgency, and choice of priorities in the use of scarce resources—as interpreted by the Nation's elected Representatives in Congress.

The CHAIRMAN. Senator, I would just like to ask one question.

How does this compare to the Forand bill?

Senator MCNAMARA. I don't know anything about the details of the Forand bill, but it has the same general approach in that it uses the so-called social security system to provide prepaid medical insurance for retired people.

I think to that degree it is similar.

The CHAIRMAN. Have you got a list of the patrons of the amendment here?

Senator MCNAMARA. The 23 Senators who joined me are: Senators Kennedy, Clark, Randolph, Symington, Humphrey, McGee, Williams of New Jersey, Young of Ohio, Douglas, Gruening, Long of Hawaii, Murray, Hart, Magnuson, Morse, Hennings, Jackson, Pastore, McCarthy, Bartlett, Engle, Green, and Mansfield.

The CHAIRMAN. Thank you very much, Senator.

Senator MCNAMARA. Thank you for your courtesy.

The CHAIRMAN. Senator Gore?

Senator GORE. I wish to congratulate you, Senator McNamara in the work you have done. I have read carefully your proposal and the speech you made with respect to it. It is a vigorous program which you present, and in a number of respects the bill which I have introduced is similar to the one which you and others have introduced. Indeed the various bills which propose medical care and hospitalization programs within the social security program, of necessity must have similar provisions. I think you would agree to that.

Senator MCNAMARA. Yes, or any other prepaid plan, I think would have similar provisions.

Senator GORE. There are several differences which in and of themselves would be of considerable importance, between the bill which I have introduced and the one which you have introduced.

One difference, I believe, is that my bill would place more emphasis upon, shall we say, outpatient care, more emphasis upon home visits by physicians, upon visits to offices of doctors, nurse care, and one reason why I felt that it would be advisable would be the scarcity of hospital beds and rooms at this particular time.

Senator MCNAMARA. I think, if you will permit an interruption at this point, you find our bill emphasizes the use of nursing homes and a good program of home care.

Senator GORE. Yes, I agree that it does. I think my bill perhaps places more emphasis upon that.

Senator MCNAMARA. I would only comment by saying it would be hard to place more than we do, but then it is a matter of degree. [Laughter.]

Senator GORE. Well, you wouldn't say it would be hard to do more of anything—well, I might agree it would be hard to do more of anything good than the senior Senator from Michigan.

Senator McNamara, I did want to congratulate you on the fine work that you have done, and the staff of the committee.

In working with the staff of the subcommittee which you have gathered together, I find them to be competent and very helpful and cooperative.

Senator McNAMARA. Well, I think they deserve that praise and I appreciate it coming from you, Senator. I might just add, Mr. Chairman, at this point that we could have brought reams of editorials from the leading newspapers of the country as well as many of the very slick magazines endorsing the approach that we use to a solution of this problem.

Senator GORE. What do you mean various slick magazines? [Laughter.]

The CHAIRMAN. We are always very happy to have you, sir.

Senator McNAMARA. Thank you.

Senator BENNETT. Senator Gore, magazines whose paper is loaded with casein. [Laughter.]

The CHAIRMAN. The next witness is the distinguished Senator from New York, Senator Javits.

You may proceed, sir.

STATEMENT OF HON. JACOB K. JAVITS, U.S. SENATOR FROM THE STATE OF NEW YORK

Senator JAVITS. Mr. Chairman, I thank you for this opportunity to appear and I will not detain the committee too long because we all have our chance to debate this on the floor.

I think it is very important to have a record made before the committee, and so I am glad to have this opportunity to do so.

Mr. Chairman, I appear here in support of the amendment 6-27-60-H, in the nature of a substitute to title VI of the bill which is before the committee, which is in its essentials the health insurance for the aged act introduced some months ago by me together with other Senators. Those who are on this amendment in the nature of a substitute are Senators Cooper, Scott, Aiken, Fong, Keating, Prouty, as well as myself.

Now, the proposal which we make is contained in an analysis of our bill which I ask unanimous consent may be made a part of my statement for the record.

Senator GORE. Without objection so ordered. (See p. 489 staff analysis, departmental views, and text of amendment.)

(The analysis referred to by Senator Javits follows:)

ANALYSIS OF HEALTH INSURANCE BILL, S. 3350, AS AMENDED JUNE 27, 1960, AND INTRODUCED AS AMENDMENT 6-27-60-H TO H.R. 12580

Title.—Health Insurance for the Aged Act—sponsors: Senators Javits, Cooper, Scott, Aiken, Fong, Keating, and Prouty.

Organization.—Administered by State plans subject to approval of Department of Health, Education, and Welfare.

Purpose.—To assist States in establishing State plans for health insurance for individuals 65 years of age and over on a voluntary basis and at subscription rates they can afford to pay.

State plan.—Must designate a single State agency; provide for financial participation by the State; permit every individual over 65 (and spouse) to sub-

scribe; provide both "service" or "indemnity" types of benefits; provide physician's care up to one-third premium cost; provide coverage during temporary absence from State.

Benefits.—Minimum benefits specified per year include (*a*) physician's services for 12 home or office visits; (*b*) 21 days of hospital or equivalent nursing home care; (*c*) first $100 of costs for ambulatory diagnostic laboratory and X-ray services and (*d*) 24 visiting nurse's home service visits as prescribed by a physician. Maximum benefits computed as generally practicable under income divisions at stepped-up rate schedule starting at 50 cents monthly for subscribers with income of $500 to $1,000 per annum to maximum subscription charge of income of $3,600 per annum—no subscription charge for income under $500 per annum. Maximum benefits can receive Federal matching grants up to $165 per annum per capita; minimum benefits above can be obtained at $70 per person per annum.

Maximum benefits.—Sixty days hospital or equivalent cost care in a nursing home; surgery in or out of hospital, medical care in hospital, doctor's office visits with laboratory tests, diagnostic X-rays, and specialist consultations; visiting nurse service at home.

Subscription rate.—Schedule to be determined by the State, proportioned to subscriber's income by negotiation with Secretary of HEW.

Coverage.—Insurance will be placed with either nonprofit service agencies (i.e. Blue Cross, Blue Shield, etc.) private or nonprofit insurance carriers under contract with State agency, or with an insurance carrier set up by the State for such purpose.

Federal participation.—Federal percentage worked out on a ratio of State per capita income to national per capita income. Similar to Hill-Burton Hospital Act formula, which has been so successful. In no case shall Federal percentage exceed 75 percent or be less than 33⅓ percent.

Cost of program.—Minimum benefits program would cost at maximum a total of $840 million with Federal share about $400 million estimated on participation of 12 million over 65 without any payment by any benefited individual; maximum benefits would cost $1.5 billion and with estimated payments by subscribers of $400 million would make Federal Government share of $480 million.

Controls.—Act provides for cutting off Federal funds if State fails to comply; for appeals to U.S. Court of Appeals for reports to Congress.

Senator JAVITS. The principal step encompassed in the bill which we have submitted, as it is now revised, is the establishment of a State-Federal medical system for the aged, which will have certain basic benefits guaranteed in every State system and in which the costs will be shared by the State and the Federal Government on the formula of the Hill-Burton Act, the hospital construction act, for those basic benefits.

Above and beyond those basic benefits, and up to a maximum benefit which is purchasable at a total cost of $13 a month or $156 per capita a year, there is a maximum set of benefits which we estimate can be bought for that premium; and between the minimum and the maximum it will be a State option proposition: if the State desires to have a more inclusive program, then it may schedule subscription charges from those who can afford it based upon their income, its plan to be negotiated with the Secretary of Health, Education, and Welfare. But I wish to emphasize the distinctive feature of our plan, which is that the minimal benefits can be made available to all who are 65 and over without any cost to the individual and outside the social security system.

Now these minimal benefits, which are very important aspects of the proposition, are the following:

Twenty-one days of hospital or equivalent nursing home care; 12 home or office visits by a physician; the first $100 of costs for ambulatory diagnostic, laboratory or X-ray services; and 24 visiting nurse home service visits per annum as prescribed by a physician.

Now, the reason for establishing these benefits, Mr. Chairman, are that they are adequate benefits considering the actuarial findings on what our older people require. For the source of that, I refer the committee to the national health survey conducted by the Department of Health, Education, and Welfare, series B–1, entitled "Physicians Services Utilization" (published by the Public Health Service in November 1958); also series B–7, "Hospitalization Services Utilization," published in December 1958. These findings were also checked against the OASI statistics for 1959. The Department comes up, for example, with the proposition that average utilization of hospital care by people over 65 is 14 days per year, and under our plan as a minimal basis you have 21 days. And so, for the care of physicians, care of nurses, and ambulatory diagnostic services, et cetera, this bill provides a minimum which is fully adequate as developed from the actuarial findings of the Department based upon fundamental studies for ordinary health care.

Now, Mr. Chairman, the social security approach, and the objections to it, I am sure, have been very well discussed by the Secretary of Health, Education, and Welfare, and I would not undertake to go over that ground again, although I am perfectly glad and ready to debate the issue on the floor when we get to that point; but I would like to say in support of our own program, that it is a first cost program. There is no deductability. The subscriber gets the benefit of it at once, as soon as he needs it. It is designed on the minimum basis to provide what normally he actually needs, and it represents participation by the States and Federal Government in a cost bracket which has been pretty well accepted as the estimate of what this ought to cost.

Let me explain that. As you look through these plans, in this comparison form, you find right across the board the cost is about $400 million per year for the Federal Government.

Even the McNamara bill, which I think is broader than the Forand plan, if you accept that approach, because it does take in those who are on old age assistance, contemplates an expenditure of about $400 million a year for that purpose.

The Forand plan necessarily encompasses that kind of an expenditure over and above what is contributed into social security. So as you look into these plans, no matter which one you take, you are going to have an appropriation of about $400 million from general revenues—this is quite apart from the social security contribution. This plan is apportioned to the need on a minimum basis where you share with the States just about what everybody agrees the Federal Government is going to pay out of the general revenues anyhow; at the same time you don't get involved in the social security system with all the argument and objection there is against getting into it. It seems to us—my colleagues and myself who have combined on this—that it is a fair ground upon which to stand in the effort; and I understand from Mr. Lesser of my office, who was here this morning, that the Secretary made a most eloquent statement in respect to the need for legislation in this field.

Gentlemen, any figure that you pick demonstrates it. For example, 60 percent of the aged have less income than a thousand dollars a year and their average medical bill is $125 a year; 16 percent of them spend as much as $500 a year.

It just seems to me that people who have given their lives in the service of our country—in terms of the economy of our country—are entitled to this kind of consideration from us in their declining years, when they need it.

I think this is one ground upon which all proponents of all bills agree, whether it is Senator Gore's bill, or any other bill. It seems to me we meet on common ground at that point, that is, we feel there has to be legislation in this field, whatever may be our differences as to the way in which it should be approached.

Also, Mr. Chairman, in commendation of our plan I would like to point out that 127 million people are now under some kind of a medical care program. It may be inadequate and I think in many cases it is, especially for our older people, but there is some kind of a program. Now we build upon that by taking advantage of the fact that you just don't then have to start out from first base with the Federal Government running a national health scheme, and I think that is the fundamental problem which is presented by the social security, so-called compulsory approach. In our case you don't do that, you can build on everything that you have, and use it, and I think that has great advantages.

Then, in our plan, you also build upon what the States have in the way of facilities; facilities differ very materially among the States. Some States can give a much higher level of medical care than others. There is no reason why one should be retarded over the other. And, third, and very importantly our plan is very heavily based upon physicians' care, and here I would like to refer to a seminar which I conducted at the College of Physicians and Surgeons in New York about 3 months ago, in March of this year and I would like, Mr. Chairman, to have permission to include the report of that seminar as part of my testimony before this committee if I may.

The CHAIRMAN. Without objection.

(The document referred to follows:)

CONFERENCE ON THE "ROLE OF THE FEDERAL GOVERNMENT IN PROBLEMS OF HEALTH AND MEDICAL RESEARCH," SATURDAY, MARCH 12, 1960, 9:30 A.M.

CONFEREES

Senator Jacob K. Javits and staff:
Mrs. Jacob K. Javits.
Mr. Allen Lesser.

Columbia staff:
Dr. H. Houston Merritt, dean, College of Physicians and Surgeons, and vice preisdent in charge of medical affairs, Columbia University.
Dr. Willard C. Rappleye, dean emeritus and vice president emeritus in charge of medical affairs, College of Physicians and Surgeons.
Dr. Aura E. Severinghaus, associate dean, College of Physicians and Surgeons, and professor of anatomy.
Dr. Melvin D. Yahr, associate professor of clinical neurology.

Others:
Dr. John Bourke, hospital survey and planning committee.
Dr. Francis Browning, University of Rochester Medical School.
Mr. George Bugbee, president, Health Information Foundation, Inc.
Mr. Winslow Carlton, vice president, Group Health Insurance.
Dr. Martin Cherkasky, director, Montefiore Hospital, New York City.
Dr. John E. Deitrick, dean, Cornell University Medical College.
Dr. Marcus D. Kogel, dean, Albert Einstein College of Medicine, New York City.

Mr. McAllister Lloyd, chairman of the board, Teachers Insurance & Annuity Association.
Dr. Aimes C. McGuinness, executive secretary, New York Academy of Medicine.
The Honorable George P. Metcalf, State senator.
Dr. David Seegal, professor of medicine, College of Physicians and Surgeons.
Dr. Martin R. Steinberg, director, Mount Sinai Hospital.
Dr. Thomas Thacher, superintendent of insurance, State of New York.
Dr. A. W. Wright, Albany Medical School, Albany.
Dr. Frederick D. Zeman, chief of the medical services, Home for Aged and Infirm Hebrews.
Members of the press.

MEMORANDUM

Summary

The problem of health care for those 65 years old and over is distinct from the problem of health care for those under that age; Federal assistance is necessary in handling any health care program for the aging; and any such health care program should be voluntary, with contributions by the beneficiary as well as by State and Federal Governments. These are the major conclusions that may be drawn from the papers and discussions of those who engaged in the conference.

Discussion—1

The first paper was delivered by Dr. Frederick D. Zeman, chief of the medical services of the Home for Aged and Infirm Hebrews, who spoke on medical preventive services for the aged. He said that the problem of caring for the aged so far as medicine is concerned starts on the day the individual is born, and stressed the need for retraining professionals so that they could handle the problems that older people present. He described the advantages of a geriatrics institution, the specialized equipment used by such an institution as contrasted with the hospitals. There were no operating rooms, no X-ray laboratories, etc., but the geriatric institution could provide better postoperative care than a general hospital and had many advantages in caring for those 65 and over.

Zeman emphasized that the problems of care for those 65 and over are quite different from those we usually anticipate. He pointed out that of the 100,000 or more who are institutionalized in New York State mental hospitals, many are over 65. At Central Islip, for example, more than 50 percent are 65 years old and over. However, he said, these 50 percent were not necessarily hopelessly insane; their mental illness is part of the whole process of aging, and with proper care they could be taken out of this kind of an institution.

Prevention of disease among the older people is part of the larger picture of preventive medicine, and begins long before the individual has reached the age of 65; a dynamic aggressive approach to the problems of preventive medicine with particular reference to the early detection of chronic illnesses before they become obvious in the aged is what is needed. These preventive services are extremely important.

Dr. Martin Cherkasky, director of the Montefiore Hospital in New York, pointed out that the older patients primarily suffer from chronic illnesses as contrasted with the acute character of the illnesses that strike younger people. He said it is impossible to provide adequately for the older people because there is a wide gap in the amount of knowledge that physicians have about treating them. One should start in preventive medicine long before the patient reaches the age of 65. General medical care must exist first if the program for the older patients is to be considered.

Dr. Cherkasky said that to prevent chronic illnesses, one must be able to detect them at a very early stage. Usually the onset of a chronic ailment is insidious, the patient doesn't even know that he has it. The patient, therefore, must have "easy" access to physicians if chronic illnesses are to be checked in their early stage. It must also be "easy" for the doctor to use all the tools of preventive medicine, and in this connection the economic obstacles must be overcome. The complexity of modern medicine means that the group treatment, the group setup, is important for proper diagnosis and treatment.

Dr. David Seegal, professor of medicine at the College of Physicians and Surgeons, pointed out that great progress has been made in the last 40 years in the

treatment and knowledge of chronic diseases and that 38 diseases which then were fatal are now under control. He pointed out, however, that medical schools need considerable strengthening if specialized training for aging people is to be developed to any great extent. He suggested that in the accurate treatment of the aging, the word "appraisal" be substituted for "diagnosis," and "management" for "treatment."

An important point was made by Dr. Martin R. Steinberg, director of the Mount Sinai Hospital. He pointed out that younger physicians usually attempt to make a complete cure of the patient. Insofar as the aged are concerned, Dr. Steinberg pointed out accurate diagnosis and complete cure are not as urgent as the need to keep these older people up and about. Being ambulant is probably the most important part of the treatment.

Another important suggestion was made in this early morning discussion by Dr. Martin Cherkasky. He said that older patients needed a variety of services and he outlined an ideal community situation in which the hospital was the centralized medical agency around which was linked the nursing home, home-care programs, and other measures designed to get the patient on his feet as fast as possible. Outpatient services would broaden the services of the hospital but custodial institutions were also needed, all of them linked with the central hospital. This was the way in which an effective community program could be organized. Dr. Cherkasky visualized a community set up in which the hospital with all its medical and diagnostic services would be the first to take the older persons, who would then be transferred as soon as possible either to nursing homes, to outpatient services, or to some other custodial institution as quickly as possible, thereby providing adequate service without placing too great a burden on the hospital itself.

Dr. Zeman stressed the need for "clinical humility," by which he meant that doctors should develop at an early stage a realization that they can achieve only limited goals. He strongly supported Dr. Cherkasky's suggestions.

Dr. Willard C. Rappleye, dean emeritus and vice president emeritus of the College of Physicians and Surgeons, pointed out that one should not focus only on those 65 years old or over. He stressed that one had to consider the whole practice of general medicine, medical education, and the ways and means of financing this education. He enlarged upon this at a later stage in the discussion.

Dr. John E. Deitrick, dean of the Cornell University Medical College also pointed out that where the aged were concerned, prevention calls for making people happy, and to see that they get proper nutrition. He stressed the fact that poor nutrition lay at the root of a great many of the problems faced by the aging. He cited the perils of isolation inactivity and depression as part of the problem that had to be overcome.

George Bugbee, president of the Health Information Foundation, seconded this observation. He stressed the need for the doctors to emphasize to their aging patients that they find ways and means to live with themselves.

Another suggestion came from McAllister Lloyd, chairman of the board of the Teachers Insurance & Annuity Association. Mr. Lloyd suggested regular medical examinations by busines firms for their chief employees as one of the ways in which preventive medicine could be most effective in early diagnosis and prevention of chronic illnesses.

Dr. Aimes C. McGuinness, executive secretary of the New York Academy of Medicine, pointed out that the old and aging needed twice as much care as those under 65.

2

Dr. John Bourke, executive director of the New York State Hospital Survey and Planning Committee, delivered a paper on hospital trends and the needs of those who are chronically ill. He pointed to the development in recent years of fewer but better and larger hospitals, and emphasized that the gap between the apparent need and the number of hospital beds is not as large as the statistics would seem to indicate. The gaps that do develop are the result of chronic cases being placed in the hospital where they don't belong instead of using the hospital beds for acute cases with consequent much more rapid turnover.

Dr. Bourke's paper, which he summarized very briefly, provided statistics showing the differences between costs of 10 years ago and costs today. He said, however, that despite sizable increases, costs to the patient were not much higher because the average length of stay in the hospital has been short-

ened. This means that intensive treatment is provided over a much shorter period of time than 14 years ago. Dr. Bourke warned against overinstitutionalizing the population and emphasized that the development of nursing home units as part of the hospital complex can take care of many of the problems of the chronically ill.

Dr. Bourke called for the reexamination of ways and means to cut down or avoid hospital stay altogether. He praised the Hill-Burton program and said that it has changed completely the rural hospital system in upstate New York and vastly improved medical care in that region. The hospitals were better staffed and better equipped and he had only words of the highest praise for this program.

Dr. Bourke favors the large centralized hospital, and he pointed out that planning must include the full range of facilities and required services which will allow the hospital to serve as a central core for such needs as chronic disease care, the nursing home type of care, ambulatory, diagnostic, and treatment facilities and home-care programing. Sound community planning, he said, will tend to avoid unnecessary costly construction and duplication. He emphasized that it did not make good sense to keep the patient in a general hospital bed which cost $26 a day when the required care could be given in a nursing home unit for an approximate cost of $9 or $10 a day.

Dr. Bourke stressed that the prevention of disease should be our primary goal and that good quality medical care and hospital care should be available to all as needed. The cost of such care, he said, should be studied within the broad framework of the health of our community and with regard to our overall economy. More doctors should be trained and more services were needed. Satisfactory methods must be developed jointly by voluntary enterprise and government so that all ages of people and all economic groups can share equally in the rich benefits which the health, and medical and related sciences have provided toward a more healthful life.

Dr. McGuinness praised Dr. Bourke's presentation and went on to point out the need for more research in the administration of medical care. He pointed out that the Hill-Burton program provided only $1.2 billion for research, a ridiculously low level.

Dr. Rappleye cautioned that the problem of costs in taking care of the aging will change because those now covered under lower rates will get older and then continue to be covered by some form of insurance. Dr. Steinberg urged that we look into the quality of insurance coverage, not only the number of those who are covered.

Dr. Marcus D. Kogel called attention to the desperate shortage of registered nurses for round-the-clock care, and Senator Javits cited the amendment to the Hill-Burton Act which helps nursing homes. He said that we could do much more in that direction.

Dr. Rappleye said that at least one-third of those in the hospital need some other kind of care. He minimized the Forand bill; but said that some kind of subsidy would be necessary if insurance were to be made available to a much larger proportion of the population. He pointed out that you cannot sell a complete insurance program once the premium reaches the point of more than 40 percent of the total cost of the health coverage. In Canada, he said they had arbitrarily picked on 33⅓ percent as the limit.

The recurrent theme in the general discussion that followed on levels of care was that any broad program needed structuring lest the load on hospitals become staggering as it would under the Forand bill. There is need for an incentive to put the patient where he belongs, not just to dump him in the hospitals willy-nilly.

The question was raised by Dr. Martin Cherkasky as to whether the Federal Government could possibly require employers to carry a health insurance program which would meet minimum standards for their employees in a fashion analagous to workmen's compensation insurance. In reply State Senator Metcalf of New York said that bills had been introduced to require employers of more than three or four persons to provide basic insurance coverage on a 50–50 matching basis if the individual were single, and 35–65 matching if he had a family. Provision was also made for the payment of premiums during employment—there would be basic coverage only. Senator Metcalf pointed out that the Governor opposed this bill because New York State might be singled out and lose industrial business.

An extremely important point was made at this stage of the discussion by Dr. Martin Cherkasky. He stressed that the figure of 43 percent of those covered by health insurance was misleading because it did not indicate how much coverage they were carrying. He pointed out that the problem of health coverage was really two problems: (1) involving those 65 and older and for them Federal support was absolutely essential; (2)however for those 55 and under some form of voluntary services or insurance plan with a noncancelable clause might prove more acceptable.

Superintendent Thatcher pointed out that the cost of health insurance would be more than double if it had to include those 65 and over in any long-range program. The State alone could not carry this kind of cost and therefore a Federal subsidy would be essential.

In his summary of the morning discussion, Senator Javits pointed out that there were alternatives to institutional care and that the need was primarily for intermediate care between the hospital and the home. He took note of the fact that the upstate (New York) hospital program had been accelerated by the Hill-Burton Act and also that its extension to cover nursing homes was inadequate. He reviewed Dr. Bourke's finding that at least one-third of those in the general hospital at present could really be taken care of at home or in nursing homes. At the same time he recognized the inadequate availabilities of present nursing homes. There was need for the Federal Government to get into the field of aid to the States and to help accelerate all medical programs. He pointed out the contribution of NIH and also the fact that there was pressure in Congress to help pay the beyond tuition cost of nongovernmental medical schools.

Mr. George Bugbee was opposed to Federal participation in any health insurance program. He said that employers can pay more of the cost of health care, and he was not ready to accept the statistics, cited by Dr. Rappleye which placed one-third of the cost of care as the limit of the premium which the worker could afford to pay.

Dr. Rappleye referred to the experiences in Europe with health insurance and pointed out that there was a decided shift in plans to cash indemnities rather than services. This is because cash indemnities resulted in relatively lower cost than services. He said that Blue Cross and Blue Shield were also shifting to the cash indemnity types of insurance. Dr. Steinberg, however, said that patients covered by Blue Cross still largely received services rather than indemnities.

The conference adjourned for lunch.

3

The afternoon session opened with delivery of Dr. Steinberg's paper on plans and proposals for health insurance for the aging. Dr. Steinberg first described the American Medical Association's insistence on a voluntary prepayment type of insurance.

Dr. Steinberg's point was that the voluntary approach alone without governmental help was not feasible. The cost for the aged cannot be borne entirely by lounger persons paying increased social security taxes, nor will strengthening Blue Cross alone provide the answer. The aged themselves, of course, cannot afford the full cost.

An approach purely by the State and local governments based on need would call for a means test. Financing for the indigent by the Federal Government means that the cost would spiral anywhere up to $2 billion a year. It would be undesirable to attempt to get this fund out of the general revenue.

Dr. Steinberg then described a proposal made in Colorado for statewide care which would be limited primarily to hospitalization. It was based on the fact that the aged can participate to some extent in financing the program, and the remainder of the program would be paid for out of the general fund.

Dr. Steinberg made his own proposal which would earmark an increase in the social security tax for placement in a separate trust fund to provide hospital care for the aging in which the Federal Government would participate as it does now in the Hill-Burton Act. Under his proposal approximately 60 days of hospitalization would be provided, and those 65 to 70 years old would be eligible to participate.

Dr. Steinberg explained that his approach differs from the Forand bill in that the Government does not pay for hospital service as such but purchases voluntary health insurance on an actuarial basis. However it does make coverage mandatory since the Government would buy Blue Cross insurance for the aged.

Dr. McGuinness recommended that the cost for such program come out of general revenue or out of a compulsory tax. Dr. Rappleye warned against Federal

participation and said that Dr. Steinberg's approach had been rejected in La-Guardia's administration. Dr. Bourke cautioned against the purely welfare approach to the problem and called again for an integrated community health program in which the contribution to the system would come out of the general revenue.

Winslow Carlton proposed that a health program be developed in each State and the plan submitted to HEW. He would set a minimum level of benefits but make provisions for several types of care and would use the indemnity approach in preference to services. Anyone 65 or over would be eligible. Insurance would be contracted by the States from private carriers and the cost would be shared by those eligible to participate who would pay 8 percent of their income. This he estimated would cover approximately half of the cost. The remainder of the cost would be shared 50–50 by the State and the Federal Government. Mr. Carlton would earmark a tax on excises to provide the funds for the Federal share.

Dr. Steinberg questioned whether the people would have the 8 percent and pointed out that it would be doubtful whether the States would do more in this area to cover cost than they are doing now. Dr. Bourke suggested adding a means test. Dr. Cherkasky said that only the rich would buy this kind of health insurance. The needy, he said, get such services as they need now from the general assistance.

In his summary, Senator Javits said that there could be health coverage for the aged in which the Federal and State Governments would make some contribution as well as the individual concerned depending upon his income. Different plans for different States were indicated because of the widely different range of costs, standards, and available facilities. The Federal share in any plan might be covered by some form of tax, but appropriations out of general revenues—making the program voluntary for the individual rather than an added social security tax making it in effect compulsory—seemed indicated.

Senator JAVITS. This seminar, Mr. Chairman, was a galaxy of the leading experts on geriatrics in our part of the country and from other parts of the country, and the consensus was that the most important single kind of service which could be given to those over 65 was physician's service, and that it was a great mistake to make them go to a hospital in order to get the benefit of a health plan for two reasons: One, you would overtax facilities, and second, it wasn't good for the older people themselves; there had to be a great concentration upon physician's care and that is what your plan seeks to do.

It seeks to place emphasis on the fact that there is doctor's care.

Now, to conclude, Mr. Chairman, the social security approach to medical care for the aged presents the serious problem as we see it, of providing mainly benefits of hospitalization and surgery rather than of adequate physician's care despite the fact, as I said, that as people grow older they need more care from the doctor. The overwhelming evidence of medical statistics shows that subsidizing hospital care to the exclusion of office and outpatient care is misguided and will tend to create critical situations in sections of the country where such institutional facilities are even now overtaxed and where any program of expansion will take years to put into effect.

In that connection, Mr. Chairman, I would like to point to the McNamara proposal, which is entirely well intentioned. I think, I said a minute ago, it had certain things that broadened it over the Forand approach but I point out that this problem of medical facilities taxes even those who would take the most optimistic view of this whole situation. Under the McNamara bill it is necessary to defer certain aspects of the service for a period of years because facilities just have to catch up with what they might promise.

For example, under the McNamara proposal you have five categories of service, the last two being diagnostic health, hospital services, and

very expensive prescribed drugs—and there you have to wait until the Secretary of Health, Education, and Welfare can work this out with his advisory council over a period of time; and they don't promise that you are going to get any such thing until 1962–63.

Now the reason for that is obvious, because—and I think the McNamara plan is a pretty optimistic plan, and no matter how you might try to meet this, the fact is you have to take account of what exists.

An argument that has been made against our plan is that it depends upon action by the States, and there, Mr. Chairman, I understand the Secretary of Health, Education, and Welfare has also produced evidence as to 15 plans of various kinds, particularly in the health field, where action by the States was very responsive, and where it seems to me we are borne out by the fact that there ought to be State participation because this participation—in view of the enormous demand for this particular kind of improvement in our law—is bound to come from the States.

The States respond when their people want something, and that is best shown by the tremendous participation in such programs as the Hill-Burton Act for the development of hospitals, and other programs of that character, where there is Federal-State participation.

I assume, that the Secretary of Health, Education, and Welfare put this schedule in?

I would like, then, to put in a schedule as part of my testimony prepared by the Department of Health, Education, and Welfare as to the response to Federal-State grant programs, especially in terms of the promptness of the response, and to point out, for example, that in the Water Pollution Control Act passed in 1956, all the States came in the first year; in the National Defense Education Act, between 45 and 48 of the States came in in the first year.

(The material referred to follows:)

RESPONSE OF THE STATES TO FEDERAL-STATE GRANT PROGRAMS

A review of State response to the various Federal-State grant programs of this Department shows that with rare exceptions the programs have found universal acceptance by the States. In a number of instances, the grant programs were adopted by all of the States within the first year of operation. Furthermore, the programs have almost universally called forth State expenditures ranging far in excess of that necessary to meet matching requirements.

STATE FINANCIAL CONTRIBUTIONS

In the public assistance area, 27 of the States, all of which have vendor medical care provisions, have contributed substantial amounts of money in financial assistance to the aged above that capable of being matched by the Federal Government. The remaining 23 States have not utilized Federal funds up to the maximum possible; 15[1] of these have vendor medical care provisions, and the other 8 make no provisions for payment of medical care under the old-age assistance titles of the Social Security Act.

In the vocational education program, the State contributions have been four times the amounts called for by the matching provisions. In the health areas, all of the programs have evoked a response far exceeding that required by the matching provisions of the various programs. This resopnse ranges from contributions of more than twice the matching requirement in the Hill-Burton hospital construction program and the water pollution program to contributions of more than 17 times the requirement in the case of the cancer control program,

[1] One of these will initiate its medical care provisions early in 1961.

and to more than 20 times the matching requirements in the case of the general health grants program and the mental health grants programs.

NUMBER OF STATES PARTICIPATING

With respect to health programs in which the Federal Government has administered grants to the States with matching requirements, an impressive number of these programs won participation by all of the States beginning with the first year of the program. Such programs as the hospital and medical facilities construction program (Hill-Burton), the water pollution control program, the tuberculosis control program, and the general health grants program were adopted by all of the States in the first year of their inception. In the case of the cancer control program, only one State did not join the program in its first year. In the case of the heart disease control program, only two States did not join the program in its first year. In the case of the mental health grants program, all but five States joined the program in the first year, and those five joined within the first 3 years of its operation. In the case of the maternal and child health services program, all but three States adopted this program during its first year, and those three States joined it the following year. In the crippled children's services program, 37 States began participation in the first year, 7 States in the second year, 5 in the third, and 1 in the fourth.

In the field of education, the vocational education program was approved by all of the States in its first year. The program of grants to the States for library services was approved by 49 States within the first 2 years. The new National Defense Education Act, which has four titles establishing State grants, has gained participation of from 45 to 48 States in all of these titles.

The promptness of State response to the seven grant programs in the welfare and rehabilitation fields has been phenomenal, considering that many of them required substantial dollar outlay and extensive new administrative structure. More than 30 States adopted four of these program within the first year of operation. Within the first 3 years of operation, more than 40 States had adopted five of the seven programs, and more than 30 States had adopted the remaining two programs.

The extent of State acceptance of the seven grant programs in the welfare and rehabilitation fields is indicated by the fact that all States are currently participating in all but two of these program. In one of these, aid to the permanently and totally disabled, only four States (Alabama, Arizona, Indiana, and Nevada) have not yet participated. In the other extension and improvement of vocational rehabilitation, only three States (Idaho, Louisiana, and Maryland) have not yet participated.

Promptness of State response to grant programs

Program and year began	Number of States participating	
	1st year	By end of 3d year
General health grants, 1936	All	
Tuberculosis control grants, 1944	All	
Cancer control grants, 1948	49	All
Mental health grants, 1948	45	All
Heart disease control, 1950	48	All
Hospital and medical facilities construction, 1947	All	
Water pollution control, 1956	All	
Vocational education, 1918	All	
Vocational rehabilitation, 1920	8	34
Extension and improvement of vocational rehabilitation services, 1955	32	46
National Defense Education Act (4 titles), 1959	45–48	Inapplicable
Library services, 1959	36	49
Old-age assistance, 1936	41	50
Aid to the blind, 1936	26	43
Aid to dependent children, 1936	26	41
Aid to the permanently and totally disabled, 1950	33	37
Maternal and child health services, 1936	47	All
Crippled children's services, 1936	37	49
Child welfare services, 1936	33	49

Senator JAVITS. Now it seems to me, Mr. Chairman, that if you are dealing with such orders of magnitude, the argument that the States won't come in is not a very good one.

Mr. Chairman, one last word: I think we have to watch one thing and that is how unfortunate and disillusioning it would be especially in view of the widespread demand for a bill for medical services or care for those over 65, if we pass such a bill and then the beneficiaries face the breakdown in its operation because facilities are inadequate to the demand.

I hope very much that these fundamental principles to which I have tried to address myself will be borne in mind by the committee, and I express the hope finally, Mr. Chairman, that this committee will come out with a bill; that it will screen all of this evidence and information, all of these bills, and will come out with a bill which will go further than the bill which came over from the House. I would like to put myself in accord with those, including the Secretary of Health, Education, and Welfare, who feel that a more comprehensive method of dealing with this admittedly great problem must be understood by the Congress than the one which was sent over to us from the other body and which confines itself essentially to medical indigents is not enough.

Thank you, Mr. Chairman for this opportunity.

The CHAIRMAN. Thank you, Senator Javits.

Any questions?

Senator Gore?

Senator GORE. I would like to ask one question, if I might.

I have seen in the paper that Governor Rockefeller has presented a plan to the Governors' conference. Have you had an opportunity to review his plan or is his plan similar to your plan?

Senator JAVITS. Well, Senator Gore, I saw his plan on the ticker, and of course I have talked with Governor Rockefeller, and I am well aware of his views on this subject. He feels essentially that—from the ticker story, I gathered that his plan is partially a social security plan and partially a plan like ours—social security to take care of those who are under social security, but a plan like ours, which is at a minimum a straight general revenue plan and as you go up higher, a contribution or subscription plan. This is what he seems to have in mind, judging by the ticker report, for those who are not under social security.

As you know, and as everybody knows, I am a very ardent supporter of my Governor and his ideas, on the overwhelming majority of subjects to which he is addressing himself in terms of national policy, I find myself in agreement with him. He and I don't see eye to eye on this social security question in terms of medical care for the aged, including that part of it which he wants to put under social security. We do see eye to eye—as I imagine I do with you and Senator McNamara and our other colleagues—as to the fact that there ought to be and must be legislation in this field, if humanly possible at this session.

Senator GORE. Do you agree that it would require some considerable time for both the committee and the Senate to arrive at a proper solution to this problem with which we must deal?

Senator JAVITS. Senator Gore, I am one of those who is very unhappy about this recess, and I don't think that it would take all that

time. I think that sometimes you get more done when people know they have to decide and get the job done. I think we have all studied these medical plans so much, had so much testimony on them, had so many facts and figures adduced, have had such crystallizations of sentiment in the country, that I think a good 2- or 3-day debate on the floor, with the various alternatives being presented, and following a report after this 2-day hearing by your committee—I should think if we really wanted to we could have done this job by the end of next week. I don't charge any bad motive to anybody, I assure you, and I fully accommodate my understanding of the good faith involved to the views of those who would thoroughly disagree with me. I respect them and they may be right and I may be wrong. I am only giving my opinion.

Senator GORE. Thank you, Mr. Chairman.

The CHAIRMAN. Any other questions?

Senator BENNETT. May I ask one question, just to clear up my own thinking.

In the paragraph on your analysis which says "Cost of the program," do I understand that the program, your estimate of the cost of the program is that the minimum benefits would cost the Government about $400 million, and the maximum benefits might cost as much as $480 million?

Senator JAVITS. That is correct.

Senator BENNETT. So we are looking about $800–$900 million as the total cost, the complete cost of the Federal programing if it were installed.

Senator JAVITS. No; the complete Federal cost will be $400 to $500 million, both between the minimum and maximum and the reason is this: When you get above the minimum our plan contemplates payment by the subscribers based on their income.

Senator BENNETT. Well, I read this that the maximum benefits would cost a billion and a half.

Senator JAVITS. Yes.

Senator BENNETT. With estimates of payments by subscribers of $400 million.

Senator JAVITS. That's right.

Senator BENNETT. Which would make the Federal share $480 million.

Senator JAVITS. That is right, as against the $400 million for a minimum plan with the subscribers paying nothing.

Senator BENNETT. Then what you are saying is that if only the minimum part of the program were adopted it would cost about $400 million, but if you add the two of them together you add another $80 million to the $400 million.

Senator JAVITS. That is right, because under the minimum basis we are assuming you charge the subscriber nothing. He gets the plan free.

Senator BENNETT. I am still a little confused but I am glad to have the basic figures straightened out. You are not adding the $400 million and the $480 million.

Senator JAVITS. Senator Bennett, it is important that you do, that you are not left confused because you have a keen and fine mind and I would like you to understand it because you can be very helpful in respect of it.

Senator GORE. Why don't you say that to me?

[Laughter.]

Senator BENNETT. You didn't ask the right questions.

[Laughter.]

Senator JAVITS. I will.

I think Senator Gore knows I have a very high opinion of him that I have expressed on other occasions and I don't have to apologize.

It is very important to pinpoint what we are trying to get at.

We have got a minimum set of benefits here for the total gross cost of which overall, for the participation of roughly 12 million over 65 whom we assume will take advantage out of a total of 16 million who are in the country, which is $840 million. Now on the Hill-Burton division between State and Federal Governments——

Senator BENNETT. First you had better put the figure 12 in front of the word million on the third line of that paragraph.

Senator JAVITS. All right.

Senator BENNETT. Which might help straighten it out.

Senator JAVITS. So we have got $840 million in gross costs, division under the Hill-Burton formula makes the Federal Government pay roughly $400 million.

Senator BENNETT. That is clear.

Senator JAVITS. That is right, now if you take the maximum benefits then you get into that phase of the plan which says that if a State wishes to go above the minimum benefits then it has got to go, to make some provision for payments by those who are the beneficiaries. And so, taking the other end of the stick, the maximum, we say that plan will cost a billion and a half dollars, but there you get the benefit of a higher payment by the States and $400 million from the subscribers.

Senator BENNETT. Well, the thing that is not clear to me, let me say it back to you, the so-called minimum and the so-called maximum are not exclusive. The maximum includes the minimum.

Senator JAVITS. Exactly right.

Senator BENNETT. And the maximum costs include the nonparticipating feature which you have described as the minimum, plus the participating added values would step the total cost of the program up from 840 million to a billion and a half.

Senator JAVITS. Exactly, and that maximum program under a service plan could provide 60 days of full costs semiprivate care in a general hospital, or equivalent cost care in a nursing home or home for the aged which might be many more days, in hospital doctors' care, visits to the doctor's office, with needed laboratory tests, diagnostic X-rays, and specialists consultations and visiting nurse service. You can also have, as an alternative an indemnity plan which would pay you if you needed it up to $10,000, in aggregate of monetary compensation care benefits. I would like to point out too, Senator, that is very important, that notwishstanding all the debate about a social security plan when you got down to cases in a medical plan for Government employees you adopted a plan exactly like the one we recommend.

Senator BENNETT. That is all.

The CHAIRMAN. Thank you very much, Senator.

Senator Robert C. Byrd of West Virginia?

Senator, we are very happy to have you, sir, and you may proceed.

STATEMENT OF ROBERT C. BYRD, U.S. SENATOR FROM THE STATE OF WEST VIRGINIA

Senator HARTKE. I might comment, Mr. Chairman, that he has a very fine name.

The CHAIRMAN. I will agree with that.

Senator BYRD of West Virginia. Thank you, Mr. Chairman. I have a good bit to live up to, may I say.

I am grateful for this opportunity to appear before your distinguished committee in behalf of amendment 6-24-60-N which I have offered to H.R. 12580. (A copy of amendment 6-24-60-N referred to, an analysis and departmental report, thereon appear on p. 469.) My amendment, which is cosponsored by 19 other Senators, would amend the Social Security Act so as to permit men to receive reduced benefits at age 62 in exactly the same manner and under the same conditions as reduced benefits are provided for women at age 62 under existing law. Under existing law, a female worker, or wife, who is otherwise qualified may elect to receive actuarially reduced benefits at age 62, and any widow or female parent who is otherwise qualified may receive full benefits at age 62. My amendment would treat men workers, husbands, widowers, and male parents in exactly the same way as their counterparts of the opposite sex are treated under existing law.

I have been advised by the chief actuary of the Social Security Administration, Mr. Robert Myers, that the adoption of my amendment would involve no appreciable additional cost. As a matter of fact, I was advised by Mr. Myers that the net additional cost to the social security system would be about one-twentieth of 1 percent. No additional payroll tax would be involved. The amount of additional cost is small enough that it could be borne within the current financing of the system, according to Mr. Myers.

Under my proposal, a man who decides to apply on his 62d birthday can draw social secuirty benefits equal to 80 percent of the amount he would receive were he to wait until he reached his 65th birthday. He would have the option of receiving a proportionate increase—five-ninths of 1 percent—for each month he delays retirement after age 62. For example, a man entitled to a benefit of $100 a month at age 65 would receive $80 per month if he chose to retire at age 62, under my amendment. If he decides to wait until he is 63 to apply, the benefit he would receive for life would be increased to $86.67 monthly. If he applied at age 64, his monthly benefit would be $93.34.

It is my understanding, Mr. Chairman, that the provisions which were adopted into law with respect to reduced benefits for women have occasioned no administrative difficulties. In the light of the experience gained from the years in which the lowered eligibility age for women has been in effect, I think one could be confident that the adoption of my amendment would prove to be similarly beneficial and advisable. In other words, the 1956 amendment has worked out all right in the case of women, and it should prove to be the same for men. At the time the 1956 amendment was adopted, there was some skepticism about how well it would work. It was charged that the lower retirement age would encourage employers to lower the com-

pulsory retirement age for women employees. Opponents maintained that it would discourage the continued employment of older women workers whose potential work life would thus be shortened. Experience, however, has failed to bear out these skeptical fears and the average age of retirement for women has not been lowered by the reduced annuity.

I realize that there is some question as to whether it is desirable policy for the Government to encourage early retirement when the science of geriatrics is lengthening the life span of men. Yet it is my understanding that only about half of the women eligible for retirement at age 62 elected to retire when the 1956 amendment was adopted. I think we can properly assume that not so great a percentage of men would elect to retire at 62. Many of the women who took benefits in 1956 had been working during the war years and had not been working immediately before the adoption of Senator Kerr's amendment. Most men will continue to work until age 65 or somewhat thereafter as long as they are physically able or as long as there is employment. Moreover, Mr. Chairman, automation is here to stay and it constitutes a growing problem with which our society is going to have to deal more and more in terms of unemployment. A recent study of automation prepared by the National Planning Association points out that, according to Census Bureau estimates, the average annual increase in the labor force is presently 700,000 to 800,000 and that, by the year 1965, it will reach the figure of 1 million or more. It is necessary then that we find new job opportunities for these younger workers who are annually entering the work force.

Additionally, the problem of changing markets poses itself in the question of whether or not the needed job opportunities will appear at the right place and at the right time. The rate of increase in employment in some of the industries now being automatized does not begin to match the increase in productivity made possible by new processes. For instance, in the chemical industry, productivity rose 53 percent between 1947 and 1954, but employment rose only 11 percent. In oil refining, output increased 22 percent since 1947, but total employment fell by 10,000. Automation has made itself felt in the mining areas of my State. Whereas only a few years ago, 135,000 miners were employed in West Virginia, today less than 40,000 are employed. A continuous mining machine operated by 6 workers will load the coal originally requiring the time and labor of 40 men. The problem is not peculiar to West Virginia. The textile and shoe workers in the New England States have experienced the same sudden shift in an employment pattern which had existed for over 100 years. Further changes will create catastropic dislocations of workers.

The distinguished senior Senator from Oklahoma, Mr. Kerr, who is a member of your committee, Mr. Chairman, pointed out in presenting the 1956 amendment which brought about the same change for women workers, that the privilege of electing earlier retirement with proportionately reduced benefits is one that has demonstrated its effectiveness in the civil service retirement system, the railroad retirement system, and in many private pension plans. The principle is one which makes possible an added flexibility to the retirement program without excessively increasing the cost to the contributor.

Mr. Chairman, I would like to refer to my amendment in the same words as those which were spoken by Senator Kerr in 1956, and I

will only take the liberty to substitute the masculine gender for the feminine. An important consideration in connection with my amendment is the fact that the choice of the date of retirement is voluntary. No man will be required to retire at age 62. The choice will be his. If he does not elect to take a slightly lower benefit to qualify before age 65 and instead decides to wait until he is 65 years of age to apply, he will still be entitled to his full benefit.

Mr. Chairman, there are approximately 1.8 million men who potentially would be eligible to retire at age 62 immediately if this amendment were to be adopted. They would not be forced to retire. The choice would be an optional one, and it would be up to the individual. There are many—in fact, a majority, I would assume—of these men who would prefer to continue to work. Yet, on the other hand, there are some who would want to retire and who should retire. There are many individuals who are not physically able to continue working after they reach the age of 62; yet they are not disabled to the extent that they can qualify for disability benefits. This amendment would permit these individuals to retire and make room for younger workers.

Mr. Chairman, certainly at this late date in the session, I would be very reluctant to ask your committee to accept an amendment of a controversial nature. However, the amendment which I am presenting to you here today, if I may summarize its purpose and effect, merely accords to men the same privilege of earlier retirement on an actuarially reduced basis that has been available to women since 1956. This amendment would involve no appreciable increase in cost to the social security insurance system. Furthermore, it is not envisioned that any great percentage of eligible men will wish to avail themselves of the election which it offers. Still this amendment is of great importance to that relatively small number of men who, because of ill health, unemployment, underemployment, or other personal reasons, find it impossible or ill advised to continue working until they attain the age of 65. Moreover, it should be pointed out that the benefits provided by the social security system are not gifts of charity or handouts from the Federal Government, but are payments actually earned and paid for by the workers and his employer. Why not then make it possible for those who, perhaps for adverse reasons beyond their control, wish to receive at an earlier age that which is justly theirs and for which they themselves have paid?

You gentlemen know, as a practical matter, that there will not be another opportunity to present an amendment of this nature for approximately 2 or even 4 more years, until such time as a social security bill again comes over from the House, and whenever a social security bill does come from the House it customarily reaches the Senate at a late date in the session. The situation here today is no different from what it has been in the past and probably will be in the future. Therefore, Mr. Chairman, I respectfully urge that consideration be given to the adoption of my amendment at this time.

The CHAIRMAN. Thank you very much, Senator.

Your amendment has already been referred to the Secretary of Health, Education, and Warfare, for report thereon.

(The report referred to appears on p. 469.)

Senator BYRD of West Virginia. I thank you, Mr. Chairman, for this opportunity to appear before you today.

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The CHAIRMAN. Any questions?

Senator CURTIS. One question. In your statement you say:

> Moreover it should be pointed out that the benefits provided by the social security system are not gifts of charity or handouts from the Federal Government but are payments actually earned and paid for by the worker and his employer.

I am not raising the question as to earned, but on the question of paid for, can you cite any actuarial evidence of that statement?

Senator BYRD of West Virginia. Are you saying, Senator, that the worker does not pay for these benefits?

Senator CURTIS. I am asking you if you can cite any actuarial evidence that anyone who has retired in the past, if he retired during the calendar year 1960 or anytime within the next 5 years will have paid the cost of his benefit, I will not project it farther.

Senator BYRD of West Virginia. I would say, to the Senator, in answer to that question that over the long run certainly it can be truthfully said, that the workers are getting back what they have paid for.

Senator CURTIS. Now over the long run for all the people collectively or for an individual?

Senator BYRD of West Virginia. Over the long run, for all people collectively, who participate in the program, and I think you have to view this system and the effects of the program from the standpoint of the long run.

Senator CURTIS. What I wish to point out is this: That the social security system is a tax on the present producers to pay a social benefit to those who are retired or disabled. If the individual who retires this year at 65 would get a benefit commensurate to what he paid, including what his employer paid although that is not earmarked for him, I am afraid that benefits would be far lower than they are. I do not mean to quarrel or in any way question the distinguished Senator from West Virginia in his notions about what the program should be. But I merely point out for the record that often Members of Congress are challenged with this: "We are paying for this program, there is a surplus in the reserve, why don't you give us more?"

Actually, the surplus in bonds wouldn't pay out to the end the benefits of the people who are already retired. If everybody eligible for retirement now would retire, there wouldn't be enough money to go around, but the program is not something bought and paid for, at least not for a number of years, by the individual and his employer, but rather it is a tax on the producing people to pay a social benefit, with which I have no quarrel.

That is all, Mr. Chairman.

The CHAIRMAN. Thank you very much.

Senator GORE. Mr. Chairman, I want to congratulate Senator Byrd of West Virginia upon presenting a point of view with respect to an acute problem. I recall that when I, along with a few others, was waging a battle to permit a person with total and permanent disability to receive his entitlements from social security, at that time, as if he had reached retirement age, that many people, including the administration, vigorously opposed it. I was pleased this morning to hear Secretary Flemming say that our experience with that proposal has been so satisfactory and successful, that he urged a further lowering of that age.

Now, you presented, if I correctly understand you, an additional point of view, that a person be allowed to elect to draw his benefits before reaching the age of 65, a male, and if I may venture a suggestion to you for your consideration, if you would couple with that some measure of substantial disability I would think it would reach a very necessary point of need. The State of West Virginia has more people engaged in the mining of coal than does the State of Tennessee, but, as you know, the State of Tennessee is a large coal-producing State also. Men who labor heavily, such as coal miners, frequently are forced to retire before age 65, would the Senator agree with that?

Senator BYRD of West Virginia. That is correct; yes.

Senator GORE. It may not be a permanent and total disability as it is interpreted now which almost requires one to be bedridden. Yet there, again, full employed judged by any reasonable standard may have come to an end at age 60. Would the Senator be willing to give some thought to that point of view?

Senator BYRD of West Virginia. Mr. Chairman, in reply to the suggestion offered by the distinguished Senator from Tennessee, it would seem to me, and I want to preface my answer by admitting that I am certainly not a student of this subject, I don't have many of the answers and I certainly don't know all of the answers, but I would envision a difficulty in defining just what you would mean by "substantial disability."

Senator GORE. Well, I think we might find it necessary to do some defining. Of course as of now, permanent and total disability must be certified by a competent physician, and not only does it involve total disability but the doctor's best estimate that it is permanent and total. This is a very rigid interpretation. A person with a serious heart attack may have difficulty with an interpretation. I have such a case in mind now. A neighbor of mine in my home State has had a series of heart attacks which have seriously impaired his earning capacity, though there are still a few things that he can do. Therefore, he is not entitled to draw security, draw or receive security benefits.

The point of view I am trying to suggest, and I, like the Senator from West Virginia, do not have the final answer—I don't know that any of us have the final answers in this field of human relations or problems, but surely there is room to make some finding and give some definition that a person who has lost a substantial portion of his earning capacity as a result of physical disability should be entitled to consideration and perhaps entitlement to receive the benefits to which he will be entitled if he ever lives to be 65.

I am not proposing a set formula to the Senator, but as I listened to his statement it occurred to me that if he coupled this lowering of age with substantial disability, like you think it would be defined, then he would have really touched a very sensitive point of need.

Senator BYRD of West Virginia. Mr. Chairman, Congress said that there must be a strict definition of disability. There must be a cutoff point, and that definition was total and permanent disability, I believe.

I think if we would merely give the man the option of retiring at an age below 65, and as I have recommended a minimum age of 62, it would automatically take care of that in-between group of individuals who are not really physically able to do the kind of work that

they have been accustomed to doing throughout their working lifetime, but who are unable to qualify under the present definition of total and permanent disability.

Consequently, those individuals could elect to retire by taking the actuarially reduced benefits. Many of them simply can't find employment, or they are underemployed, as I have already stated, and this would give them the opportunity to retire and make room for younger workers.

You spoke of coal miners. I grew up in the home of a coal miner, and my boyhood years and early manhood years were spent in the mining communities, and when a man spends 50 years of his life, 30 years of which have been in a coal mine, he cannot find employment in any other field. He has been trained for that kind of work, and when he becomes broken down with arthritis and heart disease, and stomach ulcers and many of the other ailments that attach themselves to that kind of labor, he needs to have the option to retire at an earlier age than that of 65. Many of those men can scarcely walk around at age 60 or 62, and yet they can't qualify as being totally and permanently disabled.

I merely want to give them the opportunity, if they wish to choose retirement at age 62, to do so, and, as I say, it would not be mandatory. It would be voluntary, it does not constitute an additional burden on the system, and it would make room for some of our younger people who are entering the work force to find new job opportunities. I think it would be more in keeping with the realities of our present day industrial society, confronted as it is with automation which is here to stay, and I just feel, Mr. Chairman, that we ought to give very strong consideration to doing this for men, especially in view of the fact that the 1956 amendments have worked out so very well in the case of women.

The CHAIRMAN. Thank you very much, Senator, you have made a very clear statement.

Senator BYRD of West Virginia. Thank you, Mr. Chairman.

The CHAIRMAN. Mr. Secretary, will you resume?

STATEMENT OF HON. ARTHUR S. FLEMMING, SECRETARY OF HEALTH, EDUCATION, AND WELFARE—Resumed

The CHAIRMAN. When we recessed, Senator Hartke was interrogating the Secretary.

Senator Hartke, you may proceed.

Senator HARTKE. I have some questions. I would like to say with regard to Senator Byrd's statement that I am cosponsor of this measure and previously introduced legislation of the very same type and believe it is a good idea and thank the Senator for it.

Senator BYRD of West Virginia. I thank the Senator from Indiana and I wish to point out he is one of the cosponsors of my amendment and is a very avid supporter of this legislation and I appreciate the courtesies that have been accorded to me today by every member of this committee.

Senator HARTKE. Mr. Secretary, as I said before, you have done an outstanding job here in pointing out very succinctly and very fairly, stating obvious facts particularly concerning the human and present

need of these aged people. And the fact that you pinpoint it and say, "It is a crisis." And you fully recognize and accept the fact that the Federal Government should take additional action in this field, which in and of itself sometimes is open to dispute from other quarters representing the administration, but at least this seems to be very fair from your point of view, and the fact that a large percentage of the persons aged 65 and over do not have any protection against this particular situation, and I asked you before lunch when this first occurred to be of such a substantial nature and I believe you said something about 1954 when a program was proposed. That was not during your term, but prior to your term, is that right?

Secretary FLEMMING. When Secretary Hobby was the Secretary.

Senator HARTKE. This program is not in substance the same type of program you have proposed today?

Secretary FLEMMING. No. The same basic problem, but it was an entirely different approach.

Senator HARTKE. It dealt with the need for medical attention for the aged.

Secretary FLEMMING. That is right.

Senator HARTKE. That is about as far as they are similar; is that right?

Secretary FLEMMING. Yes. I think that is fair because this is an entirely different approach.

Senator HARTKE. So what we find is that the 1954 approach and the 1960 administration approach, and the Forand approach and the McNamara approach and the Gore approach, all of them have common ground in recognizing the need?

Secretary FLEMMING. That is correct.

Senator HARTKE. Then, since that time, haven't a number of studies been made upon this matter?

Secretary FLEMMING. Senator Hartke, at the request of the Ways and Means Committee, which I think was transmitted to the Department in 1958, the Department did make a very comprehensive study of this whole area, and submitted the results of the study to the Ways and Means Committee last April—April 1959.

Senator HARTKE. April 1959?

Secretary FLEMMING. Yes. That study was an effort to bring together the facts, relevant facts, an effort to identify the issues, and an effort also to identify the pros and cons in connection with certain possible approaches. It did not, as you undoubtedly appreciate, contain any recommendations because that was not the kind of a request that the Ways and Means Committee made.

Senator HARTKE. Then, May 3, 1960, again a report was made; isn't that right?

Secretary FLEMMING. Well, on May 4 I testified before the Ways and Means Committee and presented to the committee the plan which I presented to this committee this morning.

Senator HARTKE. That was also along with the President's own recommendations along this line?

Secretary FLEMMING. The plan I presented was the administration's plan which had been cleared with the President.

Senator HARTKE. And the President himself presented to the Ways and Means Committee on that day his own endorsement of that proposal and the need for this type of care?

Secretary FLEMMING. Well, I testified and in testifying indicated——

Senator HARTKE. I am not disputing that you did.

Secretary FLEMMING. That is right.

Senator HARTKE. But did you not carry a message or was not a message transmitted to the Congress and the Ways and Means Committee and the Finance Committee?

Secretary FLEMMING. I am sorry. I know to what you refer. Just about that time—it was not the same day but a day or two before—the President transmitted a special message to the Congress in which he underlined his desire to have legislation in a number of areas and he included in that message this particular area and also indicated that the plan that I would be presenting to the committee did have his enthusiastic endorsement. That is correct.

Senator HARTKE. At that time I think you made a statement, something to the effect that this was done after meticulous study.

Secretary FLEMMING. Well, I don't know whether I used the word "meticulous," but certainly there was a lot of study and discussion that went into it.

Senator HARTKE. Do you feel it was after meticulous study, then, if you didn't use the term?

Secretary FLEMMING. Yes; I would be perfectly willing to accept that.

Senator HARTKE. I am not trying to cross you on words, I just want to find out the situation.

Secretary FLEMMING. Yes.

Senator HARTKE. Do you think any more studies are necessary before some type of plan be inaugurated?

Secretary FLEMMING. Well, I appreciate that is an area where people have certainly differing points of view.

Senator HARTKE. I am not asking for anyone's except your own.

Secretary FLEMMING. I know it. I listened to Senator Javits' comment on a similar question, and I have felt as a result of the consideration which has been given this problem over a period of years that it should be possible for the Government to act now in an effort to be of help to these older persons. In other words, I have had the feeling that it should be possible for action to take place at this session of the Congress, hopefully action in which the President could concur, so that we would have a law on the statute books at the end of this session. I believe that it is possible to do that.

Senator HARTKE. Do you think we should wait until after the White House Conference on the Problems of the Aged is completed in January?

Secretary FLEMMING. I have not felt we should and have so indicated on a number of occasions. The White House Conference on the Aging, as you know, is being held at the direction of the Congress with the concurrence of the President, of course, who signed the bill. I think it is going to be extremely helpful in assembling basic material on many problems related to the aging and helping to develop a consensus as to what should be done in these areas. And I also feel that the State conferences that are being held prior to the White House Conference, have been, and are proving to be, very helpful along this line. But I don't think that a White House Conference on

the Aging will carry us much further down the road in terms of developing a consensus on this particular problem. I think that there have been assembled the facts that are needed to deal with this problem now.

Senator HARTKE. What I understand you to say in substance is that we can study and study and continue to find problems which we didn't know about before, and facts which we didn't know about before, but this doesn't mean that this present human need shouldn't be met and acted on now.

Secretary FLEMMING. That is correct.

Senator HARTKE. Did you make any recommendations either personally to the President, prior to January of this year and prior to the state of the Union message to the Congress concerning any proposals to meet this present and human need?

Secretary FLEMMING. No, I did not. I indicated to the Ways and Means Committee last July that our Department, on the basis of the report that we had submitted, was endeavoring to come to grips with the various methods for dealing with the problem, and endeavoring to carry on discussions within the executive branch. But those discussions were not concluded until prior to the time I appeared before the Ways and Means Committee, in May of this year.

Senator HARTKE. In other words, no proposal was submitted prior to the state of the Union message.

Secretary FLEMMING. That is correct.

Senator HARTKE. And, therefore, it could not have been rejected although it was not mentioned in the state of the Union message in any form whatsoever?

Secretary FLEMMING. That is correct.

Senator HARTKE. In fact, in the state of the Union message or in the recommendations which you made which should be incorporated in it, was this problem pointed out as being one of the present human needs of America?

Secretary FLEMMING. No, I didn't even make any recommendations along that line because I knew that we were working on the matter. I knew that we had not yet crystalized our thinking within the executive branch and reached agreement on a program. It was my feeling that I didn't need to say anything more about it until we were actually ready to present a plant.

Senator HARTKE. Is this true of all programs, in other words, that you were working on, and many programs which were mentioned in the state of the Union message, were they all crystalized at the time of the President's message to Congress?

Secretary FLEMMING. I don't have the state of the Union message in front of me and I don't recall all of the things that were in it. But certainly the things that were endorsed by the President were matters on which we had crystalized our thinking and on which we did have definite proposals. I can think of one other illustration in the area for which we have responsibility, namely, aid to education. We had proposals before the Congress in February of 1959 on aid to education, and those have been reemphasized and reiterated a number of times by the President since then.

Senator HARTKE. I don't think I want to go off to aid to education right now if it is all right with you.

Secretary FLEMMING. That is just cited as an illustration. It is on the problem we have to come to grips with in the closing days.

Senator HARTKE. Did you submit any request to the Bureau of the Budget contemplating any action which would be forthcoming from the administration?

Secretary FLEMMING. Prior to the time that I submitted the plan to the Ways and Means Committee, there were many discussions within the executive branch in which representatives of the Bureau of the Budget participated, but I made no formal submission to the Bureau of the Budget.

Senator HARTKE. And yet you recognize today that this program of yours anticipates almost $800 million plus for this particular program for which no preparation by the Budget or in the President's state of the Union message could reasonably have warned Congress that the administration was thinking along this line?

Secretary FLEMMING. Well, you can't warn people about a particular approach if you haven't yet developed the approach, and we hadn't developed the approach. And, of course, I think it is also fair to say, as I brought out in my testimony, that this particular proposal doesn't present any serious problems as far as the 1961 budget is concerned.

Senator HARTKE. It does not?

Secretary FLEMMING. It does not.

Senator HARTKE. I see; $800 million does not represent a serious problem?

Secretary FLEMMING. There has been no suggestion that there would be an expenditure of $800 million in fiscal 1961. This is a program calling for action on the part of the States. There aren't any State legislatures that are going to be in session before January of 1961, and they certainly won't finish action on it before March of 1961. As I stated in my direct statement this morning, we estimated a cost of approximately $5 million including planning costs in fiscal 1961, we estimated that by fiscal 1962 the costs would be about $400 million total, with about $200 million of that Federal funds.

Senator HARTKE. In other words, this is the present human need which doesn't need to be met now?

Secretary FLEMMING. Now I don't think that is a fair deduction at all. We have proposed a Federal-State program, because of our belief that this is the best way of handling the problem. As I indicated to Senator Douglas this morning, I recognize that it takes a little time to get a Federal-State program underway. As Senator Javits indicated to this committee just a few minutes ago when he submitted for the record a memorandum that we had developed, the history of these Federal-State programs is that they take hold very fast once the Federal Government gives the States an opportunity to participate.

We believe that there are values connected with a Federal-State form of Government that are important to preserve, and that on balance it is worth taking a little time in order to get a Federal-State program underway.

Senator HARTKE. Let me ask you, Mr. Secretary——

Secretary FLEMMING. Might I also say in that connection that I don't think you have got any proposal before you at the present time

that would become operative before July 1961 as a practical proposition. My recollection is that the Forand bill, for example, would become operative on July 1, 1961, and I don't recall on the McNamara bill, I don't recall on Senator Gore's bill but as a practical matter you would have to take that amount of time. I am told that the same thing is true as far as the McNamara bill is concerned. I don't think that in dealing with a problem of this magnitude that it is possible, no matter what approach is taken, to get it underway in a substantial manner prior, much before July 1961.

Senator HARTKE. But if it could be, would you recommend such proceedings?

Secretary FLEMMING. That is what a former President of the United States used to call an iffy question. I don't believe it can be done, so I don't see there is any point in responding to that type of a supposition.

Senator HARTKE. Let me ask you, Mr. Secretary, provided Congress provided a means by which this could be done earlier, would you be amenable?

Secretary FLEMMING. I don't believe Congress can as a practical matter.

Senator HARTKE. Why have you been unable to get a bill introduced embodying your proposals?

Secretary FLEMMING. Well, the bill has recently been drafted, and I am confident that a bill will be introduced.

Senator HARTKE. A bill will be introduced?

Secretary FLEMMING. I am confident it will be, yes.

Senator HARTKE. When?

Secretary FLEMMING. Well, I don't know when. The bill is before this committee, you can—this committee can deal with it at any time that it wants to. It has been before the——

Senator HARTKE. As I understand it, you have a proposal, Mr. Secretary, which was before the Ways and Means Committee.

Secretary FLEMMING. You have in the record of the hearing this morning the complete draft of a bill.

Senator HARTKE. But no one has introduced it.

Secretary FLEMMING. That is true, up to the present time.

Senator HARTKE. And this matter has been under continuous examination by the Ways and Means Committee for quite some time, isn't that true?

Secretary FLEMMING. That is true. The Ways and Means Committee was considering a number of different proposals that were never introduced in the form of bills. They proceeded in executive session, and explored, I think it is fair to say, at least a dozen different types of approaches to this problem. And they didn't have bills drafted on each one that they discussed in connection with their deliberations. Ours was discussed very thoroughly and very fully. I had ample opportunity to present it, and I had ample opportunity to respond to questions in connection with it.

Senator HARTKE. Do you have any knowledge, either personally or members of your staff, as to the ability of the States to raise the matching funds of $700 or $800 millions which they will be asked to raise?

Secretary FLEMMING. As I indicated in response to similar questions this morning, it is our judgment if the Congress should pass a

bill of this kind that because of the nature of the problem, the seriousness of the problem, that the States would find ways of raising the revenue that they would need to have in order to participate.

As I indicated in connection with my discussion with Senator Douglas, we feel that there are States, for example, that would use more fully than they have the income tax approach as a source of revenue. But whatever method they use, we believe that the people of this country are so concerned about this problem that if the Federal Government offered this kind of an attractive package, we would have the same experience that we have had with other Federal-State programs; namely that the States would find ways and means of participating.

Senator HARTKE. Do you think we would have the same type of results we have had in the old age assistance program?

Secretary FLEMMING. Well, I don't know to what part of the old age assistance program you refer. I think that looking back over a period of years that the country has made substantial progress in dealing with the old age assistance program under a Federal-State approach. I regret the fact that in the medical area, particularly as far as medical vendor payments are concerned, there are seven or eight States that have not taken advantage of the opportunity that the Congress presented to them starting in 1950 I think it was expanded in 1956.

Senator HARTKE. Are you familiar with the fact that the American Public Welfare Association in a recent study reported that at least 85 of the States are not presently meeting all of the requirements for the old age assistance programs?

Secretary FLEMMING. That what, 85?

Senator HARTKE. That not more than 15, that some 35 States is what I meant to say, I was thinking in percentages—35 of the States are not meeting all of the requirements in order to participate fully in the old age assistance program.

Senator CURTIS. Might I say 35 States comes to 65 percent?

Secretary FLEMMING. I am sorry, Senator, I am not familiar with the report to which you refer, but I am, of course, aware of the fact that quite a number of States do not take full advantage of what the Federal——

Senator HARTKE. It is much more than seven, is it not? Seven don't participate at all?

Secretary FLEMMING. When I said seven, I was talking about States not participating at all in the medical vendor payment part of the medical assistance program.

Senator HARTKE. Under your proposal, this would require that they almost triple their contributions to States, isn't that true?

Secretary FLEMMING. Pardon me?

Senator HARTKE. Under your proposal, it means they would almost be required to triple their contributions to the States.

Secretary FLEMMING. That is certainly correct.

Senator HARTKE. Do you have any indication from the Governors of any of the States, and, if so, how many are in accord with the proposal which you have made?

Secretary FLEMMING. We have had a number of Governors—we haven't gone out soliciting opinions, but we have had a number of

Governors indicate an interest in the program, particularly Governor Underwood of West Virginia, Governor Del Sesto of Rhode Island, Governor Hatfield of Oregon.

Senator HARTKE. Any more?

Secretary FLEMMING. Offhand, I don't think of others; there may be others.

Senator HARTKE. I want you to know I have not solicited any of them, either, but today each member of this committee received a telegram signed by 23 Governors attending the Governors' conference. I submit for the record a copy of that telegram and the resolution adopted by the Governors' conference.

"We the undersigned attending the 52d annual Governors' conference urge that you and your committee amend H.R. 12580 to provide health benefits under the provisions of the old-age, survivors, and disability insurance system. Such a program would enable the citizens of our country to contribute small amounts during their working lives and have as a matter of right a paid-up health insurance policy to protect them during retirement years when their medical needs are likely to be greatest and income lowest."

Governors signing: James T. Blair, Jr., Governor of Missouri; Edmund G. Brown, Governor of California; John Burroughs, Governor of New Mexico; LeRoy Collins, Governor of Florida; Bert Combs, Governor of Kentucky; Michael V. Di Salle, Governor of Ohio; George Docking, Governor of Kansas; William A. Egan, Governor of Alaska; Buford Ellington, Governor of Tennessee; Orval E. Faubus, Governor of Arkansas; Orville L. Freeman, Governor of Minnesota; Foster Furcolo, Governor of Massachusetts; Ralph Herseth, Governor of South Dakota; Luther H. Hodges, Governor of North Carolina; Herschel C. M. Loveless, Governor of Iowa; Steve McNichols, Governor of Colorado; Robert B. Meyner, Governor of New Jersey; Gaylord A. Nelson, Governor of Wisconsin; John Patterson, Governor of Alabama; Abraham A. Ribicoff, Governor of Connecticut; Albert D. Rosellini, Governor of Washington; Grant Sawyer, Governor of Nevada; G. Mennen Williams, Governor of Michigan.

TEXT OF RESOLUTION APPROVED BY GOVERNORS' CONFERENCE, JUNE 29, 1960, ON THE SUBJECT "PROBLEMS OF THE AGING"

Whereas the Governors' conference for many years has been acutely aware of the growing number and complexity of problems faced by our increasing population of senior citizens, including health and medical care, employment and income maintenance, provision of suitable housing, and enrichment of leisure time activities; and

Whereas the most pressing of these problems is the financing of adequate health and medical care: Now, therefore, be it

Resolved by the 52d annual meeting of the Governor's conference, That Congress be urged to enact legislation providing for a health insurance plan for persons 65 years of age and over to be financed principally through the contributory plan and framework of the old-age survivors and disability insurance system; and be it further

Resolved, That the States support and participate actively in the forthcoming White House Conference on Aging to the end that public and private agencies be stimulated and encouraged to develop approaches to all the problems of the aging.

Voted for (30): Patterson, Alabama; Egan, Alaska; Fannin, Arizona; Faubus, Arkansas; Brown, California; McNichols, Colorado; Ribicoff, Connecticut; Collins, Florida; Docking, Kansas; Combs, Kentucky; Reed, Maine; Furcolo, Massachusetts; Williams, Michigan; Freeman, Minnesota; Blair, Missouri; Aronson, Montana; Brooks, Nebraska; Sawyer, Nevada; Meyner, New Jersey; Burroughs, New Mexico; Rockefeller, New York; Di Salle, Ohio; Edmondson, Oklahoma; Del Sesto, Rhode Island; Herseth, South Dakota; Ellington, Ten-

nessee; Daniel, Texas; Stafford, Vermont, Rossellini, Washington; Nelson, Wisconsin.

Voted against (13): Boggs, Delaware; Vandiver, Georgia; Smylie, Idaho; Stratton, Illinois; Handley, Indiana; Powell, New Hampshire; Hodges, North Carolina; Hollings, South Carolina; Clyde, Utah; Almond, Virginia; Underwood, West Virginia; Coleman, American Samoa; Merwin, Virgin Islands.

Absent or not voting (11): Quinn, Hawaii; Loveless, Iowa; Davis, Louisiana; Tawes, Maryland; Barnett, Mississippi; Davis, North Dakota; Hatfield, Oregon; Lawrence, Pennsylvania; Hickey, Wyoming; Boss (Acting Governor), Guam; Muñoz-Marín, Puerto Rico.

We the undersigned attending the 52d Annual Governors' Conference urge that you and your committee amend H.R. 12580 to provide health benefits under the provisions of the old age, survivors, and disability insurance system. Such a a program would enable the citizens of our country to contribute small amounts during their working lives and have as a matter of right a paidup health insurance policy to protect them during retirement years when their medical needs are likely to be greatest and income lowest.

Governors signing: James T. Blair, Jr., Governor of Missouri; Edmund G. Brown, Governor of California; LeRoy Collins, Governor of Florida; Bert Combs, Governor of Kentucky; Michael V. Di Salle, Governor of Ohio; George Docking, Governor of Kansas; William A. Egan, Governor of Alaska; Orval E. Faubus, Governor of Arkansas; Orville L. Freeman, Governor of Minnesota; Foster Furcolo, Governor of Massachusetts; Ralph Herseth, Governor of South Dakota; Luther H. Hodges, Governor of North Carolina; Herschel C. Loveless, Governor of Iowa; Steve McNichols, Governor of Colorado; Robert B. Meyner, Governor of New Jersey; Gaylord A. Nelson, Governor of Wisconsin; Abraham A. Ribicoff, Governor of Connecticut; Albert D. Rosellini, Governor of Washington; Grant Sawyer, Governor of Nevada; G. Mennen Williams, Governor of Michigan; John Burroughs, Governor of New Mexico; Buford Ellington, Governor of Tennessee; and John Patterson, Governor of Alabama.

Secretary FLEMMING. I am not surprised at that.

Senator HARTKE. Would you feel that this would indicate that these States feel this is a proper approach?

Secretary FLEMMING. I am sure the Governors of those States, if they signed such a telegram, feel that way about it. We just don't feel that the social security approach is the right approach to dealing with this problem. We just take issue with them. I am not at all surprised, and I wouldn't be at all surprised as I indicated this morning, at any Governor of any State indicating something a little less than enthusiasm for facing the necessity of raising additional revenue in order to participate in such a program. I know that it isn't easy to do it. It is never easy to adhere to our Federal-State system of government. But I believe that it is worth the price that we have to pay to try to adhere to it. It isn't the line of least resistance by any means. I know it is a difficult road to travel. But we have traveled it and traveled it quite successfully in one area after another in this country, and I don't see any reason why we shouldn't attempt to travel it in this particular area, and then let the proof of the pudding be in the eating thereof.

Let's see how many States come in and how fast they come in, and I think that we will be surprised at the number that will come into it and the rapidity with which they will come into it.

Senator HARTKE. But you still feel the fact that these Governors should have no bearing upon the ultimate type of program to be endorsed?

Secretary FLEMMING. This is evidence that has been presented to this committee and which this committee, of course, will weigh. We simply stated to you our conviction that it would be unwise and unfortunate to attempt to deal with this problem by using the social security mechanism. We have given our reasons for feeling that to some degree you would be running the risk of jeopardizing the progress that we have made under the social security mechanism. We presented other reasons. Senator Javits has presented still other reasons in appearing before the committee this afternoon.

I think we should definitely keep in mind the fact that the possibility of using the social security approach has been under discussion for a period of 10 years, and so far it hasn't been able to get off the ground. Now that must mean that there is some reluctance on the part of the people of this Nation to move in this particular direction. And I think it is significant to note that in the Ways and Means Committee, when they were given the opportunity of voting on the social security approach, they turned it down 17 to 8.

Now it seems to me that if we really want to make progress in dealing with the needs of our fellow human beings, we should recognize as a fact that we are having trouble getting off the ground by using the social security approach, and instead of that try to use an approach that is characteristic of our way of handling problems of this kind, namely the Federal-State approach. If it works, fine. If it doesn't work you haven't foreclosed the possibility of trying the other route.

But the trouble is that we are siting around year after year discussing the desirability of going the social security route and we make no progress. We don't get off dead center at all.

Our thought is, here is a way to go to the Federal-State approach, which is typical and characteristic of the way in which we have handled other similar problems that can get us off the ground, can get us started. Some people will begin to get some help, evaluate it, and if the country feels that it hasn't gone as far—it hasn't met the problem to the extent that it should—it can try another route. You start down the social security route, however, and you have foreclosed the other possibilities, but there is——

Senator HARTKE. Mr. Secretary, just a minute. You certainly don't plan to contend that you disapprove of the social security program as presently operated?

Secretary FLEMMING. I certainly don't, and I am on record time and again for it.

Senator HARTKE. Certainly this is an American approach.

Senator FLEMMING. I didn't say it was not an American approach. You are putting words in my mouth when you say that. I didn't say that at all, and you know I didn't say that.

Senator HARTKE. Then I apologize to you, sir, you say anything you want to and I am not going to try to put any words in your mouth, but I want you to know you left the implication with me that you thought the social security approach——

Secretary FLEMMING. Just say one thing that I said that would leave an impression of that kind in the minds of any person listening to it. All I said was that the social security approach in handling this health insurance problem had been under discussion, to my knowledge, for a period of at least 10 years.

Senator HARTKE. All right.

Secretary FLEMMING. And it has never gotten off the ground.

Senator HARTKE. That doesn't mean it is wrong, or it doesn't mean it is right.

Secretary FLEMMING. Well, it does mean that there is resistance to the idea, resistance that was expressed just as recently as 2 or 3 weeks ago in the Ways and Means Committee with a negative vote of 17 to 8. My suggestion simply is if there is that much resistance to that approach why not tackle this problem by using the kind of an approach that we have typically used in this health area?

Senator HARTKE. You don't need to worry about that. I might agree with you. All I am trying to find out are exactly some of the facts that I think are necessary.

Are you also familiar with the fact that Governor Rockefeller, of New York, has endorsed the social security approach, as well as Governor Burroughs, of New Mexico, Lawrence, of Pennsylvania, in separate endorsements of this program not contained in the wire?

(See p. 187 for text of statement by Gov. Nelson A. Rockefeller referred to.)

Secretary FLEMMING. I am very much aware of the fact that Governor Rockefeller has endorsed the social security approach, and I am very much aware of the statement that he has made within the past few hours on that approach. And I am aware that he has attacked the proposal that I have submitted to the committee this morning on the ground that it is a fiscally unsound approach on the ground that it would be cumbersome to administer. As far as its fiscal unsoundness is concerned, I cannot understand the reasoning back of a generalization of that kind. As I tried to point out this morning, it is possible to move into a Federal-State approach with this program, just as we have with many other programs, and do it in a fiscally responsible manner. All you have got to do is do it in such a manner that your total budget is a balanced budget; and certainly when we are talking in terms of an $80 billion budget we don't have to assume that it isn't possible for us in 1962 to find $200 million to get this program underway and ultimately build up possibly to a total of $800 million. The country is capable of doing that and adhering to a policy of fiscal responsibility.

As far as the administration of the program is concerned, as I have indicated earlier, of course, it isn't the easiest thing in the world to administer a Federal-State program as contrasted with a centralized Federal program. But in our Nation we have come to believe that there are values that flow from a Federal-State program that you don't get from a centralized program.

Senator HARTKE. Before I put words in your mouth—there are values which flow from the Federal-State program— let me ask you, then, are there any values which flow from the social security program? There is where I guess I got lost a while ago with you.

Secretary FLEMMING. I feel that the Congress and the executive branch have followed a sound policy in providing for retirement, survivors, and disability insurance benefits through the use of the payroll tax, and the use of the social security trust fund. These are wage-related benefits. But these are quite different from the type of service benefit that is being suggested in the health insurance area.

I feel that this country should be proud of the old-age, survivors, and disability insurance program. I feel that it has moved forward on a sound basis, and I feel the proposals that are before this committee at the present time would strengthen it still further. One of the reasons why I hesitate to see health insurance get included in it, is, as I indicated this morning, that then your health insurance benefits are going to have to compete with the benefits under retirement, disability, and survivors, and I am not at all sure that we are ready to freeze those benefits at a particular point. I am not at all sure that later developments will not indicate the desirability of the improving of those benefits, and if it does indicate that desirability, and you have the health insurance program in under the same, then these two systems are going to have to compete with one another and, in my judgment, one or the other will suffer thereby. I think it is far better to take health insurance, put it out by itself, and finance it through general revenues rather than through the social security approach.

Senator CURTIS. Will the distinguished Senator from Indiana yield just briefly?

Senator HARTKE. Just one second.

I think I understand your point of view, and I will come back to it at a later time, but I wanted to cover this other point.

Senator CURTIS. I am not too impressed with these telegrams coming in from any source, but isn't it true that in the Forand bill, the payors of the social security tax would be providing medical benefits for our present aged and those who would seek retirement under OASI regardless of their need?

Secretary FLEMMING. That is correct, sir.

Senator CURTIS. So the people working now, whether it is in a grocery store, a coal mine, or any place else, will pay a regular social security tax to provide health benefits to people over 65 regardless of their income or financial status. Also, isn't it true that under the Forand bill there would be many, running into the millions, present aged over 65 who are not beneficiaries under OASI, who would receive nothing?

Secretary FLEMMING. That is correct.

Senator CURTIS. I think an appropriate answer to those telegrams might be a suggestion they read the bill.

I thank the distinguished Senator.

Senator FREAR. I think it is also true, may I call the attention of the Senator from Nebraska, that it isn't only the health benefits that a person is entitled to under social security, it is also remuneration on which they would live regardless of their income.

Senator CURTIS. That is true. But this entire problem is put in a purview of aged unable to provide adequate and reasonable medical treatment.

Senator FREAR. I don't want to get into a debate with the Senator, but I think that is true with some people. It is not true with all. It was not true with the sponsors of the Forand bill.

Senator CURTIS. I understand, and I am not in sympathy with going further in a program to put on the youth and the middle aged a social burden for people who have passed an arbitrary age when they do not need it and they are independently wealthy.

Senator FREAR. The Senator from Indiana?

Senator HARTKE. Mr. Secretary, are you also acquainted with the fact when you take these 23 Governors that I mentioned—and I only mentioned 23—that they represent 63 percent of the population of the United States of America?

Secretary FLEMMING. Well, Senator, I question whether they reflect accurately the views of every citizen in their respective States.

Senator HARTKE. I would think that would be a fair statement.

Secretary FLEMMING. They represent a point of view, but in the State of Ohio I think probably there would be some disagreement on the part of some citizens of Ohio with the point of view expressed by Governor DiSalle.

Senator HARTKE. Let me ask you sir, isn't there some disagreement with your point of view?

Secretary FLEMMING. Of course, there is; that is obvious. [Laughter.]

Senator HARTKE. Does not American Medical Association agree with your point of view?

Secretary FLEMMING. No; they don't. I said that this morning.

Senator HARTKE. So I mean, in other words, what we are dealing with are point of view, but you do feel the Governors are entitled to——

Secretary FLEMMING. They also don't agree with the social security approach. I think you realize that.

Senator HARTKE. I agree with that. In fact they don't agree with any of the approaches, is that right, that have been suggested in these bills?

Secretary FLEMMING. I think that is correct.

Senator HARTKE. I understand your contention is that one of the reasons and the basic reason that you asked for State and Federal participation is the fact that it moves the burden over on to those who are more able to pay.

Secretary FLEMMING. No, let me put it this way so we are accurate on it.

I said one of the reasons that I favor financing the Federal share out of general revenues, as contrasted with financing it through the payroll plan, is that to the extent we finance the plan out of general revenues we are relying to a considerable degree under our Federal tax structure, on an income tax which places a proportionately heavier burden on those of large incomes whereas under the social——

Senator HARTKE. As I understand you said a progressive tax?

Secretary FLEMMING. That is right, whereas under the social security approach half of the burden would go on earnings of $4,800 or less.

Senator HARTKE. Now then I understand also you realize—generally speaking—that most States have regressive taxes upon which they must depend at the present time, in fact, about close to 80 percent comes from sales or excise taxes, isn't that true?

Secretary FLEMMING. Well, I don't know whether you were here when Senator Douglas and I were discussing that matter or not.

Senator HARTKE. Yes, I heard that.

Secretary FLEMMING. He used the figure as I recall it, of 60 percent as contrasted with the 80 percent.

Senator HARTKE. 60 or 80.

Secretary FLEMMING. But as I indicated to him, I certainly will indicate to you, that I do recognize that that is the case. I regret it.

Senator HARTKE. Those are regressive taxes, you are willing to concede that, I hope.

Secretary FLEMMING. I concurred in his analysis and I concur in the analysis that you are making.

Senator HARTKE. What you have on one hand is what you call progressive taxes on the Federal level and regressive taxes on the local level and I want to see if whether you agree on one further step that the payroll deduction would be a proportional tax and be neither regressive nor progressive.

Secretary FLEMMING. I don't quite follow that. You lost me a little bit there. What is the——

Senator HARTKE. In other words, it is in proportion to his income?

Secretary FLEMMING. Yes, but——

Senator HARTKE. It would not depend upon——

Secretary FLEMMING. Well, now wait a minute.

Senator HARTKE. The percentage would come as far as he is concerned from his income.

Secretary FLEMMING. It is in proportion—it is—let me put it this way, the person with an income of $25,000 is taxed on $4,800 of his earnings.

Senator HARTKE. I understand.

Secretary FLEMMING. The person whose income is $4,800 is taxed on $4,800 of his earnings.

Senator HARTKE. That's right, sir.

Secretary FLEMMING. It seems to me that is not as fair a method of taxing as it is to use the income tax.

Senator HARTKE. I am not asking you to agree whether it is fair or not. I was just trying to get the facts in, I am not asking you about interpretations of them now. So I just want to get this straight, in oher words, we are dealing on the one hand with a situation which is going to bolster your theory on the Federal level, but deters from it on the State level at the present time under the present State tax methods.

Secretary FLEMMING. With this qualification, as I indicated to Senator Douglas, the States, to come into this program are going to have to raise additional revenue. There is nothing that says they should raise that additional revenue by using a sales tax.

They can use the income tax to a much greater degree than they are now using it, and I think most people are in agreement on that fact.

It isn't easy to persuade them to do it, I recognize that, but I think most people recognize that they could. It is my recollection that 37 States use it to some degree at the present time. Many that are using it to some degree could use it to a greater degree. The 37 that are not using it could use it.

Senator HARTKE. All right.

Let me ask you on a different subject then, do you feel that voluntary insurance at the present time can handle the problem of medical care to the aged?

Secretary FLEMMING. I stated very clear in my testimony that I do not believe it can.

Senator HARTKE. Also, I wanted to get this clear, isn't it also your opinion that under the voluntary programs even those who have it are in many cases inadequately protected?

Secretary FLEMMING. I stated that in my statement this morning, sir.

Senator HARTKE. This morning in an exchange or some place along the line, we got into this question of insurance companies involvement, do you recall that?

Secretary FLEMMING. Yes, in an exchange with Senator Douglas.

Senator HARTKE. As I recall, and I don't want to impute to anyone else what impression was left, but the Senator from Indiana received the impression that you said that this involved insurance companies in no way whatsoever. As I wrong in that?

Secretary FLEMMING. I said that as far as the operation the medical care for the aged plan, the plan under which people pay $24 in order to become participants, that this plan was to be managed by the States. Then I said that we had suggested, however, that the individual have the option of either paying an enrollment fee of $24 and becoming subject to this plan, or taking out an insurance policy and than having 50 percent of the premium up to $60 taken care of by a Federal-State fund. I also said, in order to make the record completely clear, that under the benefit plan under which people paid $24, and the plan that is managed by the States, that the State could, if it wanted to, contract with an agent to administer that plan—not the plan that the agent might want to administer, but to administer the plan that is provided for in the law.

Those are the three statements I made.

Senator HARTKE. We can agree in two instances private insurance carriers could be involved under your proposal, one individually, and one as a State carrier?

Secretary FLEMMING. No, as a State agent. Only as an agent to administer the program that is spelled out in the law. They would not be participating in the development of the plan, benefits or anything else. They would simply be used as an agent or could be used, just as the State of Colorado uses Blue Cross today to administer the vendor payment provisions of the old-age assistance program. So in terms of insurance company participation in the sense in which I think you and I would normally use it, the insurance company would be in the picture in only one situation, and that is if they offered major medical expense policies, an individual could pay a premium, and if that policy conformed to the standard set by the State, then he could have 50 percent of the premium underwritten.

Senator HARTKE. Let's take the first situation.

Taking all gloss and all coverings and all the nice phrases away, this in effect is a subsidy directly paid by the Federal Government to an individual who, in turn, pays a premium to an insurance carrier.

Secretary FLEMMING. You say this is all, I mean this whole program is that?

Senator HARTKE. I am talking about that portion of where the voluntary party——

Secretary FLEMMING. You are talking just about the option.

Secretary HARTKE. Yes.

Secretary FLEMMING. I mean the part where the individual instead of paying his $24 and becoming a part of the plan, could go out and buy a major medical expense policy.

Senator HARTKE. Up to $60 and 50 percent, up to $60, would be paid by the plan, isn't that right?

Secretary FLEMMING. That is right, the individual would be subsidized by the Government for 50 percent of the cost of the premium.

Senator HARTKE. That's right, and this is a direct subsidy to the individual.

Secretary FLEMMING. That's right.

Senator HARTKE. Which must be immediately transmitted to the insurance carrier.

Secretary FLEMMING. What do you mean, immediately transmitted?

Senator HARTKE. He can't put it in his pocket and spend it on anything else.

Secretary FLEMMING. Well, I mean there is no question about the fact that that 50 percent would apply to the premium costs of a policy issued by a private company or a nonprofit group.

Senator HARTKE. So when we get right down to it in this particular provision what we are doing through rather devious methods, we are subsidizing private insurance carriers up to 50 percent of premiums involved in voluntary insurance programs.

Secretary FLEMMING In the first place, why do we use the term devious, there is nothing devious about this.

It is right out there in my testimony.

Senator HARTKE. It is rather devious to me because I am having a rather hard time pulling it out.

Secretary FLEMMING. Why?

Senator HARTKE. I don't know why.

Secretary FLEMMING. Have you read it?

Let's see what isn't clear about it. I mean in that I prepared this testimony with the idea that I was making a clear statement of it.

Senator HARTKE. Let's wait a minute, let me clear up something for you.

Secretary FLEMMING. You said that I have covered up and have not made a clear presentation.

Senator HARTKE. I don't use the word "covered up"

Secretary FLEMMING. Well, "devious," you can use any term you want.

Senator HARTKE. I didn't say you used the term "devious."

Secretary FLEMMING. No, you didn't say I used it.

But you said this was a devious approach. Here is what I said:

Senator HARTKE. I said by rather devious method, that is all I said. You put it all on me, I am the one who used the word "devious."

Secretary FLEMMING. All right.

Senator HARTKE. And I didn't attribute it to you. I don't want to impute anything like this to you.

Secretary FLEMMING. Here is what I said.

I said:

Each State would provide an aged person eligible for participation in the program could elect to purchase from a private group a major medical expense insurance policy with the understanding that 50 percent of the cost would be paid for him from Federal-State matching funds up to a maximum of $60.

Senator HARTKE. That's right.

Secretary FLEMMING (continuing):

The States would be responsible for establishing the minimum specifications for such policies in accordance with broad standards established by the Federal Government.

It seems to me that is perfectly clear as to just what the proposal is and what it will do.

Senator HARTKE. I want to come back to that, where is that last statement there?

Secretary FLEMMING. States would be upon——

Senator HARTKE. I have got it. That is all right, thank you, sir.

Forgetting whether it is devious or not, it is, you agree, a direct subsidy in effect to the insurance carriers.

Secretary FLEMMING. I don't, no. Let's remember who we are talking about now. We are talking about 1 of 12 million people, who either paid no income tax, or whose income was $2,500 or $3,800 for a couple. All the Government is saying to them is "If you want to go out and buy a major medical expense policy, we will take care of 50 percent of the cost of the premium up to a total of $60."

That is all that is being said here.

To me this is an offer on the part of the Government to be of help to an individual who would prefer to get his protection that way as contrasted with coming into our overall plan.

Senator HARTKE. Without in any way disputing that, all I am saying in effect is that everyone who gets a subsidy thinks that this is an offer of help from the Federal Government and therefore it is justified in the public interest, otherwise we would not approve the legislation.

Let's come on back one more moment then to this part where the insurance company becomes the agent of the State. Under such a situation, who would govern and who would regulate the insurance carriers' activities?

Secretary FLEMMING. The State.

Senator HARTKE. All right.

Secretary FLEMMING. Now, wait a minute, remember, I mean the insurance carriers' activities would only be the activities of carrying out the program spelled out in thsi law. They would have no opportunity to exercise any judgment on anything.

Senator HARTKE. They would have a right to audit it certainly, wouldn't they?

They would have a right to audit.

Secretary FLEMMING. Who would have the right to audit?

Senator HARTKE. Federal and State Governments.

Secretary FLEMMING. What I am saying is, my point is that the insurance carrier or Blue Cross, whoever they contracted with, would have no right to exercise judgment on anything. All of the judgment, all of the auditing, would be done by the Federal and State Governments with the State government having the primary management responsibility.

Senator HARTKE. That is what I said. In other words, the auditing and the contracting of the insurance carriers activity, all of this would have to be done by the Federal and State Government.

Secretary FLEMMING. What on the part of the insurance company?

Senator HARTKE. The actions on the part of the insurance company would be subject to the audit and examination by the Federal and State Governments. You would agree with that?

That is correct. You agree that under your proposal the States would be responsible for establishing the minimum specifications for such policies, in other words, regulation of the insurance carriers?

Secretary FLEMMING. That is correct.

Senator HARTKE. Under both of these types of programs, all I was wanting to get at was that any insurance carrier participating under this becomes immediately subject to State and Federal audit and inspection?

Secretary FLEMMING. Well, I mean, if any State decides to contract with an insurance carrier, in other words to carry out this program, of course, its operations in carrying out this program would be subject to inspection.

May I again call your attention to the fact that the State of Colorado has entered into an arrangement with Blue Cross in connection with the medical vendor portion of the old-age assistance program. May I also call your attention to the fact there is nothing mandatory about this at all any more than it is under old-age assistance. The State can or cannot do this as it sees fit, and certainly if anybody is worried about the inability of the State to contract effectively with an agent to carry out this responsibility, why that part of it can be dropped out. But that was just simply put in just as it is in the existing public assistance law.

It is simply building on that particular experience, but as far as the policies of the individual that he can take out are concerned, the Federal or the State Government would not make any payments on the premium costs unless the policy was one that the State was willing to recognize as a policy that dealt with major medical expense.

Senator HARTKE. All right.

Secretary FLEMMING. Let's keep in mind that on this one, the insurance companies, of course, would be providing whatever protection they set forth in their policy, they were willing to provide and it would be——

Senator HARTKE. They would have to come up with a minimum requirement of your program, wouldn't they?

Secretary FLEMMING. No; what they would have to do is to provide a policy that would take care of major medical expense.

They would not have to come up with a policy that would provide for all of these benefits that I have outlined in this plan. These are benefits that would be provided under the Federal-State plan, that is the benefits listed on page 13. An insurance company won't have to come up with all of those but they would have to come up with a policy that would take care of major medical expense. The State would have to approve it as such a policy——

Senator HARTKE. When they approve it——

Secretary FLEMMING. And they would have to offer the policy to anyone, let's assume it is a policy that carries a premium of $120. Anybody could go in and purchase that policy by paying a premium of $120. In the case of the aged who are eligible for this plan, they would be paying $60 instead of $120.

Senator HARTKE. All right, now to another matter, have you dropped the reinsurance proposal of 1954 as being unworkable and unsuitable?

Secretary FLEMMING. Yes.

Senator HARTKE. In your opinion this is equally unsatisfactory as far as the administration is concerned,—

Secretary FLEMMING. What do you mean equally unsatisfactory?

Senator HARTKE. Equally unsatisfactory as the social security approach.

Secretary FLEMMING. I wouldn't say that. I just think we have got a much better approach here.

Senator HARTKE. All right, but you have dropped for all intents and purposes——

Secretary FLEMMING. If we had not dropped it I would have it up here because there is what I am recommending and backing.

Senator HARTKE. You are very strongly in favor of the deductible provision, isn't that right?

Secretary FLEMMING. That is right.

Senator HARTKE. And you recognize, of course, I hope, that under your proposal, that there is no incentive for diagnostic medical care—there is no incentive under the deductible provision for diagnostic examinations.

Secretary FLEMMING. Well, in our package of benefits we have got physicians' services unlimited.

Senator HARTKE. But after they pay the deductible——

Secretary FLEMMING. Let's keep this in mind, the fact that that $250 applies to any of the services that are listed in the package, in their dental bills, all of the bills that they may incur in connection with any of the services in this benefit package would apply to the $250.

After that the plan picks up.

Senator HARTKE. Let's come back to this, aren't you willing to agree at least there is a deterrent to seeking preventive diagnostic treatment? Maybe not a complete bar, but certainly a deterrent by having the deductible feature?

Secretary FLEMMING. I don't know that I will concede that, no.

I mean because I think there are other incentives at work that would lead to a person moving in that direction.

Senator HARTKE. Well, the most important one is though enough money to pay the bill, isn't it?

Secretary FLEMMING. There is not any question about that.

Senator HARTKE. Sure, Doctor John Porterfield—the Deputy Surgeon General—testified that this, is in his opinion, one of the real needs and I think you are acquainted with him, are you not?

Secretary FLEMMING. Yes, sir.

Senator HARTKE. The real need is for preventive medical care for these people. You agree with that. Let me assume then that this is a deterrent to preventive medical treatment.

Now, about the statement this morning concerning the overtaxing of hospital affairs. You are acquainted with the McNamara proposal which permits a direct care in the home and also that he does not have to go to the hospital before he goes to a nursing home as was required in which you objected to in the Forand bill did you not?

Secretary FLEMMING. I testified this morning that I felt that the

McNamara bill on that particular point, assuming without regard to the basic approach, was an improvement over the Forand bill.

Senator Javits testified the same way just a few minutes ago.

Senator HARTKE. All right, fine. Now then, in regard to physicians you feel that one of the basic deficiencies in the McNamara and Forand bills and the others is the absence of physicians' fees?

Secretary FLEMMING. Let me put it this way: My conviction is that the real need here is to provide protection agaisnt the costs of long term illnesses. If we are going to provide protection against the costs of long term illnesses, I think it is necessary to include physicians' services as well as all of the other services that we have identified.

Senator HARTKE. I won't find myself very far from you on that point.

Then in regard to that, however, you must realize that if you are going to provide physicians' services it must increase the overall costs; we can agree on that.

I am not talking about how much and where, but if you are just going to add physicians' fees.

Secretary FLEMMING. Sure.

Senator HARTKE. It is going to increase the overall costs. And also by the testimony given here, the McNamara proposal and your proposal, are estimated to run about the same $1.2 billion and $1.3 billion, isn't that right?

Secretary FLEMMING. I think that is the estimate of the McNamara proposal—about $1.3 billion.

Senator HARTKE. Therefore, it is reasonable to assume that the difference in picking up this additional cost for physicians' fees has to be covered in the amount which is taken in the deductible feature because this being the major difference——

Secretary FLEMMING. Well, I would want to analyze the two sets of benefits pretty carefully before I agreed with that generalization, you are certainly correct that one of the factors that leads to the additional cost which is reflected in the deductible is the physicians' services but I am not at all sure that there may not be some other things in our package which also add to the costs in terms of taking care of the long term illness, in other words, I would like to have somebody check both sets of benefits carefully.

Senator HARTKE. I am not going to hold you to it but as to that, that is a fair assumption at least for the moment subject to it being checked by your staff, is that right, and if it is incorrect, I am sure your staff could supply that information for the record to correct it at this point.

Secretary FLEMMING. I am certainly willing to agree that this is one of the factors that leads to the additional costs, the additions of physicians' services; there may be some other factors in there.

Senator HARTKE. So we must agree then that the McNamara proposal is less expensive as far as overall costs in regard to the fact that it eliminates physicians' fees?

Secretary FLEMMING. No; the McNamara bill basically is less expensive because of the fact that it does not do as good a job of taking care of the costs of long-term illnesses as does the proposal that we have submitted to the committee.

Senator HARTKE. You mean as far as any other type of thing except physicians' services.

Secretary FLEMMING. Well, we are right back where we were. I am sorry I just can't react off the cuff on that. I would like to have the opportunity of analyzing it a little more carefully.

Senator HARTKE. Let me state then that it is my opinion that this is the primary difference in services.

Will you accept my statement, how is that?

I don't want to put words in your mouth, you see.

Secretary FLEMMING. I indicated in the testimony that I gave this morning by taking a specific example which did not include a large amount in terms of doctors' services, that our package of benefits would be much more helpful in dealing with long-term medical expense than the McNamara bill.

Let me just give you that figure again. You will recall I was talking about a woman in her 70's who had had a stroke, was in the hospital 30 days, skilled nursing home, 22 months, private duty nurse for 5 days, medical services in the hospital $125, medical services in the nursing home every other week, $22, drugs $100, and I said that under the McNamara plan that she would receive $3,350 of assistance, and would be called upon to pay $3,575. Under our plan she would receive $5,140 of assistance and would be called upon to pay $1,833. There is much more in that than just the additional physicians' costs or fees. This is geared to a long-term illness and does a much better job for the individual in also giving assistance to a long-term illness than does the McNamara plan and of course is way ahead of the Forand plan.

We have, the other factors that we have, just quickly, we have longer durations as far as nursing home and hospital care is concerned, we also have surgeons' fees, and we have dental services and drugs, and as I recall it, the McNamara plan makes no provision for drugs.

(NOTE.—The McNamara bill provides for inclusion of the costs of "very expensive drugs" on or after July 1, 1962.)

Senator HARTKE. I didn't plan to get into that example just for the sake of the record to clarify, I just would like to give you an example of a 68-year-old man, cardiac failure, hospital 30 days, home treatment 120 days, medicines, drugs, and so forth, under your proposal portion would be $766 and under the McNamara proposal the cost to the individual would be $56.

For a widow with carcinoma of the breast, surgery, home visits, nursing home for terminal care under the McNamara proposal would cost her $350 and under your proposal would cost $594.

Single man—bronchial pneumonia treated at home under the McNamara plan would cost him nothing, under your plan would cost him $200.

Married person, fractured hip, hospital surgery, nursing home and home care under McNamara proposal $345, and under your plan would be $583, and I would imagine if both of us dug up cases we would probably stay here all afternoon coming up with various proposals showing which plan was doing the best job and costing the least amount of money.

Secretary FLEMMING. Senator Hartke, the difference is a clearly reconcilable difference. The proposal that we have placed before the Congress is designed to deal with heavy cost of long-term illnesses.

The other proposals which are before the Congress place their emphasis on first-dollar costs. The Forand bill would be a first-dollar cost of a fairly short-term illness. The McNamara bill moves in our direction, but that is the reason for the difference.

I have got illustrations just like yours here, and it depends on the duration of the illness.

We feel that the most serious issue confronting the country at the present time are these long-term illnesses that elderly people become involved in.

Senator HARTKE. Well, I would hope that you are right but according to your statement on page 8, you point out the fact, which I commented upon very carefully, that the problem here involves about 12 million people who do not pay income tax and 2⅘ million who are the recipients of public assistance. I am not going to argue that with you but I feel if you read your own figures you will find out this does not deal necessarily just with long-term illness but with people who have a present need for medical attention and who are not getting it.

That is the problem.

Secretary FLEMMING. But how are you going to take care of this person with a long-term illness using the illustration that I used? You are asking that person to find $3,500 some place under the McNamara bill in order to take care of the expense incurred.

Senator HARTKE. Well, the man who has an income of less than a thousand dollars, is not going to come up and pay a $3,500 doctor bill.

Secretary FLEMMING. What are you going to do for that person, that is my problem?

Senator HARTKE. I would imagine——

Secretary FLEMMING. That is our problem, it seems to me.

Senator HARTKE. Well, you and I probably are going to disagree there on what part of the problem is and that is that.

Secretary FLEMMING. I think the person is better off if the plan pays $5,100 and the individual has only got to get the $1,800.

I think that is better than forcing the individual to find $3,500.

Senator HARTKE. Well, the average for this group shows that their health and medical expenses according to the Secretary of Health, Education, and Welfare is $177.

Secretary FLEMMING. That is an average.

I also pointed out if you read a little further on, that 15 percent or 2¼ million aged have total expenditures on the average of $700 per year.

Senator HARTKE. What percentage of this group upon which you feel there is such a present human need, what percentage of that group are in the so-called $6,000 class?

Secretary FLEMMING. What I have said is that 15 percent of the persons 65 or over, or 2¼ million have some total medical expenditures on the average of $700 per year, and I then went on to point out that the only reason or the reason you have that high average is that you have these people who become involved in illnesses that spread out over a year or 2 years.

Senator HARTKE. In other words, we can assume even from your own statements that certainly 85 percent of these people have expenses of less than $700 per year.

Secretary FLEMMING. That is what I have said here, yes.

Senator HARTKE. So we are certainly dealing with far less than 15 percent, we are dealing with $6,000 a year.

Secretary FLEMMING. Senator my point is this: We have not made any start in dealing with this problem. Let's get started by identifying the most serious problem that we have got namely the people who are up against these heavy expenses for long-term illness.

Senator HARTKE. All right, let me ask you in regard to your provision regarding physicians, payment of physicians' fees and setting up physicians' schedules which are required, does it not call for the schedule of fees being approved?

Secretary FLEMMING. Well, any State that entered into this plan would certainly, just as it does under public assistance, have to set up a fee schedule of some kind.

Senator HARTKE. All I want to know is do you think this in any way interferes with the physician-patient relationship?

Secretary FLEMMING. I do not.

Senator HARTKE. Do you think your proposal would not?

Secretary FLEMMING. I certainly don't.

Senator HARTKE. If we established a separate fund for medical benefits on a payroll deduction method, how could that possibly affect the "orderly development of the retirement survivor disability features of the social security system" as indicated in your statement?

Secretary FLEMMING. Simply because of the fact you are putting an additional load on that particular form of taxation and I don't care whether the fund is separate or not, it becomes perfectly clear to the person who is paying the payroll tax instead of paying 9 percent he is paying 10 or 11 or 12 or whatever the case may be.

Senator HARTKE. He is paying his withholding tax whenever you increase his taxes on withholding.

Secretary FLEMMING. Sure, but whenever anybody comes before this committee in the future, and asks for an improvement in the retirement or survivorship or disability features of the bill, and says "This is going to take another 1 percent as far as the payroll tax is concerned" people are going to say "Well, we have got to look at that in relation to the amount of payroll tax that is required for health insurance," and inevitably they will be in competition with one another. Either you will go the whole distance and take care of all of them and build your payroll tax up to a very high figure or you will decide that you are going to take one and not the other, and human beings may suffer as a result.

Senator HARTKE. Let me ask you a question and I think you can answer this and I think I know what you will answer, do you consider your proposal fiscally responsible?

Secretary FLEMMING. Well, didn't I already answer that? I thought I spoke on that for 3 or 4 minutes in response to Governor Rockefeller's statement.

Senator HARTKE. I am not asking for 3 or 4 minutes but just yes or no.

Secretary FLEMMING. Didn't I answer that a little while ago?

Senator HARTKE. I just kind of like to know is it all right——

Secretary FLEMMING. I mean in response to your question, didn't I answer it a little while ago? Of course I consider it fiscally responsible.

Senator HARTKE. That is all I want to know. If you would say "Yes" in the first place we would all save time.

Secretary FLEMMING. I know but I said it three times.

Senator HARTKE. Would you be in favor of reducing any specific program in the Federal budget today in favor of the proposal of yours for the care of the aged?

Secretary FLEMMING. I don't know that I can look at the total Federal budget and make decisions of that kind. My only point is that for a program that is as needed as this program is it is possible to work it in in an $80 billion budget. I would not want to be specific because I am not in position to be a competent witness.

Senator HARTKE. Would you care to compare it with the mutual security program?

Secretary FLEMMING. I am not going to compare it with anything. If you are building an $80 billion budget it should be possible to develop a balanced budget and work something like this into this balanced budget.

Senator HARTKE. I don't want to go into a long discussion on this if you don't care, Mr. Secretary, but I just wanted to know whether you believe the $1,200 limitation which is placed on the present income of social security beneficiaries should be raised or removed?

First, should it be raised?

Secretary FLEMMING. We submitted a report, a rather detailed report to the Ways and Means Committee dealing with that problem and I would want the opportunity of refreshing my memory on that report before commenting on it. I didn't know anybody wanted to discuss that today or I would have done it last night, if you want me to come back at another time and discuss that I will be happy to do it.

Senator HARTKE. I am just reading from a Life editorial in Life magazine concerning the age, health, and politics in which they stated that moreover many oldsters able and eager to work to better provide for their own security if the $1,200 limitation were raised on income they earned without forfeiting social security pensions. The only thing I asked you whether or not you would agree whether this would help.

Secretary FLEMMING. I just say this, Senator, in my judgment we have not solved that problem in a satisfactory manner as yet and I don't believe we should feel that the way the law stands at the present time should be the last word by any means.

I am not satisfied with the way it stands at the present time but I am not prepared to discuss proposals, specifically, for improving it at this point.

Senator HARTKE. Would you be willing to state whether or not you feel that this statement in the Life editorial was in fact desirable or undesirable?

Secretary FLEMMING. I will rest with the statement that I have made. I don't think that the law as it stands at the present time represents a satisfactory solution to that problem and I will be glad to come back some other time and discuss possible solutions.

Senator HARTKE. Do you think that this is proper public business, this question of medical aid to the aged?

Secretary FLEMMING. That is the tenor of my testimony. It certainly is.

Senator HARTKE. I am asking a question.

Secretary FLEMMING. If I made anything clear, I hope I made that clear. The answer is "Yes."

Senator HARTKE. All right. And you think it should be decided according to the Nation's sense of justice, urgency, and choice of priorities in the use of scarce resources?

Secretary FLEMMING. OK, I will go along with that.

Senator HARTKE. Since you state the need is so great and that Federal action is necessary, if the Congress should accept the benefits which you propose, and if we accepted the deductible provisions which you have proposed and if we extended the coverage to help those who are not covered under the social security program, but either in one of two fashions put on an attachment that the payment be by social security or by payroll tax, would your oversensitivity to this particular approach be such that you would still oppose this legislation?

Secretary FLEMMING. I so indicated to Senator Douglas and I will indicate again.

Senator HARTKE. And in your opinion, Would you recommend to the President that if all of these conditions were accepted, would you recommend to the President that he veto such a bill?

Secretary FLEMMING. I normally don't discuss communications that I either send or might think in terms of sending to the President on a matter that is properly before the President. The President has stated time and again that he will not indicate what he will do with a piece of legislation until it is on his desk. Certainly it would be inappropriate for me as a member of his administration to comment on a hypothetcal situation as to whether or not I would recommend or not recommend.

Senator HARTKE. Let me change it then: Would you be very strongly opposed to it to such an extent that you would feel it would be unacceptable legislation from the viewpoint of the Secretary of Health, Education, and Welfare?

Secretary FLEMMING. I stated to Senator Douglas and I have stated to you that I would be opposed to the legislation. I stand on that.

Senator HARTKE. Even if we accepted all of these other principles?

Secretary FLEMMING. I stand on that.

Senator HARTKE. In your opinion, would the President veto such a bill?

Secretary FLEMMING. I am not going to speculate as to what the President would or would not do, but the President has made it very clear to the Nation through his press conferences and otherwise that he is completely opposed to the use of the social security mechanism for dealing with this problem.

Senator HARTKE. In other words, you would disagree with the conclusion of the Life editorial of April 25, 1960.

Secretary FLEMMING. I would. I read it.

Senator HARTKE. In which they say, in principle such a principle is proper public business. The issue, therefore, is inevitably a political one. It should be decided according to the Nation's sense of urgency, justice, and choice of priorities and in use of scarce resources as determined by the Nation's elected Representatives in Congress.

Secretary FLEMMING. In my judgment if the plan we have presented to the Congress were accepted it would fit all of those qualifications very nicely.

Senator HARTKE. Except for the fact that you are in effect saying that you would deny to the Congress the right to make its own determination of how it is going to provide.

Secretary FLEMMING. When did I say that? This is the kind of thing that I object to. I mean the Congress has got a perfect right to do anything in matters of this kind. The President of the United States is a part of the legislative process, and he has got, too, the right to make up his mind as to what he would do. I haven't said anything about what the Congress should or should not do. I have got a point of view which I have been here presenting, and trying to justify. Of course, it is up to the Congress to determine what it would do. I haven't said anything about denying the Congress the right of doing anything.

Senator HARTKE. All right, then you haven't denied Congress the right to do anything and I want to thank you for the time you have given me.

Secretary FLEMMING. Thank you, sir.

Senator GORE. Mr. Secretary, I have not yet had an opportunity to review a copy of your bill. If you have a copy, I will be glad to see that it is introduced unless you have some other person whom you would prefer as an author of the bill.

Secretary FLEMMING. It is my understanding that it will be introduced and as you know I did make available a copy of the draft bill.

Senator GORE. I understand you made a copy available to the committee but I have not been able to see it.

Secretary FLEMMING. That's right.

Senator GORE. But I am glad it is going to be introduced. As you know it is customary for legislation of, shall we say, uncertain support to be introduced by Members by request.

Secretary FLEMMING. That's right.

Senator GORE. And I can understand why, if you have already contacted someone you would prefer that they introduce it, and I think it deserves to be introduced.

Secretary FLEMMING. I appreciate that.

Senator GORE. It is a serious proposal to deal with a very serious problem, and I wish to congratulate you upon the amount of study which you have given the problem, and upon your ability to bring the administration into agreement upon a proposal in this vexatious field.

Several proposals, of which you have indicated your awareness, are before the committee. There is one by Senator Humphrey, one by Senator Kennedy, and I think Senator Anderson is preparing one for introduction perhaps today or tomorrow. I will be unable to interrogate you in any detail on your proposal, not having had an opportunity to study it but I followed your statement and your description of it with care, and from that would like to submit a very few questions.

For what period of time would the initiation fee, you described it by another term, what did you call it?

Secretary FLEMMING. Enrollment fee.

Senator GORE. Enrollment fee, maybe one name is as good as another.

For how many years would it be necessary that this enrollment fee be paid before a person would be entitled to benefits which you recommend?

Secretary FLEMMING. In our proposal there isn't any limit. It would be paid each year.

Senator GORE. You mean he could pay for 1 year and then be entitled to benefits?

Secretary FLEMMING. Well, he would be entitled to the benefits during that benefit year, but then the next year he would have to pay another fee of $24. And so on. It is an annual enrollment fee.

Senator GORE. I believe there are some more questions and I am sure after your bill is introduced and we all have had a chance to study it that you will have an opportunity to return because this is a question that can't be solved in 2 days, or should not be, in my opinion.

Suppose a person who has not been enrolled is advised by his private physician that he may need surgery?

Would there be any estoppel in your program so that he could not pay the enrollment fee and then be immediately eligible for the payment of his hospital bill?

Secretary FLEMMING. He could enroll at that point.

Senator GORE. In other words, if he knew that he was going to have to go to a hospital for an operation, he could then pay $24 and be eligible to have you pay or have the Government pay a hospital bill of $5,000?

Secretary FLEMMING. As we visualize it, something like the way your Blue Cross and Blue Shield operate at the present time, there would be an enrollment period during which persons would have the opportunity of enrolling.

Senator GORE. That is the first question I asked you.

Secretary FLEMMING. That is right.

Senator GORE. I thought of necessity there would be an enrollment period.

Secretary FLEMMING. That is right and given a situation such as you describe, he would not come under the plan that we have proposed. He would in all probability then come under the old-age assistance benefit schedule. As you will recall, we are recommending that the same schedule of benefits be set up for the old-age assistance people that are set up for people who would come under this plan, so that if he did not have resources to deal with that situation, he would come under the old-age assistance and be given all of the assistance provided for in our plan.

Senator GORE. What is the enrollment period?

Secretary FLEMMING. Our thought there was the State would make the determination, or at least include in the plan that it submitted to the Federal Government for approval provision for an enrollment period, and if the provision that they put in appeared to be reasonable to the Federal Government, it would then be approved as a part of their State program.

We did not have in mind writing into either Federal law or regulation any uniform provision on that for all 50 States although that could be done.

Senator GORE. You say you did not have that in mind.

Secretary FLEMMING. We felt that, just thinking out loud, it would be better to let the State make proposals to us and the proposals were

reasonable, if they were, approve them, rather than having any uniform provision for the entire country. But certainly you could think in terms of a uniform provision.

Senator GORE. Your answer is thus far——

Secretary FLEMMING. When you get into something of that kind following this a little further, if you had a fixed enrollment period, then you have got to make provision for the people who reach age 65 between enrollment periods and that certainly could and should be done.

Senator GORE. Well, your answers thus far lead me to the conclusion that perhaps the Department could give some further study to this problem with profit during the proposed recess of the Congress.

I think of necessity you would have a qualifying period, or else you would certainly have a rash of enrollment fees after visits to the doctor's office.

I agree with your point of view that it's more equitable to derive revenue from a progressive income tax than from a payroll tax or sales tax or manufacturing excise tax, and I congratulate you upon presenting that point of view. It has been a little cold around here lately, but I think you are sound in that point of view.

However, when applied to this particular situation, I am constrained to the view that it is only through a program sufficiently widely based that we will have a truly national program.

If you proceed upon the enrollment fee of $24 per year that is equal to 1 percent of a $2,400 salary, which is more than would be deducted from an income, from wages, by either of the proposals pending before the committee with the social security approach.

For instance, a person with a $3,000 per annum wage would pay $15—let's take the example of a person with a $4,000 annual wage.

Under the bill I have introduced he would pay $10 per year, and the employer would pay $10 a year. Now under your plan before he would be eligible he would have to pay, the person himself would have to pay, $24 a year for a period of years on which we are now uncertain.

Secretary FLEMMING. Senator, just to back up a minute, does your bill provide for a one-half percent increase in payroll tax?

Senator GORE. Yes; one-quarter by each, employer and employee.

Secretary FLEMMING. I might say we have not had the opportunity of studying your bill in detail, but taking the McNamara bill as an illustration, if I understand, if yours is fairly close to that although possibly a little more liberal in terms of some of the benefits.

Senator GORE. More liberal in some and less liberal, I think, in others.

Secretary FLEMMING. Yes.

Senator GORE. Pardon me just a moment.

Secretary FLEMMING. The McNamara bill, Senator Gore, would require in our judgment, from an actuarial point of view a 1-percent increase in payroll tax.

Senator GORE. Eventually.

Secretary FLEMMING. Well, when it is adopted, by the Congress our recommendation—if it is adopted by the Congress, our recommendation from the actuarial point of view would be that it includes a 1-percent tax. That is if we made the same kind of a recommenda-

tion that we do in connection with all of the other matters involving OASDI, we would recommend to you that you impose a 1-percent payroll tax.

So that that would be a half percent on the employer and a half on the employee.

Senator GORE. Well, in either event——

Secretary FLEMMING. But you see, I mean, I get your point, and, of course, I think in weighing the two, you do have to take into consideration not only when you weigh that $24 but when you weigh the $250 deductible and the 20-percent cost-sharing provision, all three of those put together, what it can mean to the individual in terms of being helped on long-term illness. I appreciate that you or the others might take issue with me on feeling that that is the No. 1 problem, that is the problem we should concentrate on.

But in evaluating our plan, I think that you do have to keep in mind the fact that that is what we did concentrate on, namely, developing the very best practical benefits that we could in order to deal with the long-term illness.

Senator GORE. But even though I acknowledge with appreciation your concern for the catastrophic illness, your plan lays itself wide open for people who may have been advised of an impending physical catastrophe to take advantage of it.

Secretary FLEMMING. Well, I mean, I get your point there, but after all is there anything wrong with it? If they have been advised of it and in all probability it is going to take place, they are going to be up against this heavy expense and of course this is one of the reasons why we build in the deductible and the cost-sharing feature so that there is some check on the use of the services and on the expenses that might be incurred. Let's assume that our enrollment period was the month of January, just to take an illustration, in a given State, and let's assume that in the month of December a person who is 70 or 71, who had not yet ever come into the program, is advised of the necessity for a major operation, advised that it might lead to other complications, and so that person said "Well, in January, I will; when the enrollment period comes around I will enroll in order that I can take advantage of the program."

I appreciate that is what insurance people would call adverse selection, and yet considering the nature of the problem, and considering the income that this person has and so on, I don't think the Government should object to that kind of an adverse selection.

Senator GORE. Well, I would like to examine that a moment with you. I realize you have had a long and a hard day. I noted with interest that you would not apply the property test but rather an income test.

Secretary FLEMMING. That is right.

Senator GORE. So let us imagine a couple with an income of $3,000 per year. I believe your limit would be $3,800 per year; would it not, sir?

Secretary FLEMMING. For a couple; yes.

Senator GORE. For a couple.

Secretary FLEMMING. Yes.

Senator GORE. Let us assume that this couple is retired, that they have a comfortable home, without encumbrances, of some reasonable

value, say $25,000, and that they own a farm. It is very possible to own a farm of a thousand acres and have no income at all.

But this farm is perhaps worth $100,000, and let us assume that the same couple has $100,000 invested in Government victory bonds on which they receive 2½ percent interest, $2,500, and a few other odds and ends that would make their total net worth a quarter of a million dollars.

Yet under your plan by paying $24 they could receive Government payment of a hospital bill, I believe you said, up to——

Secretary FLEMMING. There isn't any limit.

Senator GORE. No limit?

Secretary FLEMMING. Let's say, a bill of $6,000.

I recognize that that type of thing could happen, but let's start over here. Under the social security approach, there isn't any consideration of need at all, of course.

And people such as the ones here you have described, plus people who are drawing salaries of $25,000, $50,000 a year, and so on, could, I mean would be, not could, but would be under the plan.

I recognize that under the kind of a plan that we have proposed there would be some people who would or could qualify for it, and you and I would agree they did not need this kind of help and assistance in dealing with a major medical illness.

But certainly a much smaller percentage than in the case of social security would be willing to take that kind of a calculated risk, in other words, that some such as you have described would slip in, in order to be able to avoid all of the administrative complications and all of the personal negative reactions that are involved in the application of a means test. In other words, I am not very enthusiastic about a means test, and I know the problems that it involves.

I mean that are involved in it when you get over into it in the welfare field.

So in order to avoid that, I am willing to take a calculated risk on having some people come under this plan who don't need this help, but again my point is that under this plan you would have a much smaller percentage of persons under the plan who do not need help than would be the case under social security.

So that I think this is better from that viewpoint—if you judge it against the test of are we helping only the people who need it, I would say we are coming closer to helping only the people who need it under our plan than you can under a social security approach.

Senator GORE. Well, one fault of your plan is that it permits a citizen who has been advised of arson to take out insurance on his house. It seems to me that we must choose here between a health, hospitalization, medical care program, that is truly national in character, or to take a far more restrictive one, such as you have suggested, which will not cost as much, but which can be greatly abused. In making that choice, it seems to me that where you have given great emphasis, and I applaud you for giving emphasis, to the catastrophic illness, the lifetime illness, the invalid, but the thing that you have overlooked, it seems to me, and you understand, I have not given this the study to which you have given it, is the value of preventive medicine, a stitch in time, visits to the doctor 's office or to the nursing

home, if an old person whose means are very limited must bear the first $250 cost of hospitalization.

Secretary FLEMMING. Not of hospitalization, I mean of all conceivable types of expense that could be incurred in this area, but go ahead, yes.

Senator GORE. The reluctance depends heavily on his limited means which might discourage and forbid the possibility of corrective attention which might come much cheaper than the cataclysmic, catastrophic illness that might occur otherwise.

Secretary FLEMMING. Senator, I certainly appreciate the point of view that you have expressed there, and I think it is one that should be given consideration. I would be the last to deny the desirability of our doing everything we can to encourage people to prevent, I mean to take steps that will prevent major illnesses. I certainly think that both Federal and State Governments and private groups and so on should do everything they can along that line.

I appreciate the fact that a good case can be made for putting the emphasis on first dollar costs as over against putting the emphasis on the long-term illness.

And I appreciate the fact that you don't necessarily have to choose between the two. You could say it is both—and, it is not either—or, but I think both of us would probably agree if we tried to make it both—and, the initial expenditure would get up to a figure where it would probably be very difficult for us to get any program started; I mean there would be a resistance to the program because of the expense involved.

So, faced with that kind of a situation, our feeling was that it was better, in order to get the Government's participation in this area off dead center, to concentrate on the long-term illness, and to come up with a plan which would really take care of that in an adequate manner, recognizing that there are other programs and so on that can help out on the first dollar costs.

I know reasonable people can differ on that. I mean, as to our choice, but as we went into the problem, the thing that impressed us more than anything else was this terrific burden that the long-term illness puts, not only on the older generation, but on the next generation also, because, as you and I know, the older generation use up their life savings in order to take care of it, and then the next generation comes along, and they use up their savings, and this gets to be kind of a vicious circle, because their savings are savings that otherwise would be used to educate their children, who are coming along and they can't use it for that purpose.

In other words, we feel that the situation that presents a terrific problem for the older generation and for the next generation is this long-term illness, and we felt that it was better to concentrate on that and come up with a plan that would really take care of that situation. I think you can see that if a State came in under our plan as we have outlined it here that it really would do a good job of taking care of the long-term illness.

Now, the Forand approach didn't really take care adequately of the point on which you have put your finger either, because it just provides hospital and nursing home benefits for a comparatively short period of time, so there isn't really any of the preventive aspect there.

I appreciate that Senator McNamara's bill, the bill that you have introduced, moves in the direction that you have talked about, and your bill also, moves in the direction of doing a better job on the long-term illness than the Forand bill would do. It doesn't do as good a job as our package would on the long-term illness but it certainly moves in that direction. This is, I appreciate, a matter of judgment, but we just felt that that situation is so serious that this is what we ought to concentrate on and what we ought to try to get the Government to do something about.

Senator GORE. Well, as I have said to you, I appreciate your efforts, and I am not going to keep you longer.

Secretary FLEMMING. Might I say this, Senator Gore. I want to be fair to the staff who have worked on this. When you first asked me about that enrollment figure my memory just slipped for a moment, we had a rather long discussion on that, I recall that very distinctly, because again we are focusing the attention on the long-term illness. I started out by hoping that we could avoid an enrollment period, but I was persuaded by the staff that we couldn't, just as you recognized we couldn't, and in our draft bill there is definite provision for that. I just wanted to make that clear. My memory slipped on it for a moment.

Senator GORE. I concluded that either your memory or your staff work had slipped, and I am glad that you were generous enough to say it was your memory.

Secretary FLEMMING. It certainly was, no doubt about it.

Senator GORE. Well, our brief discussion here illustrates that neither can claim to have either a perfect or final answer to this problem, and if the lightning shouldn't strike you out in Chicago and I survive Los Angeles [laughter], we will have an opportunity to discuss this further.

I do want to join you in your feeling that the House bill in and of itself is inadequate. I can't go along with your approach. I feel it is necessary to have a truly broad based program, and that your eloquent presentation argued for a broadening of the program.

As I have looked over the report on the House bill, it appears to me that 4 States out of the 50 would receive, according to the estimates, 60 percent of the benefits from the program. Would you agree with that?

Secretary FLEMMING. You mean that is under title 6?

Senator GORE. Under title 6, yes.

Secretary FLEMMING. That is right. I mean—of course you understand, Senator Gore, on that I want to be perfectly fair to the House bill and title 6, these estimates are estimates that you have to build up by using an awful lot of subjective judgment because there are not any floors or ceilings really written into title 6. I mean a State can set any kind of a needs test that it wants to set. It could provide a cutoff point at $2,000, $3,000, $4,000, $5,000, so that those who have to work on the development of cost estimates are somewhat handicapped because they have to kind of speculate as to what the State, what certain States might do and what certain other States might do.

Senator GORE. Well, I agree with that, and I acknowledge that. But, even so, for the sake of discussion, the best indexes we have are the estimates we have been supplied.

Secretary FLEMMING. That is right.

Senator GORE. And according to those estimates 4 States would receive 60 percent of the benefits, and the benefits estimated for 44 States would approximately equal that estimated for 1 State.

Secretary FLEMMING. I am sure you have stated that correctly. I will ask Mr. Myers—is that correct?

Senator GORE. Is that correct?

Mr. MYERS. It is correct that 60 percent will go to the four highest States, and the remainder of the States would get just a little more than the 1 largest State, was that what you were saying, Senator Gore?

Senator GORE. I was saying that 44 of the 50 would receive approximately the same amount, according to these estimates as 1, and that is out of all proportion to the number of old people or to the needs involved, and, as I understand these tables they are based upon, the present legal qualifications for old-age assistance in the respective States. Is that generally correct?

Mr. MYERS. Yes, Senator. As we try to point out in connection with these estimates, it is very difficult to make them, particularly on a State by State basis, since it is difficult to know just which States are going to act and to what extent.

Secretary FLEMMING. Of course I might say this, Senator Gore, I think you could take any of one of the proposals pending before the committee and telescope it with title 6, and that is why I have no hesitancy in saying we recommend approval of title 6, because it can do some good and then I went on, of course, to indicate that I feel that nevertheless the plan that we have recommended should be adopted. Now, I got into a little difficulty this morning on the cost of the two plans. There would be some overlapping because some people obviously would be eligible for the plan that we have proposed and consequently wouldn't come under this plan on title 6, but I think if you look at title 6 carefully, I think we could probably all agree on the fact that it is not in conflict with any of the proposals that are here. In other words, it could supplement any of the proposals.

Senator GORE. Well, as you know, the leadership of the two parties in Congress have agreed that Congress will recess this weekend and return early in August, I believe it is, and, therefore, this will give you an opportunity and me an opportunity and other members of the committee an opportunity to study this problem with greater care, so it is entirely possible that the committee will wish to extend to you an invitation to return.

Secretary FLEMMING. I would be very happy to at any time.

Senator GORE. And I will have some witnesses to suggest when we return. I am going to suggest to the committee that it invite Governor Rockefeller to testify, he having presented a challenging program today.

Senator FREAR. In other words, you want all the presidential candidates to testify? [Laughter.]

Senator GORE. Well, by then, there will only be two. [Laughter.] Thank you.

Senator FREAR. Before I recess the committee, Mr. Secretary, and this is a suggestion only, you call Glacier National Park and turn that Under Secretary of yours loose over there and you think you might get a different telegram than the one that was read here this afternoon.

The committee will stand in recess until 10 o'clock tomorrow morning, and thank you very much for your testimony. Sorry we kept you all day, but I appreciate the information that you have brought to the interest of the people.

Secretary FLEMMING. Thank you, Senator.

(The following memorandum by Senator Paul Douglas and accompanying statement by Gov. Nelson A. Rockefeller were submitted for the record:)

JULY 7, 1960.

MEMORANDUM

Re inclusion of statement for hearings on social security bill.
To Hon. HARRY FLOOD BYRD.
From Hon. PAUL DOUGLAS.

In the course of the hearings on H.R. 12580 there were a number of references to the position taken by the Governor of New York, Hon. Nelson A. Rockefeller. At the time, however, the text of the statement of the Governor was not available. I request that the text now be made a part of the record of the hearings so that it will be available for study to the Members of the Senate.

PAUL H. DOUGLAS.

[For release in the afternoon, June 29, 1960, Robert L. McManus, press secretary to the Governor]

STATE OF NEW YORK, EXECUTIVE CHAMBER,
Albany, June 29, 1960.

STATEMENT BY GOV. NELSON A. ROCKEFELLER, PREPARED FOR DISCUSSION AT THE GOVERNORS' CONFERENCE, MANY GLACIER HOTEL, GLACIER NATIONAL PARK, MONT.

The provision and equitable financing of adequate medical care for our senior citizens is one of the great unsolved problems of our Nation.

Those over 65 years of age constitute a substantial, steadily growing and predominantly low-income segment of the population.

By 1975, there will be 22 million Americans over 65 years of age, or more than 10 percent of the then population. Yet, while the elderly are increasing in number, their ability to be economically self-sufficient through employment is decreasing. The proportion of older workers in the labor force has decreased from nearly 75 percent of those over 65 in 1890 to about 35 percent in 1958.

The net result is that, according to Government estimates for the year 1957, only about 20 percent of our senior citizens have incomes of more than $2,000 a year—and 60 percent of them receive less than $1,000 a year. These figures include social security payments received.

These senior citizens require, on the average, two to three times more medical care than the rest of the population. Many have special need for long-term institutional care. Estimates for 1958 indicated that 78 percent of those over 65 were afflicted with one or more chronic diseases. In spite of the great need of the aged for health insurance protection, nearly 60 percent of them have no health insurance at all, and of the remaining 40 percent who do, the coverage is frequently inadequate to meet the demands of chronic illness.

These facts constitute a human problem of major proportions. A substantial portion of the burden of providing necessary health services falls upon dwindling savings, upon relatives, and upon public welfare, or upon hospitals, and the medical profession through charity treatment.

The magnitude of the problem is underscored by the fact that in New York State alone there are some 83,000 persons aged 65 or over receiving care in hospitals or nursing homes at State expense.

All too often, a lack of funds may discourage the elderly from seeking the early care and preventive treatment so essential to mitigating the effects of illness and prolonging life. Many of those living on small social security payments or pensions or annuities may face—or feel that they face—a choice between paying the rent or seeking health care, often with tragic results.

There is substantial reason to doubt that commercial insurance carriers or voluntary health insurance organizations can ever hope to meet the total health insurance needs of the aged as matters now stand.

From the standpoint of the older persons themselves, such insurance is often too expensive for their limited incomes or is unavailable because of existing illness or for other reasons. Recognizing this, the New York Legislature recently passed a law at my request mandating the conversion of group health insurance policies to individual policies upon retirement at premium levels not exceeding 120 percent of prior payments. This measure represents a major advance, but not a complete solution. No one State can solve this problem alone. It is essentially a national problem.

From the carrier standpoint, health insurance for the aged is likely to be a most unprofitable type of business unless premium costs can be spread over all age groups. The latter is difficult in the competitive, experience-rating conditions which exist in the insurance industry.

For voluntary plans, there are serious financial problems in providing such coverage. In 1958, for example, I am advised that the Philadelphia Blue Cross collected $3.5 million in premiums from its 65-and-over subscribers and paid out $9.7 million to meet their hospital bills. Had the Blue Cross not spread this loss among all its subscribers, the premiums of the older subscribers would have been prohibitively high. At the same time, the increasing numbers of such high-cost subscribers not only raise costs for everyone, but threaten the very existence of the Blue Cross system.

It is now clear that some type of Federal Government action is needed to solve this problem—a fact recognized in the wide variety of plans now under consideration in the Congress. In 1954, as Under Secretary of Health, Education, and Welfare, I participated in developing an administration proposal for limited Government involvement through a Federal reinsurance system to assist voluntary health plans in undertaking broadened protection, including improved protection of the aged. The proposal was not adopted by Congress. Since then, the problem has become no less acute.

The issue has ceased to be whether to do anything at all. The issue is how best to do what so obviously needs to be done.

And the issue is immediate. Last Thursday, the House of Representatives passed a bill contemplating some medical care benefits, through Federal grants sharing costs with States, provided on a basis of need. This is an extremely limited measure—seemingly in the nature of an election-year stopgap. There is substantial evidence that the Senate during the coming week will begin serious consideration of expanding this measure into a comprehensive effort to meet the problem. I sincerely hope that this is the case.

Of the various proposed programs of health insurance for the aged, the best known are the Forand bill and the administration bill. There are many differences between these two bills, but the fundamental difference is in the two approaches to financing the proposed benefits. The Forand bill would increase the social security payroll tax to encompass health insurance for those over 65, while the administration bill proposes a Federal-State program of health insurance for older persons, paid for primarily by general tax revenues of the Federal and State Governments, but with the older persons themselves (other than those of public assistance) paying an enrollment fee of $24 a year.

As a businessman concerned with employee welfare, as Under Secretary of Health, Education, and Welfare, and as Governor of New York, I have been concerned with the health insurance question for many years. It seems to me that there are four grave weaknesses in the Forand measure.

1. The Forand bill would not provide health insurance coverage for any of the 4 million persons now over 65 years of age who are not included in the social security system.

2. It lacks any element of choice and would therefore tend to stifle further development of voluntary health insurance for the aged in this country.

3. Administration of the Forand bill program would be under centralized Federal control with no flexibility for accommodation to varying conditions in the different States.

4. It fails to provide the standards needed to maintain the quality essential to good medical care.

In the admiinstration bill, the basic flaw is the method of financing, which I regard as fiscally unsound. Instead of extending a proven contributory system of insurance—the administration bill provides subsidies from the general revenues, shared by the States and the Federal Government under an equalization formula.

Under a contributory system a definite percentage of the cost is born by those who ultimately receive the benefits. This provides a built-in safeguard against the constant pressure for irresponsible and extravagant additions to the scheme which is politically difficult to resist. The administration plan would be particularly vulnerable to such pressure, based as it is on the concept of subsidy.

The financing of the administration plan also would represent a serious financial drain on the States; New York, for example, would have to allocate to the program nearly 10 percent of its current State purposes budget if it participated. It is likely that a number of States would decide not to participate at all, as would be their right.

In addition, the administration bill has "means test," deductible and coinsurance features unrealistically limiting benefits and requiring cumbersome and costly administrative mechanisms in all 50 States. It does, however, provide for minimum standards of care and its benefits would come closer to meeting the medical care needs of the aged than do those of the Forand bill.

What, then, are the elements of a workable approach? In my judgment, we must begin with the principle that our basic reliance for health insurance protection for the population as a whole should be voluntary health insurance. But, recognizing the special problem of insuring the health of the aged, I believe Congress should enact a program based on the principles I shall set forth.

In considering these principles, we should keep in mind that taxes levied by the Government to support a health insurance system are equally compulsory, whether they are in the form of general revenue taxes or earmarked payroll taxes. Hence, the alleged distinction between plans on the basis of "voluntary" versus "compulsory" is, in my opinion, both illusory and irrelevant insofar as financing is concerned. As to the voluntary or compulsory nature of the receipt of benefits, I shall comment further.

The principles I advocate are these:

1. Health insurance should be provided for as many as possible over 65 without reference to a means test.

The concept of an "earned benefit" resulting from a contributory system is an important one to retain—one which stresses individual initiative and dignity in our society.

2. The basic mechanism for achieving this should be the contributory social insurance system, supported by payroll taxes, which exists in the old-age survivors and disability insurance system. A separate health benefit trust fund should be established in this system to account for the taxes received and benefits paid.

This well-administered system has proved to be effective and economical. Its contributory nature has been completely accepted and is indeed, strongly supported by employees as well as their employers.

3. The full payroll tax increase required to finance the additional health benefits should be enacted at the same time as the new benefits.

The maximum additional tax needed for the benfits I propose would be one-half of 1 percent for employees and the same amount for employers.

4. Some 4 million persons over age 65 are not covered by OASDI insurance. Nearly half of these are recipients of old-age assistance payments, paid from Federal, State, and local general revenues. A second group among these 4 million are receiving retirement benefits from the civil service, railroad retirement, or other programs. A third group receive their support from the other personal resources or are dependent on others for their support.

These older persons not eligible for benefits under the OASDI system must, nevertheless, have comparable health insurance protection available to them.

I believe that the Federal program should permit payments into the separate health benefit trust fund for the purchase of the same health protection for these persons as would be available to retired OASDI beneficiaries. The Federal Government should match according to a formula any payments which an individual State wishes to provide to assist its older persons not eligible for OASDI in purchasing the OASDI health benefits. The Federal Government would also, of course, continue to provide Federal matching grants for old-age assistance payments, including those for medical care purposes.

5. Each OASDI beneficiary eligible for the statutory health benefits should be given an option to forgo those benefits in favor of receiving a special monthly cash benefit added to his regular social security check, provided he presented proof that he carried a health insurance policy at least equivalent to the protection afforded by the statutory benefits.

This option would give the benefit phase of the program, as distinct from the financing phase, a truly voluntary nature. It would encourage commercial carriers and voluntary health insurance organizations to continue their efforts to develop sound coverage plans for the senior population. Furthermore, individuals covered during employment by outstanding health insurance plans would thus be encouraged to continue such plans after retirement.

6. The program should provide at its outset for hospitalization, nursing-home care, and visiting nurse services, with additional benefits to be added as experience may indicate their desirability and feasibility.

A benefit schedule offering more total days of care according to the proportion spent in nursing-home care and visiting nurse services would encourage beneficiaries to use less costly facilities as soon as their medical condition permitted.

Early diagnostic services should be added to the benefits as soon as possible, to help minimize instances of hospitalization. Subsequently, it should be found possible to cover broader forms of organized home-care services, the costs of certain drugs, surgery, and possibly other physician services.

7. A State agency should be chosen or established to maintain standards set by the Secretary of Health, Education, and Welfare.

This agency would make reimbursement to hospitals, nursing homes, and visiting nurse services on the basis of actual costs. The agency would review and certify rates for payment based on actual cost as determined by uniform cost accounting methods. It would certify expenditures under the program and maintain a continuing review of operations within the State.

This program should be regarded as only one part—though a major part—of a larger overall effort to make better provision for our senior citizens who have already made their great contribution to our way of life.

For example, improved housing for the aged ranks as an important aspect of their well-being. But a sound health insurance program is the most urgent immediate need—to the end that the retirement years shall be made as free as possible from the crushing cost burdens and anxieties attendant upon illness.

In the achievement of these objectives, our elder citizens deserve decisive and prompt action.

(By direction of the chairman, the following is made a part of the record:)

CALIFORNIA, PA., *July 6, 1960.*

Senator HARRY F. BYRD,
Chairman, Senate Committee on Finance,
Senate Building, Washington, D.C.:

Strongly urge passage of legislation adding health care benefits for aged under OASDI system. Would appear before committee but realize this may hold up hearings, so suggest entry of this telegram in Senate records.

CENTERVILLE MEDICAL GROUP,
Dr. ROBERT SCHWARTZ.
Dr. JOHN WEBER.
Dr. GERALD SCHOR.
Dr. MORRIS MASER.

MIAMI, FLA., *July 6, 1960.*

Senator HARRY F. BYRD,
Senate Office Building, Washington, D.C.:

Six hundred blind delegates assembled in the convention of the National Federation of the Blind representing many thousands of blind people throughout the United States of America urge your active support in the Finance Committee and on the floor of the Senate of the Hartke amendment included in S. 3449. This would amend title X of the Social Security Act so as to include the exemption of the earnings of blind aid recipients from $600 annually to $1,000 plus 50 percent of amounts over $1,000 until self-support is achieved. The blind aid program would thus be made a means of rehabilitating blind people in returning them to productive, economically independent lives.

Dr. JACOBUS TENBROEK,
President, National Federation of the Blind.

JEWISH FAMILY SERVICE OF TRENTON,
Trenton, N.J., July 8, 1960.

DEAR SENATOR BYRD: I would like to call your attention to the following resolution that was adopted at a recent meeting of the board of directors of the Jewish Family Service of Trenton, N.J.

"The Jewish Family Service of Trenton, N.J., heartily approves and endorses the principle that public financing of medical care for the aging be provided as a part of the social security insurance program. The board of directors of this voluntary family agency feel deeply that passage of a bill embracing this principle will fulfill a serious unmet social need of our community and country in a most expeditious and encompassing manner."

The board sincerely hopes that you will wholeheartedly support and work for the passage of a bill that will embrace these principles.

Very truly yours,

MRS. JOHN HIRSCH,
Chairman, Public Issues.

CATERPILLAR TRACTOR CO.,
Davenport, Iowa, June 28, 1960.

Hon. B. B. HICKENLOOPER,
Senate Office Building,
Washington, D.C.

DEAR SIR: We are writing to you in opposition to a section of H.R. 12580, concerning financing of the administrative and loan fund provisions of the employment security program. This section was originally H.R. 7177.

Our company supports the principle of unemployment compensation when it is properly designed and safeguarded. We have actively supported the State of Iowa program as well as many of the changes for increased benefits to meet changes in economic conditions. However, we oppose the proposed changes to unemployment compensation laws for the reasons stated below.

As we understand the proposal, it would increase the Federal unemployment tax from 3 to 3.1 percent of the first $3,000 of covered wages with the additional 0.1 percent going to the Federal Government. This would appear to be only a slight increase, but in fact a credit of 2.7 percent is allowed against both rates for payments to the States; as a result, the portion going to the Federal Government would increase from 0.3 to 0.4 percent or one-third. The increased Federal revenue would be used (1) to cover rising administrative expenses, and (2) to build up the Reed loan fund from $200 million to the larger $550 million, or 0.4 percent of covered payrolls.

We do not believe that a need for the increase has been demonstrated. Federal unemployment tax collections as compared with allocations of Federal funds to the States for administration have been as follows:

[In millions]

Year	Tax collections	Administrative allocations
1955	$277	$222
1956	322	233
1957	327	248
1958	333	295

Proponents of the tax increase point to the more rapid growth in allocations in 1957 and 1958 as compared with the growth of tax collections. However, 1958 was a recession year and business conditions have improved since that time. In our opinion continued economic growth of this country will provide sufficient funds at present tax rates to cover any needed increase in allocations to States. Certainly, postponement of action at this time would be wise in order to allow sufficient time to see whether such a drastic increase in tax is necessary.

The second purpose of the increase is to build up the Reed loan fund. This fund was impaired by States which failed to take action to: (1) Assure adequate State funding, and (2) correct loose administration and liberalization. A comparison of the ratio of benefits to taxable wages in those States with the

ratio in other States shows some of the reasons why those States needed Federal fund (5 year averages: Illinois, 1.5; Michigan, 3; Pennsylvania, 2.9; national, 1.7).

Just last year one high ratio State substantially tightened its laws covering payments for pregnancy and to pensioners. We believe such reform efforts are the preferable approach to the problem. We feel sure that many States still have not demanded that people search diligently for work before becoming eligible for benefits. Renewal of such abuses will provide additional funds under their existing programs. Meanwhile, industries in States (such as Iowa) which are attentive to administering their laws properly, should not have their taxes raised to help out States which are not doing as well. It is our belief that unemployment compensation is primarily a State matter. Increasing the amount of Federal funds available to the States will heighten the Federal role in this area and correspondingly reduce State responsibilities.

Very truly yours,

LEO F. DEKALB,
Employee Relations Manager.

GUILD OF PRESCRIPTION OPTICIANS OF NEW JERSEY, INC.,
July 6, 1960.

Hon. HARRY BYRD,
Chairman, Senate Finance Committee,
Washington, D.C.

DEAR SENATOR: The Guild of Prescription Opticians of New Jersey wish to call your attention to and urge you to vote for (the Mills bill) H.R. 12580, title XVI.

We believe that this bill in its present form affords protection against health care costs for the near needy and affords protection against an unsound and unbalanced national economy.

Respectfully,

JEROME SAENGER, *President.*

STATEMENT BY GEORGE MCLAIN, PRESIDENT, NATIONAL LEAGUE OF SENIOR CITIZENS; CHAIRMAN, CALIFORNIA INSTITUTE OF SOCIAL WELFARE, LOS ANGELES, CALIF.

NATIONAL LEAGUE OF SENIOR CITIZENS INC.,
Los Angeles, Calif., July 8, 1960.

To Senate Finance Committee:

Mr. Chairman and members of the committee, as president of the National League of Senior Citizens and chairman of the California Institute of Social Welfare, I represent more than 250,000 elderly Americans in 23 States. We may safely assume that the views of the members of these organizations parallel the opinions of the 23 million Americans of 60 years of age or older who make up our growing population of aged men and women.

In my day-to-day contacts with the senior citizens who belong to the National League and the California Institute, I am keenly aware of a new attitude on the part of the aged. Better educated and more widely informed than previous generations of oldsters, these elderly citizens are approaching open rebellion against outmoded social concepts that isolate them economically. Their working lifetimes were spent, for the most part, in fairly comfortable financial circumstances. To be condemned to pauperism in their later years is repugnant to them. They want financial security, dignity, and self-respect in old age. Moreover, they feel that they've paid for their retirement by helping to enrich this Nation in the years when they were part of its productive machinery.

At this moment, they are perilously close to crystallizing into a new, and formidably powerful, minority group. Unlike other minorities, whose loyalties are torn between race and religion, color and party, the elderly are overwhelmingly in agreement on one issue—the care of the aged. This overriding question is sufficient to overcome all other influences, political, religious, sectional, or racial. We must face their problems and act courageously and intelligently, or we may upset the Nation's political balance.

The turning point, as far as millions of needy, elderly Americans are concerned, involves the social security bill now before the Senate Finance Commit-

tee. Hopefully, they look to this committee to provide immediate help, while steps are taken to meet their broad goals of the future.

First of all, they earnestly pray that this committee will revise the so-called Mills bill (H.R. 12580) into a measure providing real health protection. Eminent experts in the field have already pointed out the many shortcomings of the Mills bill medical care plan. A proposal similar to the Kennedy bill, the McNamara bill, or the plan offered by Senator Anderson would be much more acceptable to the elderly. Moreover, approval of a bill of this kind would give the Congress an opportunity to demonstrate their sincere interest in the problems of the elderly.

But, while medical care is indeed an urgent need of the aged, another necessity must not be overlooked. I speak of money—eating money. This is a subject around which the lives of millions of old folks revolve. The struggle for survival—enough money to buy sufficient food, shelter, and clothing—occupies virtually all their waking hours. To the neediest of the elderly—and this includes roughly two-thirds of all the 16 million Americans of 65 or older—the problem of medical care is an academic one. It will remain so until steps are taken to increase social security and public assistance payments to a level sufficient to provide a decent standard of living.

Picture, if you will, the plight of a retired American who receives minimum social security benefits, about $33 per month for a retired worker. Suppose this retiree has a wife, 62 years or older, who receives the minimum dependency payment, $16.50 per month. This couple, then, receives a total social security benefit of $49.50 per month. In many States, folks receiving social security payments are ineligible for State public assistance. The result is human tragedy, multiplied millions of times. Can we, as the richest, most progressive Nation on earth, permit starvation and want to dwell in our midst while we cajole other countries to rally to our banner in the struggle against worldwide communism? I think not.

I appeal this committee to move swiftly in this critical area. Substantial increases in social security must be voted in this session of Congress.

Another improvement in the Social Security Act that must be made immediately affects the current, hopelessly outdated earnings limitation imposed on recipients. At present, those receiving benefits are prohibited from earning more than $1,200 a year without jeopardizing their Federal payments. I recommend that this figure be increased promptly to at least $2,400. The members of this committee must fully realize the hardships, injustices, and outright law violations caused by the present limitations.

Next, this committee should include an immediate increase in public assistance funds to permit the States to grant old-age assistance recipients long overdue cost-of-living increases. People receiving this type of aid are among the poorest of the poor, and millions are now caught in an irresistible squeeze between inflation and lagging pension payments. They need and deserve help now.

Your attention must be called to a situation long ignored by our Nation's lawmakers. I speak of the right of State old-age pensioners to earn small sums without affecting their benefit payments Many are fit for light, casual employment, even though their age and infirmities make them unable to hold regular jobs. They should be able to earn pin money at babysitting, gardening, or other duties without fearing financial retaliation if their well-meaning efforts are uncovered.

I propose that a provision be included in the 1960 social security bill allowing State old-age pensioners to earn up to $50 a month without endangering their Federal-State payments.

These are the steps that must be taken now if the elderly of America are to retain their faith in their lawmakers. As for the future, let me outline briefly the program adopted by the National League of Senior Citizens in their nationwide convention in Los Angeles, June 3–4.

1. Increased social security benefits, equal to earnings under the Federal minimum wage law, now about $173 per month.

2. Inclusion of all State old-age pensioners into the social security system, saving many millions of dollars annually for State and local taxpayers.

3. Reduced eligibility ages for both men and women, offsetting the unemployment caused by automation and new industrial production techniques.

4. Inclusion of the Federal Government as a one-third contributor to the social security fund, to lessen the burden on employers and employees and bring

this Nation abreast with many of our Western allies who adopted this system years ago.

5. An increased ceiling on earnings permissible for social security recipients, doubling the present $1,200 limitation to $2,400 annually.

6. A drastic change in policy regarding Federal aid for housing for the elderly, junking the "trickle down" approach for a Federal "crash program" to encourage nonprofit corporations to develop low-rent housing facilities for the aged through direct Federal loans at low interest rates with 50-year payback provisions.

This is our blueprint for the future. While we do not expect these improvements to be adopted this year, and perhaps not next year, we are confident that they point the way to a sound, adequate retirement program for elderly Americans. I will be most happy to provide additional details to any members of the committee who are interested.

Millions of elderly men and women are watching the activities of this committee with burning interest. I have attempted to outline the areas in which immediate action is necessary and the direction in wihch the aged hope America will proceed in the years to come.

Thank you for your attention.

GEORGE MCLAIN.

PHILADELPHIA, PA., *July 10, 1960.*

CHAIRMAN, SENATE FINANCE COMMITTEE,
Washington, D.C.:

I should appreciate the opportunity of testifying before the Senate Finance Committee in favor of extending social security to physicians. The American Medical Association does not—repeat not—reflect the opinions of the American physician on social security coverage. Official polls in Philadelphia and in Pennsylvania are overwhelmingly in favor of coverage for doctors.

HAROLD A. HANNO, M.D.,
Member, Medical Economics Committee,
Philadelphia County Medical Society.

CAMBRIDGE, MASS., *July 8, 1960.*

HON. HARRY F. BYRD,
U.S. Senate, Senate Office Building,
Washington, D.C.:

Glad to hear you are having hearings on health insurance. Would be glad to testify but I know there is pressure of time. Refer you to evidence before Ways and Means at earlier meeting and my statement before Senate Committee on Aging in fall 1959. Strongly urge a bill putting health insurance under OASDI.

SEYMOUR E. HARRIS,
Littauer Professor of Political Economy, Harvard University.

CHICAGO, ILL., *July 8, 1960.*

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

Of the bills now under consideration by your committee re health insurance for the aged, the President's Council of the Older Adults Department of the Jewish Community Centers of Chicago see in the McNamara bill the features offering most adequate service to the majority of aged now in our country therefore we urge that you give full consideration only to those bills containing the following elements: Prepaid insurance administered through the Social Security Administration and coverage for all aged persons.

We trust that in this election year an adequate bill will be passed meeting this vital need.

BEATRICE BANDOLIN,
Chairman President's Council Older Adults,
Department of Jewish Community Centers of Chicago.

STATEMENT OF DR. EMMETT J. MURPHY, DIRECTOR OF INDUSTRIAL RELATIONS, NATIONAL CHIROPRACTIC ASSOCIATION, WASHINGTON, D.C., JUNE 30, 1960

Mr. Chairman, my name is Dr. Emmett J. Murphy. I am the director of industrial relations of the National Chiropractic Association. I am a resident of Washington, D.C. I come before you to testify on H.R. 12580, particularly as to its provisions respecting the rights of the old age recipients under the bill to continue to obtain the services of duly licensed physicians who are presently meeting their health needs, and of any others who under the terms of this act may wish to obtain the care and attention of any one of the legally licensed doctors practicing the healing art in the State of which they may be residents.

To obtain fair and equal treatment it will be necessary to amend title XVI, Medical Services for the Aged, section 1606(e) of H.R. 12580 to read as follows:

"(e) The term 'physicians' services' means services provided in the exercise of his profession in any State by a duly licensed doctor of medicine, doctor of osteopathy, and doctor of chiropractic licensed in such State."

That wherever in the act any reference made to "physicians' services" or "physician" shall include the meaning of this section (e) as amended above.

This amendment is offered in behalf of the many thousands of elderly people whose health is maintained by the aid of the professional services of doctors of chiropractic, and by those who like these patients may seek the assistance of these doctors.

This amendment is offered, also, as a proper protection of the professionally established and licensed rights of the thousands of members of one of the healing professions, who would be discriminated against if the amendment was not included in the law. Surely, it is not the intention of the Congress to cause any such discrimination, nor to invade the rights of the States to determine who shall be licensed and privileged to render service to any of their citizens.

Doctors of chiropractic who practice among these older people are acutely aware of their health needs. We believe their economic circumstances and the unpredictability of their health, coupled with the cost of nursing and physicians' services, combine to present a problem of serious national importance. We are not expert in recommending the exact way of administering any program to meet these conditions. We confine ourselves to an expression of view strictly within our professional purview. We are aware of the need of these aging people, for many are patients of doctors of chiropractic.

We therefore respectfully request the amendment suggested above.

CHRISTIAN SCIENCE COMMITTEE ON PUBLICATIONS,
OF THE FIRST CHURCH OF CHRIST, SCIENTIST, IN BOSTON, MASS.,
Washington, D.C., June 21, 1960.

Re H.R. 12580, Social Security Amendments of 1960.

HON. HARRY FLOOD BYRD,
Chairman, Committee on Finance,
U.S. Senate, Washington, D.C.

DEAR SENATOR BYRD: The Christian Science Board of Directors, in Boston, Mass., the administrative head of the Christian Science Church, has asked me, as its Washington representative, to write you about the change in the law proposed in section 104 of H.R. 12580.

Section 104 of this bill which passed the House and is now before your committee amends subsection 211(c)(5) of the Social Security Act and subsection 1402(c)(5) of the Internal Revenue Code of 1954 so as to include doctors of medicine under old-age and survivors insurance coverage. These code sections presently exempt Christian Science practitioners from compulsory OASI coverage.

Should your committee decide to include doctors of medicine under OASI coverage, we urgently request that the status of Christian Science practitioners not be changed and that section 104 of the bill be reported as passed by the House, as it would in no way affect the present status of Christian Science practitioners.

The thoughtful consideration of this request by your committee will be appreciated.

Sincerely,

J. BURROUGHS STOKES,
Manager, Washington, D.C., Office.

U.S. SENATE,
COMMITTEE ON BANKING AND CURRENCY,
June 24, 1960.

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

DEAR SENATOR BYRD: I would like to submit an amendment to H.R. 12580, the Social Security Amendments Act of 1960. This bill passed the House of Representatives on Thursday, June 23, 1960. Your committee undoubtedly will be considering the bill very shortly.

The amendment I propose is an updated version of section 316 of Public Law 85-840—the Social Security Amendments Act of 1958. Action to include the section in H.R. 12580 was started too late to make it part of the bill at the time of its passage on June 23. Section 316 is scheduled to expire on July 1, 1960.

The purpose of section 316 was to give a number of towns and quasi-municipal corporations an opportunity to become covered under the social security program in addition to the State retirement system. In the 2 years that the section has been in effect, all but 13 political subdivisions in Maine have taken advantage of this opportunity. The remaining communities, with few exceptions, are the larger communities in the State. They are interested in social security coverage and are working with the State retirement system to integrate the two programs so that double coverage is not financially prohibitive.

I have been assured by William L. Mitchell, Commissioner, Social Security Administration, Department of Health, Education, and Welfare, that the Department will not oppose legislation which would extend the June 30 deadline of section 316 through at least 1961.

I have also received assurances from Chairman Wilbur Mills of the House Ways and Means Committee that the House managers will accept the amendment in the conference committee. The proposed amendment is appended on page 2 of this letter. I request your support and the support of the whole committee for its inclusion in the Senate version of H.R. 12580. Any attention you might be able to give to this request would be greatly appreciated.

Sincerely,

EDMUND S. MUSKIE.

PROPOSED AMENDMENT TO H.R. 12580

For the purposes of any modification which might be made after the date of enactment of this Act and prior to July 1, 1961, by the State of Maine of its existing agreement made under section 218 of the Social Security Act, any retirement system of such State which covers positions of teachers and positions of other employees shall, if such State so desires, be deemed (notwithstanding the provisions of subsection (d) of such section) to consist of a separate retirement system with repect to the positions of such teachers and a separate retirement system with respect to the positions of such other employees; and for the purposes of this sentence, the term "teacher" shall mean any teacher, principal, supervisor, school nurse, school dietitian, school secretary or superintendent employed in any public school, including teachers in unorganized territory.

(Whereupon, at 5:30 p.m., the committee recessed, to reconvene at 10:20 a.m., Thursday, June 30, 1960.)

SOCIAL SECURITY AMENDMENTS OF 1960

THURSDAY, JUNE 30, 1960

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

The committee met, pursuant to recess, at 10:20 a.m., in room 2221 Senate Office Building, Senator Harry F. Byrd (chairman) presiding.

Present: Senators Byrd, Frear, Long, Douglas, Gore, Talmadge, Hartke, McCarthy, Williams, Curtis, Carlson, and Bennett.

Also present: Elizabeth Springer, chief clerk.

The CHAIRMAN. The committee will come to order. I would like to announce that the Chair has written a letter today to the Director of the Budget to ascertain whether or not the Budget approves both the House bill and the so-called administration bill. There is some confusion as to whether the Budget approved both of them. I now insert in the record a copy of my letter to Mr. Stans. A copy of his reply will likewise be printed when received.

(The letter and the reply referred to follows:)

JUNE 30, 1960.

Hon. MAURICE H. STANS,
Director, Bureau of the Budget,
Washington, D.C.

DEAR MAURICE: In testifying before the Committee on Finance yesterday Secretary Arthur Flemming stated that the administration favored the medical aid program, title VI, of H.R. 12580, as passed by the House of Representatives. In addition to recommending enactment of the House health program, Secretary Flemming advocated the inclusion of the medicare plan which he had previously presented to the House Ways and Means Committee as the administration's proposal.

We do not have a report from the Bureau of the Budget on either of these proposals. Therefore, I shall appreciate your submitting the views of the Bureau of the Budget on H.R. 12580, as passed by the House of Representatives, and the medicare program advocated by the administration.

Specifically, I would like to have definitive answers to the following questions:

(1) Does the Bureau of the Budget recommend enactment of title VI of H.R. 12580, as approved by the House of Representatives?

(2) Does the Bureau of the Budget recommend enactment of the medicare program advanced by Secretary Flemming as the administration's plan?

(3) Does the Bureau of the Budget recommend enactment of H.R. 12580 if amended to include the medicare program, as recommended by Secretary Flemming?

(4) What is the estimated cost (based on the first full year of operation) to the Federal Government and to the State governments of the medical aid program (title VI) contained in H.R. 12580?

(5) What is the estimated cost (based on the first full year of operation) to the Federal Government, to the States, and to the individual subscribers, of the administration's medicare program?

(6) Does one program overlap the other to such a degree that the overall cost of the combined programs would be affected? If so, what is the estimated cost (based on the first full year of operation) of the combined programs to the Federal Government, to the States, and to the individual subscribers?

May I respectfully request that you expedite the submission of these reports and replies to the above questions so that they may be incorporated in the record of the hearing which we hope to send to the printer the latter part of next week.

With kindest regards, I am,

Respectfully,

HARRY F. BYRD, *Chairman.*

EXECUTIVE OFFICE OF THE PRESIDENT,
BUREAU OF THE BUDGET,
Washington, D.C., July 12, 1960.

Hon. HARRY F. BYRD,
Chairman, Committee on Finance,
U.S. Senate, Washington, D.C.

MY DEAR MR. CHAIRMAN: This is in reply to your request of June 24, 1960, for the views of the Bureau of the Budget on H.R. 12580, as passed by the House of Representatives, a bill to extend and improve coverage under the Federal old-age, survivors, and disability insurance system and to remove hardships and inequities, improve the financing of the trust funds, and provide disability benefits to additional individuals under such systems; to provide grants to States for medical care for aged individuals of low income; to amend the public assistance and maternal and child welfare provisions of the Society Security Act; to improve the unemployment compensation provisions of such act; and for other purposes. This will also acknowledge your letter of June 30, 1960, asking for answers to a number of questions regarding both title VI of H.R. 12580 as passed by the House of Representatives and the administration's proposal for medical aid to the aged.

H.R. 12580 as passed by the House of Representatives would make improvements in the old-age, survivors, and disability insurance (OASDI) programs and in the unemployment compensation program. It would also provide a new program of medical care for the aged. The bill incorporates many proposals recommended by the executive branch and also makes a number of other changes in existing law. In view of the fact that the Secretary of Health, Education, and Welfare has already testified at considerable length on this bill before your committee, we would like in this report to deal with the main features of H.R. 12580, and particularly to mention some points which might be helpful to your committee in considering certain changes which the Bureau believes are desirable.

The main changes in the OASDI programs which the bill would make are (*a*) the elimination of the age 50 requirement for disability benefits, (*b*) liberalization of the trial work requirement for disability beneficiaries who work under non-State-approved rehabilitation plans or are rehabilitating themselves, (*c*) increase in the benefit rates for each child of a deceased worker, (*d*) authorization of benefits for survivors of workers who died fully insured before 1940, (*e*) modification in the provision governing interest rates on investments of the trust funds, (*f*) broadening of coverage for certain groups, and (*g*) the liberalization of the insured status requirement to require one out of four instead of one out of two quarters of covered employment after 1950. In the main, these changes conform to proposals made by the executive branch, and although, in the net, they would somewhat worsen the actuarial status of the OASDI trust funds, they appear to be within the bounds of an acceptable actuarial balance and therefore do not require an increase in payroll taxes, which the administration would regard as undesirable at this time.

The one-out-of-four provision, in our opinion, raises the main question. This change was not recommended by the administration. Although consistent with the existing general requirement that an individual be covered only 10 years out of a potential working lifetime of about 40 years, the change would mean that during the next few years the coverage requirement for people reaching retirement age would be cut essentially in half—from 18 to 20 quarters to a very modest requirement of only 9 to 10 quarters. While the level premium cost of this change appears to be a nominal 0.04 percent of covered payroll, the change will add 600,000 individuals, including dependents, to the benefit rolls in the next several years and require payment from the trust funds of benefits averaging $250 million a year over the next decade. The extra cost entailed by this provision will thus contribute substantially to pushing projected payments from the OASI trust fund in calendar 1960 and 1961 above estimated receipts, with the result that

the balance in the fund under the bill would show a decline. The change also contributes to worsening the actuarial status of the OASI trust fund to a deficit of 0.23 percent, thus approaching the margin of the commonly accepted rule of thumb (0.25 percent) for a tolerable degree of actuarial deficiency.

We are pleased that title V makes a number of highly desirable changes in the Federal-State unemployment compensation program that were recommended by the executive branch. We regret, however, that the bill does not extend coverage to small firms and nonprofit organizations as proposed by the President. The increase in the effective Federal unemployment tax rate from 0.3 to 0.4 percent, while not following the administration's recommendation, will provide an increase in revenues of the same general magnitude as the President's proposal to increase the taxable wage base from $3,000 to $4,200. These increased revenues will be adequate to cover the full costs of administrative expenses and to build up the proposed loan fund to $550 million and the proposed administrative account in the unemployment trust fund with a reserve balance of $250 million. Improvements have also been made in the criteria for receiving loans from the loan fund when State reserves are depleted, and the Federal-State employment security program is extended to Puerto Rico.

Section 707 of the bill would amend title V to increase the statutory authorizations under grants to States for material and child welfare from $58.5 million to $70 million. In the 1961 budget the President has requested $48.5 million for these purposes, an amount below current authorizations. Under the orderly increases in requested appropriations for these programs being followed by this administration, full authorizations under existing law will not be reached until fiscal 1966. Thus, in our view, legislation to increase such authorizations at this time is not needed and was not recommended by the administration.

Section 526 would authorize a new program of research and demonstration projects in the field of child welfare. Existing legislation already authorizes cooperative research or demonstration projects in social security, which covers the subject matter encompassed by the current proposal. Therefore, we see no reason for a special new program in the children's field.

Section 706 of the bill would further extend, for an additonal 3 years, special provisions permitting two States, Missouri and Pennsylvania, additional time in order to bring their programs for the blind under public assistance into conformity with Federal law. Since 1952 periodic legistive exception has been made for these two States extending the maximum transitional period provided in 1950 legislation. During the extended transitional period, Federal participation in the costs of operating these programs has continued even though the programs did not comply with Federal standards. This Office believes that ample time has been provided for these States to bring their programs into conformity with the requirements of the Social Security Act to which all other States are adhering. Accordingly, this Office sees no reason why exceptional treatment should be provided to these two States over an aggregate period of 14 years since 1950.

Title VI of H.R. 12580 would establish a new Federal-State program of assistance for medical care to the aged. This new program, together with the related five-percentage-point increase in the Federal matching ratio for medical vendor payments under public assistance, which the bill also provides, has been estimated by the Department of Health, Education, and Welfare to have an approximate Federal-State cost of $341 million the first full year of operation with all States participating. The Federal share of this cost would be about $176 million. (In fiscal year 1962, however, the program would not yet be in full operation and the Federal cost might be in the neighborhood of $65 million.)

These cost estimates depend upon many assumptions and, in our judgment, could be greatly understated. One of the principal assumptions was that the House Ways and Means Committee intended, as we understand it, that the new program of medical benefits for aged individuals should be restricted to those who are medically indigent but at the same time are not able to meet the requirements of need under the public assistance medical vendor payments program. However, the language relating to eligibility standards in H.R. 12580 and in the accompanying House committee report is rather general in nature and in the final analysis the setting of eligibility standards would be left largely to the discretion of the States. Unlike in the administration proposal, the benefits for eligible individuals which would be provided by the States under title VI, and in which the Federal Government would share, could cover all expenses. There is no requirement in the bill for specific deductible amounts of $250 or $400 nor for 20 percent coinsurance in costs above these amounts.

Thus, if many States should establish tests of need deviating substantially from public assistance standards so that full costs would be covered for a large number of people, as is quite possible under the bill, costs under the program might greatly exceed the above estimates.

The foregoing estimates for title VI of H.R. 12580 are considerably below the $1.3 billion estimated as the full operational Federal-State cost in fiscal year 1964 of the administration's proposed medical care program. The Federal share of the administration's program would be somewhat under $700 million, including about $600 million for the new medical care program and about $65 million for augmented medical vendor payments under the old-age assistance program. Individuals enrolling under the program would also pay a total of about $182 million a year in fees. (As in the case of the title VI program, the cost for fiscal year 1962 would probably be considerably less than full operational cost—with a Federal share in the neighborhood of $200 million.)

The medical care program under title VI would authorize assistance for medical care for a large number of people who now lack such protection and it would follow the principle of giving States and their localities the primary role. However, the new program would not follow the desirable principle of the administration's proposal that primary attention should be given to providing aid to our elderly citizens in meeting the heavy expenses of catastrophic illness. Hence, we strongly urge that any program outside the present public assistance category which is to cover first-dollar costs should be strictly limited. If your committee adopts the approach incorporated in title VI of H.R. 12580, we would recommend, in order to avoid the uncertainties as to scope of program as cited above, that at a minimum a clear statement of legislative intent be provided in the committee's report that strict eligibility standards are intended under the program. Unless the intent of the House bill is made clear, there would be a risk that a large proportion of the billions of dollars which are now being spent annually for medical care for persons over 65 might ultimately be shifted to Federal-State agencies. Moreover, if great variation in eligibility standards and in benefits is permitted among States, greater unevennesses in the program will arise from State to State. This can be seen from the cost estimates in the House committee report on title VI (p. 11) which show that nearly 60 percent of the estimated expenditures under the House bill would be in four States. In contrast, the requirement in the administration proposal specifying certain benefits would promote uniform benefits among the States entering the program.

In short, the Bureau's position is to support the administration proposal but to indicate that, if the administration proposal is not approved, it would accept title VI of the House bill. However, if the Congress should determine to enact both the House bill and the administration proposal, it should be clearly understood that there would have to be an application of the needs test in the House bill so as to insure that first-dollar costs of those eligible would be paid only for persons who qualify as indigent under the present public assistance medical vendors program. There might also be other adjustments needed in order to avoid unnecessary overlapping. If the Congress should enact both programs without the indicated adjustments, the added Federal cost at full operation would probably be increased more than $100 million above the administration program.

At this time I would like to indicate that there are several technical aspects of the administration proposal to which we are giving further study. The first relates to the eligibility requirements as they pertain to nontaxpayers and to taxpayers with incomes of $2,500 for single persons or $3,800 for individuals with dependents. We want to be sure to avoid any possible inequities which may arise under the income eligibility standards which are outlined for this plan.

A related point has to do with the enrollment fees which are charged for individuals who qualify in 1 year for participation in the program but whose incomes rise above the specified income limitation in subsequent years.

We have also been considering whether, under the administration proposal, Federal facilities which provide medical care to individuals who would otherwise qualify under the proposed new program should be reimbursed from the program on the same basis as State or municipal hospitals are to be reimbursed.

If, upon further study of these points, we deem a change to be desirable, we will advise you accordingly.

The Bureau of the Budget has not had time to review a number of the numerous proposed amendments to H.R. 12580 or various substitute bills for title VI which have been introduced in the Senate and on which your committee has requested reports. Insofar as these proposals would expand the OASDI system and increase payroll taxes to provide medical care for the aged, they would not be in accord with the program of the President. We will proceed with our study of these proposals in the next several weeks and will endeavor to make such additional comments as we believe will be helpful to your committee.

Sincerely yours,

MAURICE H. STANS, *Director.*

The CHAIRMAN. The Chair has been requested to insert in the record a statement from Senator John F. Kennedy expressing his views on the pending bill.

(The statement referred to follows:)

STATEMENT BY SENATOR JOHN F. KENNEDY (DEMOCRAT OF MASSACHUSETTS) UPON H.R. 12580 BEFORE THE SENATE FINANCE COMMITTEE

Mr. Chairman, I appreciate the opportunity to appear before your committee. I know of no domestic issue of greater concern to the American people than the one you are now considering. It is my hope that despite the lateness of the session the Senate will substantially improve the social security bill adopted by the House, and that that body will agree to the Senate changes.

The House bill contains some useful provisions which should be included in any bill passed by the Congress. It fails completely, however, to meet the problem of health insurance for our older citizens.

Mr. Chairman, the need to take affirmative steps in this field is urgent. On January 26, I introduced S. 2915, a bill based on the Forand bill, which had earlier been introduced in the House. Later, after hearings on this subject were completed by the Subcommittee on Aging, on which I have served as vice chairman, I joined with Senator McNamara and more than 20 other Members of the Senate in cosponsoring another bill with a similar objective.

All of these bills—the Forand bill, the Kennedy bill, the McNamara bill—have in common health protection for our retired citizens as part of the social security system. I am convinced that only by use of the social security system can we have true health insurance. Only in this way can we achieve protection with dignity. Only in this way can we avoid the humiliating means test for benefits.

Approximately 12 million out of the 16 million Americans 65 or over are now part of the social security system. In years to come, the proportion in the social security system will be even higher. Some day, almost every single person over 65 will be in the system. By means of the Forand-Kennedy-McNamara proposals every working person will be able to finance a program which takes care of the millions of people already retired and which assures his or her own future retirement.

But I should like to caution against acceptance of the administration proposal in the field. I have four major objections to that plan.

First. It will cost the Federal Government $600 million out of general revenue, and it contains no provision for raising this money. It rejects the social security approach, which would automatically raise the money needed to finance the benefits. Social security is built-in fiscal responsibility.

Second. The administration proposal requires 50 State legislatures to act and to appropriate from already depleted treasuries. It would require, in the aggregate that the States provide an additional $600 million. It is difficult to imagine enthusiastic support from the States under these circumstances.

Third. The administration plan is confined to those with limited incomes. This is only a step removed from the undignified, humiliating means test. And it would require that even these low-income persons pay more than they can afford toward their health care—with enrollment fees, large deductibles, and coinsurance.

Last but most important. The administration plan departs from the tried, tested, and universally accepted social security system. Our older people do not want charity. They do not want to be dependent upon charity. They do not deserve to be treated like charity cases. They should be eligible for health

benefits the way they are eligible for retirement benefits—as a right they have earned.

Twenty-five years ago, when the Social Security Act was under consideration by the Congress, it was attacked as socialism, as regimentation, as compulsion. Those attacks were repulsed, and a great step forward in social progress and social responsibility was taken. Today, some of the same arguments are being raised against health care under that act. They are equally invalid today.

Mr. Chairman, I urge that the House bill be strengthened by providing for the extension of the old age and survivors insurance program to include health benefits for the aged.

The CHAIRMAN. The first witness is Dr. Leonard Larson, president-elect of the American Medical Association, accompanied by Mr. C. Joseph Stetler, general counsel.

Dr. Larson, you come forward and take a seat.

STATEMENT OF DR. LEONARD LARSON, PRESIDENT-ELECT, AMERICAN MEDICAL ASSOCIATION; ACCOMPANIED BY C. JOSEPH STETLER, GENERAL COUNSEL

Dr. LARSON. Mr. Chairman, I am Dr. Leonard Larson of Bismarck, N. Dak. I am appearing here today as the president-elect of the American Medical Association. With me is C. Joseph Stetler who is director of the legal and Socio-Economic Division of the Association.

With your permission, we should like to file for the record a full statement of our views on title VI of H.R. 12580, 86th Congress.

The CHAIRMAN. Without objection the insertion will be made in the record.

(The document referred to follows:)

STATEMENT BY LEONARD W. LARSON, M.D., OF THE AMERICAN MEDICAL ASSOCIATION

The problems of the aged and aging have been discussed and debated vigorously during this session of Congress, and considerable controversy has developed as to which of several legislative approaches should be taken to solve them.

We are convinced that the approach taken in title VI, as passed by the House of Representatives, is the proper one. But the problems which Congress is setting out to solve are both complex and difficult. It is therefore important, we think, to examine them thoroughly before getting down to the specific of proposed legislative solutions.

Despite the fact that old age is relative and based upon physiological changes, the Social Security Act has arbitrarily defined it on the basis of birthdays—65 for a man, 62 for a woman.

There are now some 15.5 million Americans over 65 who constitute living evidence that this Nation has the finest system of scientific medicine in the world, and that our standards of living are without historic parallel.

Each year, our older population will increase, until by 1970 we can expect 20 million people over age 65.

The rapid increase in life expectancy has, to some extent, caught us unprepared. Our problem as a nation is how best to take advantage of a phenomenon which has brought us a tremendous opportunity to augment America's reservoir of skills, talents, and human resources. This is not only our opportunity, but our responsibility.

Unfortunately, we are not discharging that responsibility at present as well as we could, as well as we should, or as well as we must.

For example, our society segregates the aged from employment, and from the community as a whole. We retire them from useful work, in too many instances, simply for reasons of chronological age. And because we still tend to place undue accent on youth, we all too often thrust older people aside from the mainstream of our day-to-day living.

We physicians see this at first hand, for in our practice we become uniquely familiar with the process of aging—and with its attrition, its compensations,

its inevitability, and its attendant problems. No group is more concerned with these problems than the medical profession; nor, in all probability, has any group devoted more study to the aging process or worked harder to find solutions to the many problems which accompany it.

The health problems of the aged involve far more than hospitals or doctors' care. They involve the older person's other requirements in life, whether these be housing, recreation, community understanding and acceptance, the right to be useful, the courtesy of being treated as individuals, or the opportunity of living as self-reliant, respected members of society.

These other requirements of the aged may seem peripheral, but we doctors know that they affect bodily health as directly as a virus. For example, suppose we diagnose an illness in an older person, put him in a hospital, and in due course discharge him as cured.

If that person cannot find an opportunity to use his skills, talents, and capabilities upon returning to society; if he cannot obtain the emotional support he needs; if he cannot win a place of acceptance within his family, his circle of friends, or his community; it is probable that he will seek, sooner or later, a return to the only shelter available. That means the artificial haven of a hospital, a nursing home, or a mental institution.

Most older people are, in fact, in good health. The diseases to which they are susceptible are no different from the diseases to which people in any age group are susceptible. There are no diseases of the aged, but simply diseases among the aged.

There is a greater degree of so-called chronic illness among older people. But the expression is generally misunderstood.

The term "chronic" refers to a recurrent condition, or one that persists over a period of time. It does not necessarily imply disability.

For instance, a person with impaired hearing, who uses a hearing aid, is chronically ill. This does not mean he is either disabled or incapacitated. Similarly, a diabetic is chronically ill, although with the help of insulin he can lead a perfectly normal life.

The chronically ill are simply impaired. Certain medical conditions limit certain of their capacities. They are not necessarily disabled.

Now I make this point in some detail because our older population is often represented to be sick and debilitated. This is not true. Let me repeat that most older people are in good health.

Dr. Ethel Shanas, of the University of Chicago, recently surveyed a representative group of older people with enlightening results. She found that 20 percent or fewer of persons over 65 were sick to the degree that illness limited their normal activity.

The consensus of those she interviewed seemed to be: "The way things are now, most people can expect to feel pretty good when they reach 70." I am not suggesting that the aged are as healthy as those in their prime, but I am saying that they are a great deal healthier than they are frequently pictured to be.

They would be healthier still if our society would stop shunting them to the sidelines simply because they have achieved an arbitrary number of birthdays.

From long experience, doctors have learned that the best defense against sickness is full use by the individual of his physical, mental, and social capabilities. And so, we try to keep our patients out of institutions, functioning in society, leading lives as normal as possible.

We want them, including our older patients, to remain in the main current of everyday living. When illness sidelines them temporarily in an institution, our aim is to hasten their return to independence and self-sufficiency. For the sake of their health, we do not want them to think that there is any emotional bonus in hospitalization, or in long-term residence within the walls of an institution.

The financial problems of the aged have also been greatly exaggerated.

This committee, in its consideration of title VI, should consider these questions:

Are the aged as a group too poor to pay for their own medical care?

How many of them are too poor?

To what extent is the cost of medical care the dominant problem of our older population?

In answering the first question, we know that some of the aged are indeed too poor to pay for their own medical care; but the overwhelming majority is not.

The bleak economic picture that has been painted of our older people is highly inaccurate. Income drops after retirement, true enough. But needs are also more modest once the heavy expenses of raising a family are behind.

Any assessment of the financial status of the aged must take two facts into account:

First, income is not a valid single yardstick for measuring the financial resources of the elderly.

Second, the aged are not a homogeneous group from a financial standpoint.

Many of our older people have several sources of income. Today, 9½ million aged receive OASDI benefits; over 1 million receive veterans' pensions; and over 1 million receive other Government pensions such as railroad retirement and civil service. Four million are employed, or are the wives of employed persons; 1½ million receive private pensions; about 1 million receive annuities individually purchased. About half of the aged have some income from assets in the form of interest, dividends, or rent. And three-quarters of the aged own liquid assets in one form or another—the highest of any age group.

A survey in 1957 by the National Opinion Research Center showed that only 9.6 percent of those interviewed would be unable to pay a medical bill of $500.

And according to reports of the Social Security Administration, almost 3 out of 4 beneficiary couples own their own homes—87 percent of them free of mortgage. The Bureau found that the median net worth of OASDI recipients, with a wife also entitled to benefits, has increased from $5,610 in 1951 to $9,616 in 1957—an increase of 71 percent during this 6-year period.

It is clear from the foregoing that many of the aged are in reasonably good shape economically.

It is also clear that future additions to the ranks of our aged will be in even more favorable circumstances. For example, today only about 60 percent of those over 65 are receiving OASDI cash benefits. But within a few years, more than 75 percent will be receiving them.

Private pensions are increasing rapidly. At present, more than 19 million Americans are covered by private pension plans, with total assets of nearly $40 billion. This figure is expected to reach $77 billion by 1965.

We can predict a rapid increase in the number of persons eligible to receive veterans' pensions. We can expect that many more of those reaching 65 in future years will have purchased annuities in preparation for retirement.

A few other figures should clinch the point that the aged are not as financially distressed as they are mistakenly reported to be:

The median income of aged men increased 50 percent from 1951 to 1958, whereas that of all men rose only 25 percent.

The tax picture for persons over 65 is substantially better than it is for those under that age.

Those over 65 have the lowest indebtedness of any age group, and their financial obligations—for example, to children for educational purposes—are significantly less.

In many instances, children and relatives of older people become assets rather than financial obligations as the earning capacity changes, and the head of the household status shifts from the father or mother to the children.

How does this square, then, with the statistic—which is repeated again and again—that three-fifths of all people 65 and over have less than $1,000 a year of income?

The statistic is accurate, but completely misleading.

It would be equally accurate, and just as misleading, to say that in 1957—the most recent year to which that misleading figure applies—63.7 percent of all Americans had incomes of $1,000 or less per year. And nearly 50 percent of the total of our population over the age of 14 also had annual incomes of under $1,000.

Supposing we took as a statistical sample 100 executives who earned $30,000 a year, and their wives. If the wives had no private income of their own, we could say of this sample that half of them had incomes of $1,000 a year or less. In this particular case their income would, of course, be zero.

This is the same statistical technique used to compile the figure cited so often as demonstrative of the financial need of the elderly.

It is obvious, Mr. Chairman, that such a money income figure is of little or no help in considering the financial problems of the aged. If we are to reckon their resources sensibly, we must know how many of the elderly have income from employment, social security, pensions, annuities, savings, investments,

insurance, or other assets. We can measure financial resources intelligently only if we consider them in terms of family income and assets—not individual income alone.

And if we want to determine the number of people unable to purchase adequate health care, it is important that we first know how many already receive that care through insurance coverage, from a religious group, a fraternal group, through membership in a union, as ex-seamen, as members of the Armed Forces, as a matter of professional courtesy, as members of specific religious orders, as veterans entitled to compensation and care, as recipients of help from their families.

And it is necessary to consider that 15 percent of the aged are on public welfare, and therefore eligible to receive medical care under federally aided public assistance programs.

The point here is that we should not think that we are dealing with 15½ million hardship cases, for we are not.

The fact remains, however, that many people over 65 do have serious financial problems. Two and a half million are on old-age assistance. In addition, we have an undetermined number of people who, while able to finance other costs of living, find it almost impossible to withstand the additional burden of the cost of a serious illness.

Even here, things are not as discouraging as they might be, for the percentage of persons over 65 who are needy has been constantly declining. In 1950, 22 percent of all the aged received old-age assistance. Last year, it had been reduced to 15 percent, and Government figures indicate that the figures should drop further—to 11 percent—by 1970. Thus, the improving economic status of the aged is reflected in a continuing reduction in the number of those who are on old-age assistance.

To sum up, then, any legislation considered by Congress should logically be drafted with two facts in mind:

1. That the aged are by and large in good health—with the majority neither sick nor debilitated; and

2. The financial circumstances of the aged are a great deal better than they are often represented to be.

I stress these points because they have been overlooked so frequently by those considering the problems of providing health care for the aged.

Msgr. John O'Grady, who is secretary of the National Conference of Catholic Charities, has spoken wisely on this subject. At one of the regional conferences sponsored by the American Medical Association, Monsignor O'Grady warned that too many workers in the field of aging are, in effect, not seeing the forest for the trees. By concentrating on the small minority of our aged who represent an extreme situation—medically, emotionally, socially, or economically—they are winding up with a distorted picture, he said. In effect, these people have magnified the problems of a minority segment to such an extent that their image of the total group has become blurred. They deduce, as a consequence, that most of our older Americans are in poor health, are living on borderline incomes, are substantially less able to contribute to their family or community, are no longer capable producers, and are poised on the brink of bankruptcy or total despair.

There is no doubt that Monsignor O'Grady is absolutely correct.

Unfortunately, a great many Americans seem to have accepted this alarming but distorted evaluation at face value. Unaware of the facts, or unmindful of them, these people have yielded to panic and proposed the creation of massive Federal machinery to bring about national compulsory health insurance for the aged.

Their thinking is, as I have pointed out, based upon the false premises that the aged are, as a group, sick, debilitated, and bankrupt. There is another false premise implicit in their thinking. This is the mistaken belief that the health care needs of older people can be separated neatly from their other needs.

They cannot be. Let me repeat that the aged have many and varying needs—in housing, in recreation, in preparation for retirement, in winning acceptance and understanding within their communities, in developing new interests, in finding the opportunity to use many of their talents and capabilities which are presently allowed to lie fallow.

As an example of how interrelated the needs of the aged can be, a former housing commissioner of the State of New York has estimated that hospital confinement of the elderly could be cut 20 percent if adequate housing were made available for them.

Nonetheless, the country's doctors continue to work to give our older people access to the particular health facilities they may need. If this means hospital care, we want hospital beds to be available. If this means nursing home care, we want nursing homes to be available. If this requires ancillary services, such as homemaker or home care services, we want them to be available.

Dr. Frederick C. Swartz, chairman of the American Medical Association's Committee on Aging, in his testimony last July before the House Ways and Means Committee, stated:

"Care for any segment of our population—the aged included—calls for a cooperative attack on the problem by nurses, doctors, hospitals, social workers, insurance companies, community leaders, and others. It requires flexibility of medical technique. * * *

"In the case of the aged, their health problem primarily involves acute illness and the so-called degenerative diseases. In a very large percentage of cases, the main need is not for an expensive hospital stay or a surgical operation, but for medical acre at home or in the doctor's office. In other cases, the important requirement is nursing care in the patient's home, or the home of relatives. And in still others, custodial care in a nursing home or public facility may be the only answer. The point is that the medical needs of this particular segment of the aged are subject to counless variations. * * *"

All legislation which the Congress may consider should take account, in our opinion, of this need for flexibility in meeting the health problems of the aged.

Such legislation should also consider the tremendous and continuing contribution of private citizens, working together on a voluntary basis, to meet the problem. Through cooperation at the community level, retirement villages are now being built in substantial numbers, as are new nursing homes and chronic disease centers. Home care programs are being expanded, recreation facilities are being set up, research programs are getting underway. And new approaches, such as progressive patient care, are being used more and more.

In this voluntary effort the Nation's doctors are playing a substantial part. Our AMA Committee on Aging, and similar committees established by all of the State medical societies, have been extremely active in providing leadership and initiative. These committees are working at all levels to meet the health and medical care requirements of older persons. Aging and other committees of medical societies have conducted, and are in the process of conducting, such programs as—

1. Campaigns to correct deficiencies in State and local assistance programs for the needy.

2. Leadership in construction of additional facilities for care of the aged, such as nursing homes. The American Medical Association has cooperated with the American Nursing Home Association in conducting a study of nursing homes. The two associations jointly developed and approved guides for medical standards in such facilities. These efforts toward higher standards have been simultaneous with continuing liaison with the American Hospital Association and the U.S. Public Health Service.

3. Promotion of health maintenance programs, including specific campaigns to encourage periodic physical checkups.

4. Stimulation of programs designed to permit the minority of older persons who are ill to remain in the beneficial environment of their homes. These programs include home care, homemaker services, in-the-home rehabilitation, and others which substantially reduce the cost of medical care.

We are well aware that there has been a significant increase in the cost of health care in the last 50 years. In fact, the American Medical Association announced in February an initial grant of $100,000 to study all aspects of health care costs, with resulting recommendations that we hope will produce increased efficiency and financial savings. Comparing the medical care of today with that available 50 years ago, however, is like comparing the horse and buggy with the modern automobile.

Physicians individually are also doing what they can to soften medical expenses for those over 65 in modest circumstances. Public welfare, religious, and fraternal programs, plus donated services by doctors, provide care for the indigent. And we have proved, again and again, that no person in the United States need go without medical care because he is unable to pay for it.

For the elderly with low family incomes, the AMA, in December 1958, called on State medical societies and physicians to expedite the development of low-cost voluntary health insurance and prepayment programs. Physicians were

asked to accept reduced compensation for their services, which would make such development possible.

State medical societies and Blue Shield plans immediately responded to the AMA's request. At present, 40 plans in 37 States are offering nongroup coverage to persons over 65; and 24 additional plans in 8 States are completing arrangements for such programs.

I should like to elaborate a little on the subject of private health insurance, for those who favor national compulsory health insurance for the aged state that those over 65 cannot get private health insurance; or that if they can, this insurance is inadequate.

The record disproves this completely. The growth of private health insurance since World War II has been nothing short of phenomenal.

As of December 31, 1943, fewer than 25 million civilians were covered by some form of private health insurance. By 1948, this figure had increased to 61 million. As of the end of 1958, the number of those covered had more than doubled, for 123 million persons—or 71 percent of the civilian population—had health insurance coverage. By the end of last year, some 127 million, or 72 percent of the civilian population, were covered by some form of private health insurance.

Over 100 million people have two or more types of health insurance, and by the end of 1959, some 21 million had major medical expense insurance, a form of coverage only in the experimental stage 10 years ago.

It is significant that the amount of health insurance owned by the aged is growing at a rate faster than that of the population as a whole.

In 1952, only 25 percent of our older people had health insurance coverage of any kind. Today, 49 percent own some kind of insurance coverage. The growth of voluntary health insurance coverage for the group over age 65 is greater, surprisingly enough, than the growth during the same period of voluntary health insurance coverage for all those under 65—100 percent, as contrasted with only 16 percent.

This rapid increase in coverage of those over 65 can be expected to continue. The Health Insurance Association of America estimates that 65 percent of the aged needing and wanting protection will be insured by the end of this year; and this percentage will increase to 80 percent by the end of 1965; and to 90 percent by 1970.

To sum up, private health insurance in the United States is well on the way toward accomplishing what the so-called experts in the field of social security have stated on innumerable occasions in the past to be impossible—namely, near-universal coverage of the whole population.

Back in 1948, Oscar Ewing, then Federal Security Administrator, reported to President Truman, and I quote, that "at a maximum, only about half of the families in the United States can afford even a moderately comprehensive health insurance plan on a voluntary basis."

Back in 1950, Wilbur Cohen, then of the Social Security Administration staff, testified before the House Ways and Means Committee in favor of the Wagner-Murray-Dingell bills which, at that time, proposed national compulsory health insurance for everyone on the rolls of the social security system. Mr. Cohen declared such action to be necessary because voluntary health insurance obviously could not do the job. Therefore, he said, the Federal Government must take over.

But last year, testifying again before the House Ways and Means Committee, Wilbur Cohen admitted on questioning that he had been wrong in 1950 and that voluntary enterprise had done the job. He therefore stated that he was not in favor of the extension of national compulsory health insurance below the age of 65.

It is significant that Mr. Cohen, when asked why voluntary enterprise should not be given an opportunity to do the job for those over the age of 65 as well, replied that he simply did not think it could be done.

Hindsight is better than foresight. But it is apparent that Oscar Ewing was wrong, and Wilbur Cohen was wrong. And it seems clear to me that there are many others who have been wrong when they claim that voluntary efforts and private health insurance cannot meet the problem for the vast majority of our people, the aged included.

This brings us to the question of whether or not the health insurance available to the aged is versatile enough, adequate enough, and available enough to meet the need. The answer is clearly, "Yes." In addition to Blue Cross and Blue Shield, more than 125 private health insurance firms—some of which are licensed to do business in all States—offer coverage to the aged.

Benefits are provided in a number of different ways. Without exception, older active workers are continued in group insurance plans. Most new group plans provide for the continuation of benefits to retiring workers. Still other group plans allow the retiring worker to convert his insurance to an individual policy. And a number of insurers are now setting up group plans for such associations of older people as Golden Age Clubs.

The majority of insurers continue into the later years individual contracts issued at younger ages. Those policies especially designed for older people do not require evidence of good health as a condition of eligibility, and after a short probationary period pay benefits for loss due to preexisting conditions. Finally, paid-up-at-age-65 policies are now available.

As you can see, Mr. Chairman, those who want to buy health insurance have a wide choice of plans, regardless of their age. This diversity of coverage is the result of free competition among many insurance companies, all vying with one another in the effort to improve benefits through more efficient methods.

Private health insurance and prepayment plans provide the answer to the financing of health care for the vast majority of older Americans. They have proved their ability to do the job for those under 65; and, given a chance to continue without interference, we may confidently expect them to complete the job of providing coverage for the Nation's elderly.

There is another point which should be stressed. Voluntary health insurance today cushions nearly three out of four persons against the financial impact of illness. It is logical to presume that those who have had this protection during their working years value it sufficiently to continue their policies after retirement. This was not the case, however, with most of the present aged, who did not have health insurance protection during their working years.

In other words, in the years ahead, more and more people reaching age 65 will retire with health insurance coverage adequate for their needs.

And not only will this coverage be adequate for their needs, but it will represent the free choice of the individual buyer who has been given the opportunity to select the coverage best suited to his particular situation.

This is one of the great arguments against national compulsory health insurance for any segment of the population. Under our present system, the individual can buy coverage tailored to his own requirements. Under several of the alternative plans considered by Congress, this choice of coverage would be eliminated, and in its place would be substituted a rigid, single pattern of benefits which would be imposed on everyone by the Government, regardless of his need, regardless of his wishes in the matter.

Thus far, Mr. Chairman, I have discussed the devices available to the vast majority of the aged for the provision and financing of health care.

Now let us consider the needs of the minority, who are either on old age assistance or unable to cope with the cost of serious illness on a budget otherwise adequate for self-support.

Sometime ago, the AMA suggested this eight-point program:

1. *The needy aged.*—Here the needs is for better organized medical care programs including improved preventive medical care;

2. *The near-needy.*—If the 2½ million older persons on old age relief are excluded from the calculation, then over 60 percent are currently covered by private health insurance. The AMA supports a program of Federal grants-in-aid to the States for the liberalization of existing OAA programs so that the near-needy can be given health care without having to meet the present rigid requirements for indigency. A liberalized definition as determined locally would permit an expanded program and encompass the near-needy group;

3. *Facilities.*—Better nursing home facilities for the long-term care of the aged person, especially over the age of 75, are the most urgent health care need before the Nation today. The average age of nursing home patients is 80, and their average duration of stay is 2 years. It is here that major improvement can be brought about. The AMA supports Federal programs for the provision of grants through the Hill-Burton mechanism to provide for new nursing home additions to existing hospitals. For proprietary nursing homes, the AMA supported the recently enacted amendment to the Federal Housing Act providing for Government guaranteed mortgage loans to proprietary nursing homes.

4. *Voluntary health insurance.*—Health insurance and prepayment policies tailored to meet the needs of the aged for long-term nursing home care must be developed as rapidly as possible. Health insurers and the Blue Cross-Blue Shield plans across the Nation are already experimenting in this new area of coverage;

5. *Home care.*—Care of the aged patient at home is psychologically, medically, and financially superior to institutionalization of any kind. Many programs to promote home care are being developed. Homemakers' services also provide opportunities for children caring for aged mothers or fathers to continue gainful occupation. They need to be expanded.

6. *Attitude toward aged.*—A basic change in attitude toward the aged person must be brought about. The person who reaches 65 should not suddenly be considered non productive and senescent. On the contrary, most persons over 65 are reasonably well and able to work. Increased productivity by eliminating compulsory retirement and permitting voluntary change of work is an essential part of the answer to the present problem.

7. *Health education.*—Many older persons are unaware of the need for continuing healthful nutrition and other practices that contribute to good health. Above all, the "will to live" is essential to continuing health. Preventive medicine measures instituted long before the age of 65 also can contribute materially to the promotion of good health after the age of 65.

8. *The purchasing power of the dollar.*—One of the principal economic problems of the aged person in the last 20 years has been the constant and continuing erosion of the purchasing power of his pension benefits. A top priority Government program to help the aged must be to take measures which are anti-inflationary and maintain the purchasing power of fixed pension and annuity benefits.

You will notice, Mr. Chairman, that title VI of H.R. 12580 is in accord with the principles of that program.

This piece of legislation has a great deal to recommend it:

1. It is designed to help those who really need help. It does not make the mistake of treating our 15½ million older people as a homogeneous group requiring an across-the-board approach. By providing aid only to those who need aid, it preserves the right of the nonneedy to take care of themselves.

2. Title VI, by limiting its effect to the near-needy minority, allows the majority to continue its use of the voluntary method. The measure is in no sense compulsory.

3. Title VI makes the States primarily responsible for administration of the program—not the Federal Government. We are convinced that the health care costs of the needy and near-needy can best be determined locally, and best be met locally.

It is germane to this discussion, I think, to comment on one category of legislation which has been proposed and discussed widely in this Congress. The category of which I speak includes all measures which would employ the social security mechanism to provide health care for the aged and pay the cost by increasing the social security tax.

Let me list briefly just some of the objections to this sort of legislative proposal.

1. The social security approach would cover millions of people who are financing their own health-care costs adequately at the present time. Whether they need it or not, whether they want it or not, the Federal Government would cover them, and compel 70 million workers and their employers to pay the bill.

2. Under such a system, the Federal Government would undertake to provide a service purchased from outside sources. Instead of cash benefits, it proposes service benefits irrespective of need. This is a dangerous precedent, Mr. Chairman, which hardly squares with the original purpose of the Social Security Act.

3. An approach of this sort would allow the Federal Government to control disbursement of funds; to decide the benefits to be provided; to set rates of compensation for hospitals, nursing homes, dentists, and physicians; to audit and control Government expenditures to hospitals, nursing homes, and patients; and to establish and enforce standards of hospital and medical care. Indeed, if the Federal Government adopted such a measure, it would be compelled to exercise these controls in order to safeguard the taxpayers' money.

Could the Federal Government assume these responsibilities—fiscal and otherwise—without influencing the quality of medical care which it dispensed? The answer is clear: It could not.

All of these measures disclaim their intention of meddling with the free practice of medicine. But if a single Government agency were empowered to buy perhaps 10 to 20 percent of all care in the Nation's general hospitals, it takes no crystal ball to predict that this agency would wield great power to influence the operation and management of hospitals.

It would be well nigh impossible under such a program to avoid a situation in which Government employees would be telling doctors what drugs and treat-

ment they could provide; telling hospital administrators how to run their hospitals; telling the nursing homes what they could and could not do.

4. Passage of such a measure would mean overcrowding in our hospitals, which are already hard pressed to meet the demands for care of our rapidly growing population. The overuse of hospitals is predictable, which is borne out in other nations that have experimented with national compulsory health insurance. It is human nature for people to seek to collect a benefit for which they have already paid, or for which somebody else is paying.

5. As physicians, we believe that patients should be hospitalized or institutionalized only when necessary, and that the length of their stay, as well as the treatment they are given, should be governed by their medical condition. The arbitrary limitations imposed by law or the regulations of an administrative agency are not acceptable substitutes for this medical determination.

6. The costs of such a proposal are almost impossible to predict. But it is safe to say that they would be staggering. Social security taxes are already scheduled to increase sharply in the years ahead. To increase them further might well jeopardize the entire social security structure through public rebellion.

Mr. Chairman, it is well to remember that such bills as these are irreversible in nature. Once started, they are hard to stop. The tendency is to expand them—never to contract them. As time went on, the Congress of the United States would face continual pressures for more expanded coverage and more elaborate benefits.

7. The passage of such a measure would, therefore, open the way for national compulsory health insurance to cover every man, woman, and child in the country.

8. To substitute a compulsory system of health insurance for a voluntary system that has proved its ability to do the job would result in the decline, if not the demise, of private health insurance. Those compelled by law to carry the cost of national compulsory health insurance would neither be able nor anxious to carry private health policies as well.

This type of legislation would have further bad effects.

It would restrict beneficiaries in their choice of hospital and physician, for would be to shift this responsibility from the shoulders of private and local governmental sources to the already overburdened shoulders of the Federal Government.

It would discourage, at the community level, the freedom to experiment with new techniques, such as home care programs, day hospital service, homemaker services, progressive patient care, and new concepts for treatment through outpatient departments and doctors' offices. And it is at the community level that such innovations are developed and made to work.

It would discourage families from taking care of their own.

It would restrict beneficiaries in their choice of hospital and physican, for only those physicians, and those hospitals and nursing homes entering into agreements with the Federal Government, would participate.

The professional relationship between the physician and his patient—the basis of all effective health care—would be severely handicapped. Government regulation would be imposed on the physician, and on the patient as well, bringing a third and intruding party between them. Required conformance to administrative regulations could also hamper the physician from prescribing treatment which, in his professional opinion, was indicated.

It would discourage the individual approach to patient care; and when this has been disregarded in the past, the result has been mass tragedy rather than mass cure.

These, then are some of the reasons why the social security approach should not, in our opinion, be invoked.

To review briefly the problems that confront the aged; their economic status, and the AMA's positive programs for resolving these problems:

(1) Today, approximately 60 percent, or about 9½ million of the 15½ million persons over 65 are receiving OASDI cash benefits. Within a few years, over 75 percent will receive these benefits:

(2) One and one-half million people now receive cash benefits from private pension plans. In the future, a much higher percentage of individuals over 65 will be enjoying such pension benefits, because at the present time, over 19 million workers are covered by such plans;

(3) A million persons over 65 today receive veterans' pensions, and this number will increase rapidly in future years because of the aging of the veterans' population;

(4) One million others receive railroad or civil service pensions;

(5) Four million individuals are employed, or are wives of employed persons; and their income is relatively the same as the average of other workers;

(6) One million retired persons receive annuities that were privately purchased, and the probability in the future is that many more will have purchased such annuities;

(7) The median net worth of OASDI recipients, with a wife also entitled to benefits, has increased from $5,610 in 1951 to $9,616 in 1957, an increase of 71 percent during this 6-year period;

(8) The median income of aged men increased 50 percent from 1951 to 1958, whereas that of all men rose only 25 percent;

(9) Over 70 percent of aged OASDI beneficiary couples own their own homes, 87 percent mortgage free;

(10) The liquid assets of persons over 65 are the highest in any age group and have increased the most rapidly;

(11) In 1958, three out of four persons over 65 had liquid assets in some form; 40 percent had liquid assets over $2,000 in 1958 as contrasted with only 30 percent in 1949;

(12) The income-tax picture for persons over 65 is significantly better than it is for those under that age. For example, a married OASDI beneficiary with $4,000 income, including $2,000 from social security cash benefits, pays no taxes. A person under 65, married, with two children, also earning $4,000, pays approximately $245 Federal income tax and $120 social security tax, or a total of $365 annual tax on his income.

(13) Those over 65 have the lowest indebtedness of any age group and their financial obligations—for example, to children for educational purposes—are significantly less.

(14) In many instances children and relatives of older people become assets rather than financial obligations as the earning capacity changes and the head of the household status shifts from the father or mother to the children.

There are, of course, many persons over 65 who have serious problems. Two and one-half million are now on old-age assistance and an undetermined additional number, although able to finance other costs of living, find it almost impossible to withstand the additional burden of the cost of illness. Even here, however, the picture is not discouraging. In 1950, 22 percent of all persons over 65 received old-age assistance. In 1959 it has been reduced to 15 percent, and Government figures indicate that this percentage should drop to 11 percent by 1970. Thus, the improving economic status of the aged is reflected in a continuing reduction of those who are on old-age assistance.

Voluntary health insurance has also shown a remarkably favorable trend for this group. In fact, without any Government intervention, those over 65 have voluntarily increased their coverage by almost 100 percent. In 1952 only 25 percent of all the aged were covered. Now 49 percent own some kind of insurance coverage. The growth of voluntary health insurance coverage of the group over 65, surprisingly enough, is far greater than the growth during the same period of voluntary health insurance coverage for all those under 65—100 percent as contrasted with only 16 percent.

The American Medical Association recognizes that it is not good enough simply to be against a measure. We have opposed, as you are no doubt aware, those legislative proposals which seek to employ the social security mechanism as a device for financing national compulsory health insurance for the aged. We have given this committee some of the reasons for our opposition. But we have also fulfilled our clear obligation to suggest positive courses leading to the solution of the complex problems facing our older population.

We have gone further. We have put into effect programs which have gone far to meet the needs of our senior citizens. The medical profession's efforts to achieve the best possible social, spiritual, and medical health of the aged are not new. To the contrary, the AMA program represents years of intensive work and study by many councils and committees of the American Medical Association.

Let me review that program briefly:

1. *Indigents and near-indigents.*—The AMA believes that Government agencies, National, State, and local, can properly participate in the purchase of, or pay-

ment for, health care provided to indigent persons. Our board of trustees has stated that the AMA could support "a public assistance program, including Federal funds, to cover those citizens who, on the basis of local determination, are considered indigent for the purpose of receiving health care benefits." Our board of trustees has concluded that a liberalized public assistance program of this type, designed to aid not only the needy but the near-needy, administered by the States, with eligibility and benefits determined locally, is a proper and reasonable Government responsibility, supplementing other activities in this area.

2. *Facilities.*—Better facilities for the treatment of long-term disease, especially for aged patients, are needed. The AMA supported the FHA amendment providing for Government-guaranteed mortgage loans for the proprietary nursing-home industry. The AMA is working closely with the American Hospital Association and other groups to improve the quality of institutional care and to reduce its cost. At the same time, the AMA has participated with other organizations in the development of home-care programs and homemaker services.

3. *Voluntary health insurance.*—The AMA is providing leadership in promoting the expansion of existing prepayment and health insurance plans and the development of new and more effective methods of providing coverage against health care costs of catastrophic nature.

4. *Attitude toward the aged.*—A revolution in the Nation's attitude toward our older citizens has to occur, if the aged are to take care of themselves rather than become wards of the Federal Government. The most urgent present need is the elimination of mandatory retirement at 65 and discriminatory employment practices against those over 45.

Let me repeat that the American Medical Association is entirely in favor of helping those who need help. But the association does not believe this necessitates the creation of massive Federal machinery to help those who neither need nor want help, and who are capably handling their own problems at the present time.

The question is, who should provide whatever help is needed?

At the annual meeting in June of the American Medical Association, the following statement was adopted by our house of delegates as the policy of the AMA. I should like to quote it to you.

"Personal medical care is primarily the responsibility of the individual. When he is unable to provide this care for himself, the responsibility should properly pass to his family, the community, the county, the State, and only when all these fail, to the Federal Government, and then only in conjunction with the other levels of government, in the above order. The determination of medical need should be made by a physician and the determination of eligibility should be made at the local level with local administration and control. The principle of freedom of choice should be preserved. The use of tax funds under the above conditions to pay for such care, whether through the purchase of health insurance or by direct payment, provided local option is assured, is inherent in this concept * * *"

It is clear that the policy of the American Medical Association is in no way incompatible with the principles upon which title VI is based.

Regrettably, the financing of medical care for the aged has produced violent controversy both in and out of Congress. There are two schools of thought on how it should be handled.

On the one hand are the proponents of OASDI health care amendments, who propose that a radical change be made in what is essentially a cash benefit program. Disregarding the fact that such a course can lead only to State medicine, the advocates of this approach call for Federal intervention via compulsory social security taxation for the financing of medical benefits for all OASDI beneficiaries—regardless of need.

This is paternalism at its worst.

It would compel the nonneedy to accept Federal medicine rather than buy medical care voluntarily, through their own resources. In fact, the proponents of this plan oppose the right of individuals to pay voluntarily for their own health care, for they insist that the Federal Government assume this responsibility for everyone eventually—beginning with the aged.

This is the outright socialization of the financing of medical care, and we are strongly opposed to it for reasons which we have detailed at some length in this testimony.

In contrast to the OASDI approach is the Federal grant-in-aid program for the medical care of the near-needy, to be administered locally for locally determined beneficiaries who are eligible. This is the method adopted by the House

of Representatives by an overwhelming majority. It is a method which preserves voluntaryism; which permits the nonneedy to take care of themselves. This follows the traditional Federal-State organizational structure of our Nation.

It is the economical method, which maintains local autonomy.

It is, therefore, the antithesis of the centralized, socialized, statist approach of the Forand-type proposals.

While helping those who need help, it preserves the right of self-reliant individuals to finance their own health care, and bases its approach to the problem on family and community responsibility.

This program has been criticized as "modest," presumably because its effect would be confined to the needy and near needy, instead of to millions of older people who neither want nor need Federal Government help.

To those critics who call this program modest, we say that fiscal irresponsibility, unpredictable cost, and maximum nationalization are not the accepted criteria for good legislation.

We believe that title VI merits the support of everyone familiar with the problem.

We believe that the House Ways and Means Committee is to be commended for its wisdom and statesmanship in developing so sound a proposal.

We urge this committee to accept the carefully considered conclusions of the House, based, as they have been, on months of intensive study.

In conclusion, let me repeat that we physicians believe in helping those who need help. We have bent our efforts toward providing this help for as long as our profession has existed. We are resolute in our determination to continue in this course.

Dr. LARSON. Because the committee's time is limited, my oral testimony will deal very briefly with the matters discussed in this document.

I would hope if action is to be delayed on this bill that the AMA and others who are interested in the bill and other matters pertaining to health will have an opportunity to present further testimony.

Now there is no subject outside of national defense and the budget that has caused as much concern as the subject of the care of the aged. We find ourselves in a position in which we are unable to ascertain all the facts.

In other words, we don't know and we doubt that anyone else knows, just what the problem of the aged is. We hope that after the White House Conference on Aging in January of 1961, that there will be information which will certainly be of value to everyone concerned and especially the Congress.

Now, from what we read, we understand that there is a possibility, at least, that some sort of legislation for the aged is going to be passed by this Congress. If so we are prepared to endorse title VI of H.R. 12580.

Now we do that for three main reasons:

First, it is designed to help those who really need help. It does not make the mistake, in our opinion, of treating over 15.5 million older people as a homogeneous group requiring an across-the-board approach. By providing aid only to those who need aid, it preserves the right of the nonneedy to take care of themselves.

Second, title VI, by limiting its effect to the near-needy minority, allows the majority to continue its use of the voluntary method. The measure is in no sense compulsory.

Third, title VI makes the State primarily responsible for administration of the program—not the Federal Government. We are convinced that the health care costs of the needy and the near needy can best be determined and met locally.

Any legislative proposal which seeks to meet the problem confronting the aged should be considered with these things in mind: The economic status of the aged is a great deal better than it is customarily pictured to be, with the vast majority of our 15.5 million people over 65 capable of meeting the cost of health care without undue difficulty; contrary to popular misconception, the majority of our aged are in good health—neither sick nor debilitated.

The needs of those who are sick or disabled are being met at the present time primarily through private resources, health insurance, and prepayment plans; under voluntary efforts of their families and private citizens working together at the community level.

We should, therefore, concern ourselves not with the majority which is neither disabled nor destitute, but with the minority.

There are, of course, many persons over 65 who have serious problems. Two and one-half million are now in old age assistance, and an undetermined additional number, although able to finance other costs of living, find it almost impossible to withstand the additional burden of the cost of illness.

Even here, however, the picture is not discouraging. In 1950, 22 percent of all persons over 65 received old age assistance. In 1959, it has been reduced to 15 percent, and Government figures indicate that this percentage should drop to 11 percent by 1970. Thus, the improving economic status of the aged is reflected in a continuing reduction in the number of persons who receive old age assistance. It is the needy and near needy which title VI would help effectively.

The American Medical Association emphatically favors helping those who need help. But the association does not believe this necessitates the creation of massive Federal machinery to help those who neither need nor want help, and who are capable of handling their own problems at the present time.

This brings us to the question of who should provide whatever help is needed.

At the annual meeting in June of the American Medical Association, this past time, the following statement was adopted by our house of delegates as the policy of the AMA. I should like to read it to you:

> Personal medical care is primarily the responsibility of the individual. When he is unable to provide this care for himself, the responsibility should properly pass to his family, the community, the county, the State, and only when all these fail, to the Federal Government, and then only in conjunction with the other levels of government, in the above order. The determination of medical need should be made by a physician and the determination of eligibility should be made at the local level with local administration and control. The principle of freedom of choice should be preserved. The use of tax funds under the above conditions to pay for such care, whether through the purchase of health insurance or by direct payment, provided local option is assured, is inherent in this concept. * * *

It is clear that the policy of the American Medical Association is in no way incompatible with the principles on which title VI is based.

Regrettably, the financing of medical care for the aged has produced violent controversy both in and out of Congress. There are two schools of thought as to how it should be handled.

On the one hand are the proponents of OASDI health care amendments, who propose that a radical change be made in what is essentially a cash benefit program. Disregarding the fact that such a course can

lead only to State medicine, the advocates of this approach call for Federal intervention via compulsory social security taxation for the financing of medical benefits for all OASDI beneficiaries—regardless of need.

Such a program would compel the nonneedy to accept Federal medicine rather than buy medical care voluntarily, through their own resources. In fact, the proponents of this plan oppose the right of individuals to pay voluntarily for their own health care, for they insist that the Federal Government assume this responsibility for everyone eventually—beginning with the aged.

We think this is the outright socialization of the financing of medical care, and we are strongly opposed to it for reasons which we have detailed at some length in the written statement attached.

To mention just a few of these reasons briefly, such a program would be unpredictably costly; it would unnecessarily cover millions of people; it would substitute service benefits for cash benefits; it would lead to a poorer—not better—quality of medical care; it would overcrowd our hospitals; it would lead to the decline, if not the demise, of private health insurance; and it would interfere dangerously with the doctor-patient relaitonship, which is the solid foundation upon which effective medical care must be based.

In contrast to the OASDI approach is the Federal grant-in-aid program for the medical care of the near needy, to be administered locally for beneficiaries whose eligibility is also determined at the local level.

This is the method adopted by the House of Representatives by an overwhelming majority. It is a method which preserves voluntarism; which permits the nonneedy to take care of themselves.

This follows the traditional Federal-State organizational structure of our Nation.

It is the economical method we believe which maintains local autonomy.

It is therefore the antithesis of the centralized, socialized, static approach of Forand-type proposals.

While helping those who need help, it preserves the right of self-reliant individuals to finance their own health care, and bases its approach to the problem on family and community responsibility.

This program has been criticized as modest—presumably because its effect would be confined to the needy and the near needy, instead of to millions of older people who neither want nor need Federal help.

To those critics who call this program modest, we say that fiscal irresponsibility, unpredictable cost, and maximum nationalization are not the accepted criteria for good or adequate legislation.

We believe that title VI merits the support of everyone familiar with the problem. We believe that the House Ways and Means Committee is to be commended for its wisdom and statesmanship for developing so sound a proposal.

We urge this committee to accept the carefully considered conclusions of the House, based, as they have been, on months of intensive study.

In closing, let me repeat that we physicians believe in helping those who need help. We have bent our efforts toward providing this help

for as long as our profession has existed. We are resolute in our determination to continue in this course.

Thank you.

The CHAIRMAN. Thank you very much, Doctor. As I understand it you favor the House bill; what is your comment with respect to the so-called administration proposal, which has not been introduced but was presented to this committee by Secretary Flemming yesterday.

Dr. LARSON. I have not seen the latest material on the administrative proposal. As I understand it, no bill has been introduced, so it is difficult to say. Now from what we have read and heard about the proposal that was made before the House Ways and Means Committee sometime back, we were not in favor of that approach.

The CHAIRMAN. Secretary Flemming presented a copy of a bill which he said would be introduced and was made a part of the record of the hearings yesterday, and it might be advisable for you to get that copy.

Dr. LARSON. Yes, sir, we would like to see it.

The CHAIRMAN. And then express to the committee your opinion pro or con.

Dr. LARSON. Yes, sir.

The CHAIRMAN. On those recommendations.

Dr. LARSON. Yes, sir.

(The opinion and recommendations were not submitted for the record by Dr. Larson.)

The CHAIRMAN. Any questions?

Senator DOUGLAS. Mr. Chairman, I think that the Doctor should know that the administration bill provided for meeting the cost of physicians' services for those over the age of 65 primarily by means of State and Federal appropriations, whereas the McNamara bill is restricted to hospital, nursing home, and home nursing care.

Now I wondered if you would like to express yourself on your attitude toward the provision of physicians' services paid for ultimately through a State subsidy.

Dr. LARSON. Well, there are many instances, Senator Douglas, in which physicians do accept moneys through State subsidy.

Senator DOUGLAS. That is for the needy?

Dr. LARSON. Yes, that is right.

Senator DOUGLAS. But this would be a provision not merely for the needy but for virtually all those over the age of 65.

Dr. LARSON. We have not taken a definitive position on that.

That is a very difficult situation so far as we are concerned.

There is violent difference of opinion amongst our members on that very issue, and I would prefer, sir, to give you the statement letter based on the provisions of the administration bill.

Senator DOUGLAS. You don't have the letter ready.

Dr. LARSON. No, no. We were not aware that this bill was ready for introduction or was prepared.

I can tell you very frankly, that we know of some of the thinking of the administration through conferences that were held.

Senator DOUGLAS. That is you participated in the formation of the administration plan?

Dr. LARSON. No, no. We were told what the administration was thinking and I can tell you that we did not agree with it. Now, the

trouble is that the material that was given to us was in general terms. It was not a bill that we could study, and that is why I would be very anxious to see that.

Senator DOUGLAS. Did you have representatives here yesterday to hear Secretary Flemming?

Dr. LARSON. Yes; I didn't get in until late afternoon.

Senator DOUGLAS. Did they make a report of the Secretary's testimony?

Dr. LARSON. Yes, but I don't recall that that was discussed, that is by our representatives.

Senator DOUGLAS. Well, the Secretary's testimony was very clear on this point, that out of a total cost of approximately $1,600 million or possibly $1,800 million, seven-eighths of the cost would be met by Federal and State subsidies shared equally between the Federal Government and the States, and that the benefits were to include not merely the cost of nursing home and home nursing and not merely X-ray and diagnostic facilities but were also to include physicians' care. There was a provision, which is similar to the one in the projected Anderson bill, that a large portion of the initial costs should be met by the aged person himself or herself, but with physicians' costs ultimately met by Federal and State contributions not merely for the needy but all those included in the plan. They would be virtually 100-percent coverage. Have I not made an accurate statement of Secretary Flemming's proposal?

Mr. STETLER. I didn't hear that. But we will comment on that generally that our attitude on this proposal would not turn on whether physicians' fees were covered but whether or not the group being encompassed in the program were needy. If the administration proposal would cover all over age 65 I think we would say we would not approve it, we would be opposed to it.

Senator DOUGLAS. The administration's plan is not confined to the needy, it includes the needy but is not confined to it, so you would be opposed to it?

Mr. STETLER. I am sure we would, but I would like to study it and state specifically.

Senator DOUGLAS. In other words, you take the position that whatever system is devised should be confined to those on old-age assistance.

Mr. STETLER. No, sir; as the Mills bill or this H.R. 12580 provides the present old-age assistance and then another near-needy category, which would be relatively new.

Senator DOUGLAS. A thin number around the old-age assistance recipients.

Mr. STETLER. That would depend upon your State determination.

Senator DOUGLAS. Thank you.

The CHAIRMAN. Any further questions?

Senator CURTIS. Mr. Chairman, we have a busy day and I will not take time to ask questions, but I will say to Dr. Larson that your three-page summary has some very fine principles laid down in it. One of the things that aggravates the problem of health care for anybody is inflation, and the proponents of larger and larger and larger Federal Government may be rendering a little help here and there in their alleged solutions but they are complicating the problems and creating hardship in every household in America.

I am glad you were here.

Dr. LARSON. Thank you.

Senator GORE. Mr. Chairman, I have some questions.

The CHAIRMAN. Senator Gore.

Senator GORE. Like you, Doctor, I have not yet had an opportunity to read the administration's bill. I did have the advantage of hearing Secretary Flemming's testimony at considerable length yesterday. Even so, I doubt that we could fruitfully engage in an examination of the problem or of the proposal in detail, and it may be you will want to return to the committee after you have had an opportunity to study it.

In my brief examination of Secretary Flemming yesterday afternoon, it appeared clear that there was a qualifying period, the duration of which was not specified, in which the elderly person would be required to pay $24 per year. There was some confusion in the testimony as to whether that would be for 1 year or 2 years. In fact I didn't get the impression that the administration had reached a firm conclusion on that or that it would be applied uniformly.

Secondly, it proposes to apply not a means test but an income test. I cited the illustration in which a couple might be worth a net of $250,000, and you can construct a situation where one has assets of up to half a million dollars or perhaps a million dollars, and still be eligible to pay $24 after he had been advised by a physician that major surgery or hospitalization might soon be necessary, and be eligible for hospital treatment and other medical care without limit. Would you favor that?

Dr. LARSON. It seems to me that is essentially what was given in the press long before Mr. Flemming appeared before this committee yesterday.

Senator GORE. Now that $24, isn't that a registration fee?

Dr. LARSON. No, they called it an enrollment fee.

Senator GORE. All right, an enrollment fee. But it would be compulsory.

Dr. LARSON. In order to participate in the benefits.

Senator GORE. Yes.

Perhaps I have used the wrong word. It would be a prerequisite.

Dr. LARSON. Yes; that is right.

Senator GORE. For eligibility.

Dr. LARSON. Now, the quarter of a millionaire, if one could call him that, could become eligible, but as I understood the original proposal of the administration it was to the effect that for those over a certain level of income there would be no Federal or State participation, dollarwise.

Maybe that has been changed.

Senator GORE. No. There would be an income test, but I know of at least one Member of the Senate who can testify that a man can own many acres of farmland now and receive no net income at all.

Dr. LARSON. I agree.

Senator GORE. He may be very lucky not to sustain a loss.

Dr. LARSON. That is right.

Senator GORE. There are many instances and many ways in which people can find themselves possessing substantial amounts of property measured in dollars, but who have no substantial income.

Dr. LARSON. In other words, they have assets.

Senator GORE. And I believe the proposed income limit for a couple would be $3,800 a year.

I will not proceed further to ask you about the administration plan. I only did this much to illustrate the point that I believe the administration has tried hard to reach the catastrophic illness, the long illnesses, the health tragedies that come to families, but in doing so, it seems to me that the administration may have erred, as your association may have erred, in overlooking the opportunity for preventive medicine. Now, I have introduced a bill, several people have introduced bills. Contrary to the McNamara bill, the bill I have introduced does provide for payment for visits to doctors' offices, home calls by doctors, as well as outpatient care and nursing home care. It seems to me, Doctor, that everyone concerned with this problem ought to try to approach it in the most realistic and practical way. You referred to one of the limitations and that is the availability of hospital beds. Within the past 2 weeks my own mother was required to wait for 10 days to obtain a hospital bed in Nashville, Tenn.

This brought home to me the scarcity of hospital facilities. Therefore, it seems to be very necessary that we begin with maximum emphasis upon preventive medicine, upon the care of a doctor at a time when a stitch in time might avert this catastrophe.

Would you comment on that?

Dr. LARSON. I agree that preventive medicine is very, very important. The question is how to provide it. Now there is a great deal of resistance on the part of the public. I have heard that in some instances, at least, where these facilities are available free of charge even, under a plan, for instance, that the participants in the plan either don't know about it or are reluctant to take advantage of it.

That is being broken down gradually, Senator. We find in our own practice that more and more people are coming in and saying, "I want a checkup," and it is surprising to me how many are fully aware of what a checkup should include.

Now it takes time to do that. We can't charge anywhere near what it costs us to do it.

We are glad to do it because it is a service to our people, and occasionally, as you say, a stitch in time saves nine. We discover a latent diabetes or a case of leukemia, cancer of the bowel or of the stomach, something like that. Those cases are relatively few but to the individual in which you find them, it is worth any amount of effort and money.

Now, how are we going to provide facilities, doctors, nurses, all the ancillary services to take care of millions of people in this country who, through education, which may take some time to accomplish, would be wanting that preventive type of service?

I am strong for preventive medicine, Senator Gore, and I hope the time will come when we have better screening mechanisms than we have now for that or to discover some of the more obvious conditions that a patient is unaware of and for which something can be done.

Senator GORE. And if done early it might not only prevent a long——

Dr. LARSON. That is true.

Senator GORE. Costly hospital stay but it might even save a life.

Dr. LARSON. That is true. I think diabetes, unknown to the patient, for example, discovered, adequate treatment outlined may require a few days in the hospital, to get the patient under control, as we say. He goes home under a strict regime, can take care of himself from then on, and he gets along just fine so long as he follows the instructions but unless he knows what he has, and something is done to relieve him of his situation, he can't be cured, some day he comes into the hospital in a diabetic coma, and that may require not only emergency treatment but may be expensive and require a lot of people, laboratory work, but possibly days and even weeks in that hospital. So the preventive side of this is certainly very important. There is no question about it.

Senator GORE. Well, Doctor, this being true, I included in the bill I introduced provisions to which I have referred. I tried to emphasize the kind of care that is most available now, and I agree with you that there are not nearly enough doctors. We have erred seriously either in not putting our medical schools to greater use or in not multiplying them, but, nevertheless, medical care, clinical care, nursing care, the ancillary health services to which you refer, are more plentiful now than hospital beds, as scarce as both are. Am I correct in that?

Dr. LARSON. I think so.

Senator GORE. Well, then, although I must say that I was not unaware that this provision in a bill might generate more opposition, nevertheless it seemed to me absolutely essential to a practical and realistic approach to the problem of health of our people. I know some people regard it as a political problem and a political issue. So far as I am concerned it is a human problem and I appreciate your testimony here.

I thought Secretary Flemming made a fine contribution yesterday. We may not agree with all of his recommendations but at least he and his staff have given the problem a great deal of study and made some helpful suggestions.

You, too, have been helpful today.

Dr. LARSON. Thank you.

Senator GORE. I would like to ask one other question. What was the position of the AMA in the Miami meeting with respect to the House bill?

Dr. LARSON. You mean the bill before us right now?

Senator GORE. Yes.

Mr. STETLER. The statement that was in this brief statement which quoted it was the action taken earlier in this month in Miami. It did not relate specifically to the Mills bill because there were so many proposals pending in Congress, our house of delegates merely announced its general policy. Now that policy when you read it does coincide with the principles in the Mills bill so that is why we do support it today, in our testimony.

Senator GORE. Thank you.

The CHAIRMAN. Any further questions?

Thank you very much, Doctor.

Dr. LARSON. Thank you, sir.

(The following letters were subsequently received for the record:)

AMERICAN MEDICAL ASSOCIATION,
Chicago, Ill., June 30, 1960.

Hon. HARRY F. BYRD,
Chairman, Senate Finance Committee,
U.S. Senate, Washington, D.C.

DEAR SENATOR BYRD: In a separate statement submitted today, I presented the views of the American Medical Association with respect to title VI of H.R. 12580, 86th Congress, now pending before your committee. This measure also provides for the compulsory inclusion of physicians under title II of the Social Security Act. This letter is written for the purpose of restating the position of the American Medical Association in this regard.

As far back as 1949, the house of delegates of the AMA went on record as opposing the inclusion of physicians under social security on a compulsory basis. This position has been restated by our house of delegates regularly once or twice a year since 1953. This policy statement was amended by our board of trustees in 1954 to remove any objection to the voluntary inclusion of physicians under the act.

Following the clinical meeting of the association in December 1955, many of the State medical societies, at the suggestion of the house of delegates, conducted a poll of their members on the question of compulsory inclusion of physicians under social security. Although uniform questions were not asked in these State polls, it can be concluded from the results that a majority of the profession is still opposed to compulsory coverage. It is true that several State medical societies have endorsed coverage of physicians. Our house of delegates, however, of 200 physicians representing every State, has overwhelmingly rejected proposals for coverage. The most recent action of this body in opposition to compulsory coverage for physicians was taken at the association's annual meeting held in Miami Beach earlier this month.

OASDI does not fit the economic pattern of the practicing physician. Self-employed doctors rarely retire at age 65. Therefore, the compulsory tax which would be imposed upon them, were they covered under the social security system, would be unjust and unreasonable. Physicians who are able to work prefer to keep right on practicing medicine. A survey of this point shows that over 85 percent of the doctors between the ages of 65 and 72 are in active practice. Over 50 percent of the physicians who retire do so after the age of 74. Thus, if forced under this program, the typical physician would be required to pay social security taxes until age 72 before he would receive benefits.

Finally, and perhaps most important, physicians have seen social insurance programs in other nations used as a vehicle for the establishment of socialized medicine. They have fought against the Wagner-Murray-Dingell bills of 1949 and the Forand bills of today. They know that the OASDI system constitutes the principal avenue by which socialized medicine advocates hope to achieve their goal. Naturally, they are highly sensitive to their inclusion in a system which may eventually be used to abridge their freedom as a profession.

For the aforementioned reasons, the medical profession is opposed to the compulsory coverage of physicians under title II of the Social Security Act. If you or any of the members of your committee desire further information concerning our position, I would be happy to supply it.

Sincerely yours,

LEONARD W. LARSON, M.D.

PIMA COUNTY MEDICAL SOCIETY,
Tucson, Ariz., June 27, 1960.

Senator HARRY FLOOD BYRD,
Chairman, Senate Finance Committee,
Washington, D.C.

DEAR SENATOR BYRD: In my capacity as chairman of the Pima County Medical Society, committee on legislation, I am taking this opportunity to express the society's unqualified opposition to any Forand-type proposals which purport to provide health care benefits by means of OASDI.

With the House passage of H.R. 12580 (Mills bill) and its probable early consideration by the Senate Finance Committee, undoubtedly many amendments will be offered from the floor of the Forand type. We urge continued and

thorough hearings on H.R. 12580 by the Senate Finance Committee. Clearly, any legislation adopted in haste—during the inevitable tensions of an election year—is very likely to harm the very people whom it is intended to help. Such far-reaching legislation should not be rushed through in an atmosphere of panic without adequate consideration and thorough prolonged study. The tensions of an election year certainly tend to make this issue a political football and is to the direct detriment of the best interests of our citizens.

The American Medical Association, we understand, has indicated its desire to testify before the Senate Finance Committee concerning this measure and we urge that their testimony be carefully considered.

Sincerely yours,

L. D. SPRAGUE, M.D.,
Chairman, Pima County Medical Society,
Committee on Legislation.

The CHAIRMAN. The next witness is Mr. Nelson H. Cruikshank, director, Department of Social Security, AFL–CIO, accompanied by Andrew J. Biemiller, director, legislative department.

Take a seat, sir and proceed.

STATEMENT OF NELSON H. CRUIKSHANK, DIRECTOR, DEPARTMENT OF SOCIAL SECURITY, AFL–CIO; ACCOMPANIED BY ANDREW J. BIEMILLER, DIRECTOR, LEGISLATIVE DEPARTMENT, AFL–CIO

Mr. CRUIKSHANK. Mr. Chairman and members of the committee, my name is Nelson H. Cruikshank and I am director of the Department of Social Security of the American Federation of Labor and Congress of Industrial Organizations, and my office is at the headquarters of the AFL–CIO, 815 16th Street NW., Washington.

I am accompanied by my colleague Mr. Andrew J. Biemiller who is director of the AFL–CIO Legislative Department. We are representing the AFL–CIO to urge that you recommend the House bill H.R. 12580, with certain major improvements, especially the addition of health benefits for the aged through old-age, survivors, and disability insurance.

Mr. Chairman, I submitted this statement in full which runs to some eight or nine pages but because of the pressure of time and the tight schedule of this committee which we fully appreciate, I would appreciate it if the statement could be introduced in the record.

The CHAIRMAN. Thank you, Mr. Cruikshank and we will accept your statement in full.

(The statement referred to follows:)

STATEMENT OF NELSON H. CRUIKSHANK, DIRECTOR, DEPARTMENT OF SOCIAL SECURITY, AFL–CIO

My name is Nelson H. Cruikshank, and I am director of the Department of Social Security of the American Federation of Labor and Congress of Industrial Organizations. My office is at the headquarters of the AFL–CIO, 815 Sixteenth Street NW., Washington, D.C.

I am accompanied by Mr. Andrew J. Biemiller, director of the AFL–CIO Legislative Department. We are representing the AFL–CIO to urge that you recommend the House bill, H.R. 12580, with certain major improvements, especially the addition of health benefits for the aged through old-age, survivors, and disability insurance. We appreciate the opportunity to present our views before this committee, and we are glad to cooperate with the committee's desire to keep the hearings short so that such legislation may be enacted before Congress adjourns.

AMPLE EVIDENCE FOR HEALTH BENEFITS

This Congress has already given substantial attention to proposed legislation on health benefits for the aged. A detailed report on hospitalization insurance for OASDI beneficiaries was received from the Secretary of Health, Education, and Welfare on April 3, 1959. Its 117 pages contain extensive data on the income and other characteristics of aged persons, on their medical needs and utilization of health facilities, on costs of medical care, and present and proposed methods of financing hospital care.

The House Ways and Means Committee held a week of public hearings last July, and close to 3 months of executive sessions this spring. The Subcommittee on the Aging and Aged of the Senate Labor and Public Welfare Committee heard testimony in many States, focusing largely on health problems, and has issued extensive records and reports.

The ever-growing public concern with health problems of the aged has been reflected in many statements submitted to both Houses of the Congress as well as in technical journals and the general press.

Our own experience at labor meetings and in discussions with experts in health and social security has reinforced our conviction that the established social security system is the most appropriate method through which the Government can assist aged citizens with problems of financing medical care.

To illustrate the widespread public acceptance of this approach, I am attaching statements by a leading business publication, Business Week. Similar statements have appeared in Life, the New York Times, the Washington Post, and many other publications.

Within the framework of social insurance, various possible approaches can be followed. The AFL-CIO has supported the Forand bill, ever since its first introduction in August 1957. We regret that the majority of the members of the Ways and Means Committee voted against its inclusion in the House bill.

ADVANTAGES OF SOCIAL INSURANCE

Various Senate bills on health care for the aged represent constructive approaches through the old-age, survivors, and disability insurance system.

The addition of health benefits to that program would have clear-cut advantages, under any of the patterns of benefits proposed.

1. After retirement (or, for mothers, after the husbands' death), there would be no annual contribution or enrollment fee. Contributions during years of earnings would establish the right to the new benefits as to those already incorporated in the program. This is an essential difference from private insurance, a difference that cannot be overcome by the latter.

2. Lasting protection would be provided which could not be canceled or lost because of nonpayment of premiums or the application of lifetime ceilings. Not all medical costs would be covered, but even maximum use of the benefits during 1 year would not be counted against the benefit rights in later years.

3. The Federal OASDI program can provide almost universal coverage, including persons already retired as well as 9 out of 10 persons now employed. It can give the greatest protection for the lowest cost because of its already established and efficient machinery. While some persons like to contrast what they call "voluntary" with alleged compulsory protection under OASDI, much so-called voluntary coverage is in fact what in other circumstances they would term compulsory. The essential characteristic is that of group action based on a group decision. Only the Federal program embraces a broad enough group to provide the widespread and continuing protection that results from its automatic application to nearly all kinds of work.

It is indulging in the most meaningless semantic exercise to describe a program supported out of general taxation as voluntary. I can think of nothing less voluntary than taxes levied by the Federal Government.

4. Unlike public assistance, the Federal program pays benefits as a matter of right without a means test. The medical care that is covered would be paid for before persons have used up their savings or other resources and without searching questions which might damage their self-respect at a time of great anxiety.

Important social effects would flow from the enactment of a bill including health benefits through OASDI.

1. It would ease the financial problems of hospitals by providing payment for much of the care that now they must give to charity cases without charge or at

rates far below cost. Even though public welfare payments to hospitals have been increased in many areas, they often do not cover actual expenses. Insofar as a hospital now transfers the cost of free care or partly paid care to paying patients, its rates could correspondingly be reduced.

2. Blue Cross plans would be relieved of a high-cost load and therefore could hold down their rates and compete more effectively with commercial insurance plans. Far from damaging Blue Cross and Blue Shield, enactment of such a bill might prove their lifesaver. The recently retired president of the National Blue Cross Association, Dr. Basil C. MacLean, has said: "Legislation along the lines of the Forand bill offers a means of settling an area of difficulty and relieving the voluntary prepayment mechanism to concentrate on better programs within its areas of demonstrated competence."

Commercial insurance companies would still have an ample field of activity since they would be used to supplement the Government program just as life insurance and annuities have been purchased to supplement monthly cash payments under social security.

3. Insofar as the proposal would make it unnecessary for individuals to turn to public assistance and private charity, it would relieve private welfare organizations and Government agencies of a welfare load now financed by taxpayers or donations. Social insurance as the basic protection, backed up by public assistance, is consistent with the social security principles on which this committee and the Congress have provided for the protection of American families for the past 25 years.

4. The bill would accelerate action to increase the supply of medical personnel and facilities required to make good care available to everybody. With an assured market for skilled nursing care, for example, the supply of nursing homes would quickly increase.

Total expenditures for medical care by the aged are more than $3 billion a year. Once the social insurance approach is accepted, one is confronted with a decision as to how much of this total cost should be assumed by the universal Government program.

ALTERNATIVE LEVELS OF FINANCING

A very limited, low-cost program can be developed to be financed from a combined increase in the contribution rate of one-fourth percent of taxable payrolls, or one-eighth percent each by employers and employees. An increase in the wage-base ceiling to $5,400, instead of $4,800, would produce an equal amount of revenue in the long run. An increase to $6,000 would produce a saving of one-half percent of payrolls in early years and 0.4 percent on a level premium basis. These are net savings, calculated on the assumption that benefits would be increased correspondingly for persons with earnings up to the new ceilings, partly reflecting their higher contributions.

With the funds thus obtained it would be possible to pay very limited hospital benefits to all the aged or more generous benefits to persons above the age of 68 or 72.

A contrasting choice would be a very broad spectrum of benefits, which would offer greater protection to the aged but would require substantially larger contributions. The total expenditures of the aged now equal about 1½ percent of total taxable payrolls. Knowing the very low incomes and the pressing health problems of the aged, it is not easy to make a choice that severely restricts the health benefits they would receive.

DEFECTS OF THE ADMINISTRATION POSITION

The Eisenhower administration found a way out of the dilemma of making the choice. Its program was offered not to help the old people but to help the administration. The proposal revealed by Secretary Flemming on May 4 contained a glittering list of potential benefits. But much of the cost was left to the aged themselves. And even if the administration plan were enacted by the Federal Government, its application would depend completely on State action. The administration knows full well that the States would do little to provide the more than half a billion dollars that would be required to translate the promise into reality.

The plan has many other bad features, and it is interesting to note that a bill has never actually been introduced to clarify how the proposed income test would be administered and whether the program in fact is workable.

At the time that Secretary Flemming released the administration proposal on May 4, we prepared an analysis of its inherent defects which I should like to have included in the record at the conclusion of my statement.

Secretary Flemming on behalf of the Eisenhower administration has attempted to frighten your committee and the Nation into believing that social insurance is too costly. The exaggerated figures he uses reflect slogans we have long heard from the chamber of commerce and the insurance companies. It is unfortunate that this administration is turning increasingly to such prejudiced sources for its statistics and estimates rather than to its own experienced staff.

Members of this committee will recall the similar attacks of the chambers of commerce, the insurance companies, the administration, and the doctors just before the disability benefits program was enacted in 1956. But the exaggerations as to its potential cost have been proved groundless. Just as dependents' benefits were added for the disabled in 1958, so now the House Ways and Means Committee has recommended that the age-50 requirement be removed without the necessity of any additional financing.

While I am talking about the 1956 experience, let me recall to your mind also that Senator George in leading the fight for disability benefits denounced the charge of socialized medicine which was then being advanced by the doctors, pointing out that "socialized medicine can be brought into this country only by the doctors themselves." He added: "Someone should have the courage to say to them that if they continue to make such trifling objections, they may invite something bad for them * * *."

The bill for the health care for the aged is going to be paid. Rich, generous-hearted America will not ignore their needs, and families will provide for their elderly members to the limits of their ability and often at tragic costs to their younger members.

It is precisely because health charges can be very heavy, that assured methods of payment which spread the risk are required. With an expanding economy and rising levels of earnings, taxable payrolls will grow, swelling collections, and the cost estimates of the actuary of the Department of Health, Education, and Welfare may well prove too high.

The only itemized cost estimates that we have seen from the Secretary for the Forand bill total 0.8 percent of payrolls on a level premium basis. We suggest that the 1-percent figure he presented to this committee yesterday is more political than actuarial.

It is partly because we believe that whatever Federal funds are available should be utilized most effectively that we object to costly administration by 50 separate State agencies and commercial insurance companies. We understand that Secretary Flemming himself told the House Ways and Means Committee that the per capita cost of administering his proposal would be $17 a year as compared with $6 under the Forand bill. If the Secretary is worried about the regressive nature of the present payroll tax, he could join with us in raising the tax base from the present $4,800 to $6,000 or $9,000, or, in removing it entirely, as the late Prof. Sumner Slichter of Harvard University proposed.

But a payroll tax, even with the present over-low earnings ceiling, is much less regressive, especially so far as retired people are concerned, than the sales taxes and other taxes on which States and localities rely for the major part of their revenues. The Secretary's program would put half the cost on such regressive taxes.

The social insurance approach to health care of the aged can be based, as the present program is, on clearly defined contributions. It is perfectly possible to provide a separate fund for health benefits, as in the case of the long-term disability program, and to limit benefits to the earmarked contributions. Such an approach does not involve open-end financing. It gives Congress far more control than the type of program proposed by Secretary Flemming, in which Federal expenditures are determined by what the States decide.

You will recall Governor Rockefeller's criticism of the administration proposal. He said: "The formula recently proposed by the administration, while admirable in purpose, is basically unsound from a fiscal viewpoint. It is based largely on a concept of subsidy. It would be both costly and cumbersome to administer. We have a long-established contributory system of social insurance. Its soundness is proven. We should build on it."

I suspect that Governor Rockefeller knows something about the handling of money.

But this administration, which is constantly opposing programs because they cost too much, offers a glittering plan costing many hundreds of million dollars a year from general funds of the Treasury with no corresponding proposal for raising necessary revenues.

A PRACTICAL CHOICE

We in the labor movement have been more responsible. We would like to see the aged receive very extensive protection. But we also know that promises must be backed by assured and practical financing.

This committee has the same choice between a limited program and an extensive one which the Congress had in 1935. It decided then between a comprehensive program for the whole field of social insurance or a start on a workable basis. The original old-age benefits and unemployment insurance benefits have since been supplemented very successfully by monthly benefits for young widows and children, and by long-term disability benefits.

We are now suggesting a similar workable start in the field of health benefits for the aged, even though we would like to have a much broader program. The Forand bill, with hospital, skilled nursing home, and surgical benefits is one approach. The greatest part of its cost of 0.8 percent of payrolls is for the aged, though young widows and surviving children are also included.

It is entirely feasible to work out a practical and sound program within a defined cost ceiling. For example, at a level premium cost of one-half of 1 percent of taxable payrolls a plan can be developed which would make possible a good start for all beneficiaries 68 years of ago or over. Payments could be made for up to 365 days of hospital care, and subsequent skilled nursing home recuperative care, up to 180 days, and for visiting nurse services in the home. To provide these alternative forms of care, within this cost ceiling, two separate $75 deductible payments by the beneficiary would be necessary. Such a plan would be of enormous value in providing protection in long-continued illnesses without overloading hospitals.

We are informed that Senator Anderson and some of his associates are working out a proposal along these lines, designed to supplement the limited care provided in the House bill, with a basic plan of social insurance protection. The AFL–CIO will gladly support such a program and we hope this committee will incorporate it into the bill which is reported to the Senate.

Even a broader spectrum of benefits is feasible, and there is much to be said for including these types of care which encourage early preventive treatment and which speed recuperation. In the long run, these additional forms of benefits are likely to add little to the total cost, and they will do much to enhance the health and happiness of older citizens.

OTHER DESIRABLE IMPROVEMENTS

The present House bill includes various desirable provisions liberalizing old-age, survivors, and disability insurance, though we regret that it does not include a general increase in benefits and various other improvements which the AFL–CIO 1959 convention resolution called for.

We deeply regret the omission of any Federal benefit standard for unemployment insurance or the addition of reinsurance grants to States with high levels of unemployment. The changes in financing of unemployment insurance adopted by the House do nothing to improve benefit levels.

The public assistance amendments, including the proposed new title XVI, are very limited and totally inadequate to assure proper health care and levels of living for persons forced to turn to these programs for aid. The Federal Government can afford to make more generous matching grants available to the States to make sure that no elderly person lives under the miserable conditions revealed by the studies of the McNamara subcommittee. The Advisory Council on Public Assistance in its report to the Congress has submitted recommendations which should promptly be followed.

But the great majority of aged should not have to turn to public assistance whether it is dressed up as in title XVI or in any other way. An income test and a means test are not desirable as the basic form of protection. People do not want to have to swear to indigency, declare their resources, list relatives who might help them, and be subject to investigation, often by poorly trained and inexperienced people.

If the great majority of the aged can receive substantial protection as a matter of right through old-age, survivors, and disability insurance, the States

and localities will be relieved of a tremendous financial responsibility which will otherwise increasingly overwhelm them. Without health benefits through social security, the House proposals for health care of the aged are like a roof without foundations. We urge your committee to add the foundations so that the aged may live out their lives constructively and with hope.

Mr. CRUIKSHANK. I will summarize some of the high points in it.

The CHAIRMAN. Thank you very much for your cooperation.

Mr. CRUIKSHANK. It appears plain that there is ample evidence of the need for some kind of health benefits. The administration position even within the last year has changed from one of where they said there was no need for any action to one in which they are proposing a type of action, one with which we are not in agreement, but we are now agreed with them that there is need for action.

Various reports have been submitted to the Congress, various private organizations have made reports, there has been intensive study of this whole issue.

Our own experience is that there has been a rising tide of understanding of the social insurance principle, whether or not it reflects itself in support of one particular bill or measure before the Congress. There has been a rising tide of recognition of need, and an increasing understanding of how the social insurance principle can best be adapted to meet that need.

As just one example, there are here two editorials from Business Week, which I think reflect the views of an important segment of the business community, editorials from the issues of April 16 and May 21. They, having analyzed the subject and analyzing the need, have come out in full support of the social insurance principle as a means of meeting this.

I should like, if I may, Mr. Chairman, to introduce these editorials in the record at this point.

The CHAIRMAN. Without objection.

(The documents referred to follow:)

[From Business Week, May 21, 1960]

MAJOR MEDICAL PLANS

(Submitted by Nelson H. Cruikshank, director, Department of Social Security, AFL-CIO)

In the 2 weeks since it was proposed, the administration's new plan of health insurance for the aged has set some sort of record for unpopularity. It has been hit by a heavy crossfire from the American Medical Association on one side and the AFL-CIO on the other. Conservatives like Senator Barry Goldwater, Republican, of Arizona, and liberals like Senator Pat McNamara, Democrat, of Michigan, have taken potshots at it. And even the in-betweeners like Governor Rockefeller of New York and Governor Meyner of New Jersey have greeted it with harsh words.

With left, right, and center all expressing distaste, there isn't much chance that Medicare will be seriously considered by Congress, let alone adopted.

Nevertheless, the fact that the administration has submitted the Medicare plan is extremely important: It means that both political parties have now acknowledged the need for a Government program of health insurance for the aged, and that both parties have committed themselves to working out such a program. That's why the astute Senate majority leader, Lyndon B. Johnson, Democrat, of Texas, was one who held his fire. Johnson found it encouraging that the administration had come through with a plan, reserved comment on its merits pending further study, observed: "But once a need is recognized, it is usually possible to find a solution."

How about the merits of the administration's solution? It does face up to the real problem—that the medical bills of the aged can be met only by spreading them to the rest of the community. The administration would pay the bills by a complex system involving contributions from the aged, and heavy Federal and State subsidies, either to provide direct health insurance for those aged persons whose incomes are sufficiently low or to subsidize private insurance companies.

This approach is fiscally hazardous, administratively clumsy, and unnecessarily costly. Moreover, it would be extremely difficult, if not impossible, to get the States and private insurance companies involved. An approach along the lines of the existing social security system, in which costs of benefits are regularly met by the payroll contributions of the future beneficiaries, would appear to be vastly superior to a Federal-State subsidy approach.

But the administration's plan does have a couple of real advantages over the Forand bill, which is favored by many Democrats:

By providing for home care, prescribed drugs, and other outpatient services, Medicare avoids the dangers of "hospitalitis" (BW–Apr. 16, 1959, p. 184), where the Forand bill would, as Vice President Nixon puts it, "put a still heavier load on already overburdened hospitals * * * since its benefits are available only in institutions."

Medicare would extend protection to many of the aged who are not presently covered by social security and whom the Forand bill would not help.

Some Democrats already recognize these weaknesses of the Forand bill and so should welcome the administration's initiative on both counts. —

Indeed, if leaders of both political parties are willing to renounce the effort to make political hay out of this vital issue at each other's expense, there is no doubt that a sound and workable program of health insurance for the aged can be worked out. And, as we said before, the sooner the better.

[From Business Week, Apr. 16, 1960]

THE TREND—A CHALLENGE THAT CAN'T BE DUCKED

(Submitted by Nelson H. Cruikshank, director, Department of Social Security, AFL–CIO)

Health insurance for the aged is fast becoming the No. 1 issue facing Congress this year (p. 25). And there's political dynamite in it: Any candidate suspected by the millions of old people—and those concerned about their health problems—of taking a cold or know-nothing attitude toward the issue is likely to be in serious trouble this election year.

One thing about the issue is clear: Although plenty of politicians may see it as a vote-catching device, there is nothing synthetic or phony about the problem. Everyone who has seriously studied the situation has concluded that the provision of better health care for the aged is a serious—and growing—problem. Thanks to medical progress, the number of aged is increasing rapidly. In 1930, there were 6 million people over 65 in the United States; today there are 16 million.

For far too many of these long life has meant shrunken incomes, increased sickness, loneliness, and the shame of being a candidate for a handout from society. Health, Education, and Welfare Secretary Flemming, in his thorough report to the House Ways and Means Committee last year, concluded that three out of every four aged persons would be able to "prove need in relation to hospital costs." That is to say, they would be able to prove that they simply could not afford to pay for the care they needed when taken seriously ill.

The issue, then, is not whether there is a problem but rather how to meet the problem.

TWO APPROACHES

Representative Aime Forand, Democrat, of Rhode Island, has proposed to deal with it through a system of compulsory Federal insurance within the framework of the Social Security Act. The Forand bill would provide insurance covering 60 days of hospital care, or 120 days of combined hospital and nursing home care, together with surgical services, to all those eligible for old-age insurance benefits. It would be financed, initially, by boosting social

security payroll taxes one-half percent, divided equally between employees and employers.

The Forand bill has been attacked for a number of reasons by various groups, especially the American Medical Association, which sees it as the camel's nose of socialized medicine coming under the tent.

But the main weakness of the Forand bill, as specialists in the health field see it, is not that it does too much but too little. They condemn it as too narrow and as an encouragement to "hospitalitis"—the tendency, inherent in many of our present voluntary insurance programs, to put the sick into hospitals because there are no provisions for covering treatment at home or in doctors' offices.

The bill sponsored by Senator Javits, Republican, of New York, strikes at this weakness. As Javits points out, though hospitalization costs comprise a large part of an aged person's annual medical bill, the average older couple spends $140 a year on health costs unrelated to hospitalization. "One out of every six persons 65 years and older," says Javits, "pays over $500 in medical bills annually." Yet 60 percent of the old people have annual incomes under $1,000 and can't afford home or office care that might cut down the length of hospitalization or eliminate it altogether.

Javits would deal with the problem by a voluntary program that would combine Federal and State subsidies, contributions scaled to income by the aged themselves, and both commercial and nonprofit insurance companies such as Blue Cross and Blue Shield. The program would not become operative in any State until the State put up the money, arranged with the insurance carriers, and agreed to certain standards for the program.

Although the Javits bill makes a hard effort to provide a voluntary—and heavily subsidized—program, it does not appear to meet the test of practicality. The program would take a very long time to negotiate with 50 individual State governments and with the insurance carriers—assuming that it would be possible at all to get them involved in a program whose costs are unpredictable.

Indeed, after studying Flemming's able report, and the arguments on all sides of this issue, we are forced to conclude that the voluntary approach simply will not do the job.

The problem basically is that the aged are high-cost, high-risk, low-income customers. Their health needs can be met only by themselves when they are young or by other younger people who are still working. The only way to handle their health problem, therefore, is to spread the risks and costs widely. And that can best be done through the social security system to which employers and employees contribute regularly. By comparison with the heavily subsidized schemes, this approach has the advantage of keeping old people from feeling that they are beggars living off society's handouts.

We do not pretend to know all the answers to the problem of enlarging the social security system to include a health insurance program for the aged. Even a modest study of the problem immediately convinces anyone of its difficulty and complexity. At this point, we don't think that the complete answer to it has emerged.

Nevertheless, no democratic government can refuse to grapple with a problem of such demonstrated urgency and importance. The issue cannot be evaded and, before it becomes a political football, the politicians of both parties should accept responsibility for finding the best possible answer in the shortest possible time.

Senator DOUGLAS. Mr. Chairman, could I interrupt for a minute? Am I correct in the understanding that Gov. Nelson Rockefeller of New York has endorsed the principle of caring for the aged through the principal of social security rather than Government grants?

Mr. CRUIKSHANK. That is correct, Senator, he has in very emphatic terms. And on that point I was about to remark that just yesterday, a resolution was passed by the conference of State Governors by a vote of 30 to 13 supporting this principle. It is very significant action taken by the Governors, I believe, because a resolution was introduced in their conference out at Glacier National Park that first called just for a recognition of the need. This resolution

in the course of discussion was amended to provide for meeting this need through the social insurance mechanism, and this amendment was adopted, and then the final resolution, with the amendment, was adopted by a vote of 30 to 13, and those 30 include the Governors from States whose total population is the vast majority of the population of the United States.

Senator GORE. Were there any abstentations, or do you know?

Mr. CRUIKSHANK. There must have been some not there or not voting, I don't know really. The total vote was 43, so I don't know whether there were registered absentions or whether there were just merely people who were not there to vote.

Senator GORE. Those things can occur at a convention.

Mr. CRUIKSHANK. Yes, but at the Governors conference, as you know, they cannot take a position other than by a two-third vote. When they take a position with respect to a proposal or principle of this kind, it is done quite consciously and they don't take many positions on current legislation partly because of the two-thirds rule that they have, but it must be two-thirds of those present and voting because this resolution was passed. It will be available later, I believe, for inclusion in the record, if the committee would care to have it.

Now within the framework of social insurance there are various possible approaches that can be followed. Social insurance does not mean just one rigid plan, of course. Now we in the AFL–CIO, as is well known have supported the Forand bill ever since its first introduction nearly 3 years ago now.

We regret that the majority of the members of the Ways and Means Committee voted against its inclusion in the House bill but I should like to point out the inherent advantages that there are in the social insurance approach.

In the first place, of course, this meets this problem of whether you just take care of the needy or those who are not immediately in need, because in a sense it insures against the likelihood of your being in need, and this has been a principle of our social insurance program adopted 25 years ago.

And you don't have to wait until a man is in need before the program comes into effect, and it also meets the very practical problem that a person can very well get into a position of need during the course of a long illness, and the long illness itself can contribute to this need. He can start out with what may appear to be a minor illness, and be in a fairly safe position, at least a solvent position financially, but as it goes on, his resources are drained, and his income is cut off, and he finds himself threatened by it.

This threat of becoming an indigent can also even contribute to his physical condition. So that the insurance approach meets the problem of taking care of all those who are in need as well as those providing insurance against the likelihood of their being in need.

Now, after retirement or for mothers after the husband's death, there would be no annual contribution or enrollment fee. In other words, at the time people have their incomes greatly reduced after retirement, there would be no additional economic burden on them under the insurance approach.

Thirdly, lasting protection would be provided which could not be canceled or lost because of nonpayment of premiums or the application of lifetime ceilings. That is a provision which is so predominant in commercial insurance protection.

The Federal OASDI program can provide almost universal coverage and of course this is very important in any insurance approach. There is no adverse selection. You do not, under the Federal system, get those who are already ill, or about to be ill, rushing to cover themselves with insurance which, of course, under any other systems, means you have to have high premiums because you are covering a high risk group.

So the social insurance provision has this inherent advantage.

Now as to the question of whether or not it is compulsory or voluntary, really that gets down to be a pretty serious exercise in semantics. The administration program and the House bill have been described as voluntary because no one would have to take out a particular type of insurance, but actually the compulsory feature of a social insurance program is only confined to the payment of the social security tax. There is nothing compulsory about whether or not they avail themselves of the services that are available. Now, in that sense the payment of the contribution is compulsory under a social insurance approach. It is equally compulsory under the administration program or under the House bill, because my experience has been there is nothing of a less voluntary nature than the payment of my Federal income tax or any other Federal taxes. So if you are going to finance this out of the general revenues of government as the House bill proposes, or as the administration proposal envisages, the payment is going to be compulsory in any event, and just as compulsory as the social security tax is compulsory.

Senator GORE. Mr. Chairman, might I ask a question?

The CHAIRMAN. Senator Gore.

Senator GORE. Mr. Cruikshank, would not that apply equally to the requirement of an enrollment fee for a period of time?

Mr. CRUIKSHANK. No, sir, not quite.

Senator GORE. Well, the——

Mr. CRUIKSHANK. Because the enrollment fee would be only for those who would choose to go under the system.

Senator GORE. But it is compulsory for anyone who receives any benefit.

Mr. CRUIKSHANK. Compulsory on any one who avails himself of the benefits, that is right, and failure to pay the enrollment fee would disqualify him for benefits, so you are correct. If he has the benefit of the program, the $24 enrollment fee would be compulsory, yes, sir.

Senator GORE. Well, isn't this a battle of words that is somewhat——

Mr. CRUIKSHANK. It appears to us that it is, and compulsory has been chosen as a word of stigma and yet in many other ways it is not.

We have compulsory selective service under which men serve their country in the Armed Forces. We have compulsory education and I don't think anybody is against that.

It seems to me compulsory participation in a program of mutual self-protection is in the same category.

Senator GORE. Well, if a program for health care and hospitalization is to be condemned because of that, would not the social security program logically fall for the same reason?

Mr. CRUIKSHANK. Precisely, yes indeed it would, and this was, as you will recall, Senator, although I don't believe you were in the Senate at the time, but this was an issue that was fought out in the Congress just 25 years ago. The Clark amendment proposed that there would be an electing out procedure under the social security legislation, and it was determined that any effective system of protection would have to be compulsory, that is universal in coverage, if it was to be effective at all.

Senator GORE. Well, you are right, I had not reached here by then but I assure you, I am thinking about it.

Senator CURTIS. Were you thinking about the Clark amendment, is that your evidence? [Laughter.]

Mr. CRUIKSHANK. There are many important social effects that would flow from the enactment of a bill affecting health benefits under the OASDI. One, it would ease the financial burden of hospitals by providing payment for the care that now they must give to charity cases.

Second, it would greatly strengthen the private and voluntary health insurance programs such as Blue Cross because it would relieve them of the very highest risk and high-rated group which now they must carry in some way.

Blue Cross has been forced away from its community-rating provisions, which it had when it started, to an experience-rated standard, so that they have to apply rates according to the risk of the group covered. This means that when Blue Cross extends its coverage to any of the older group, because they are a high-risk group, they must up the rates to the point where it is almost prohibitive.

Senator CURTIS. Mr. Chairman, could I interrupt at that point?

Medical costs are high because it takes a lot of money to run a hospital, rare and expensive drugs, pay help, all of these things. Why is it that you contend that the Government can get that at less cost than private groups?

Mr. CRUIKSHANK. Senator, I don't maintain it can get it at less cost. I maintain that it can get it at lower fees.

Senator CURTIS. Now that is because the people who are producing pay it for those who receive it, is that right?

Mr. CRUIKSHANK. That is right, sir. At any given time.

Senator CURTIS. You have in here, "Unlike public assistance, the Federal program pays," and I assume you are talking about a proposed health program "pays benefits as a matter of right without a means test."

Mr. CRUIKSHANK. Yes.

Senator CURTIS. You do not propose to pay those hospitals less than the cost of operation, do you?

Mr. CRUIKSHANK. No, sir.

Senator CURTIS. But you propose a different method of paying.

Mr. CRUIKSHANK. That is correct, Senator.

Senator CURTIS. And that would be a compulsory tax.

Mr. CRUIKSHANK. That would, out of the social security tax or some similar tax.

Senator CURTIS. And everybody in retirement regardless of income or property owned would get the benefits.

Mr. CRUIKSHANK. That is correct; yes, sir.

Senator CURTIS. Does that mean, for instance, that a young individual, paying his own medical bills and that for his family, buying a home, and perhaps paying some college expenses, will have a payroll deduction to pay the costs of medical care for people who happen to be over 65 even though they are individuals of great wealth and still able, some of them, and desirous of producing?

Mr. CRUIKSHANK. There might be some such instances, yes, just as with other insurance systems. A person paying in his premiums in Blue Cross, for example, at the time he is not making any claims—and he may not make any claims for 5 or 10 years—is paying the hospital expenses of somebody else who carries Blue Cross regardless of whether they are wealthy or in poverty.

Senator FREAR. But the great difference being voluntary and involuntary, isn't it?

Mr. CRUIKSHANK. No, I don't think that is the great difference, sir, because a large part of Blue Cross is group coverage which is selected by a vote of groups covered, and those who are in the minority are covered whether or not they voted for it.

That is it isn't an individual choice in Blue Cross in all cases. In some cases it is, and in other cases it is not, it is a group choice.

Senator FREAR. But under this proposal there is no choice by anyone?

Mr. CRUIKSHANK. There is no choice as to whether he pays the contribution or not, that is right.

Senator CURTIS. Mr. Cruikshank——

Mr. CRUIKSHANK. If I may interrupt for just a moment, I am only pointing out this operates just like any other insurance. A person paying a current premium is paying a benefit for somebody else currently and thereby of course establishing his right to the benefit when the contingency against which he is insured arises.

Senator FREAR. Yes, sir, but again I say that individual has his choice of whether he wants to or he doesn't want to. Aren't you taking a right away from an individual in this instance?

Mr. CRUIKSHANK. No, sir, I don't think we are. I think that we are proposing just to extend the social security principle. You are not taking away anyone's right, I don't think to insure against a contingency of dependent old age and that is compulsory and he is required to do it.

Senator FREAR. I respect your views but maintain mine. [Laughter.]

Senator CURTIS. I would think we would all agree that diabetes is a very expensive continuing illness. According to your views a lady might be a diabetic patient, still working, perhaps supporting some children, and it is a type of illness that requires cash to be paid out out week after week in order to live. You are suggesting a further deduction from her pay to pay medical benefits to people who happen to be over 65 regardless of their wealth or ability to pay for themselves.

Doesn't your program amount to that?

Mr. CRUIKSHANK. Yes, it amounts to that but if she is in any voluntary group she does exactly the same thing.

Anybody who works in a shop, for example, that has negotiated a health insurance plan with the employer covering health contingencies, is doing exactly the same thing, because, Senator, that very same lady that you described may find herself in a condition later on where she is no longer able to work and she would then be able to collect a benefit and have protection.

Senator CURTIS. She might find herself in that position for 50 years while she is carrying the load to care for this select few. Do you at the present time favor the Forand bill?

Mr. CRUIKSHANK. Yes, sir.

Senator CURTIS. You state here you suggest benefits for those already retired. Suppose those who are beyond the employable stage are not the beneficiaries of OASI. The Forand bill would not do anything for them, would it?

Mr. CRUIKSHANK. Not in itself but other proposals that we support would.

Senator CURTIS. In other words, all of these millions of people working would have a further deduction out of their pay envelope to pay part of our present aged some of whom, I don't know how many, don't need it at all, but the individual retired, and there are several million of them, who are not by chance OAI beneficiaries would be left out under the Forand bill, if we enacted it tomorrow, isn't that correct?

Mr. CRUIKSHANK. Well, they would be left out of those particular provisions, yes, sir, but they would be eligible for other types of protection. What we are proposing——

Senator CURTIS. I have known you a long time, and I know how well you know this social security law, and I am utterly astounded at your lack of altruism in your proposal.

Senator DOUGLAS. Now, Mr. Chairman, may I interject by——

Senator CURTIS. Should we act to tax those who can be taxed to take care of those who can't care for themselves? Do your proposals here abandon those?

Mr. CRUIKSHANK. No, sir, it does not, because what we are really proposing is that a Forand-type amendment, if you wish to call it that, be added to the provisions of title VI. Let title VI operate, and take care of these people, who are not under the social security system, in the only way that they can be taken care of. The public assistance approach has always been our second line of defense.

Now I think there is one other point we need to get at, if I may, that while not everyone at any moment needs health care, I think it is generally accepted in this country that everyone at all times needs health insurance.

So that the person who is paying this contribution is not paying for something for nothing, he is not paying something for which he gets nothing. He gets the protection which the insurance affords him, and he has that all the time.

Senator CURTIS. I disagree with the loose manner which you use the word "insurance" but the committee is too busy for us to debate that. But if you are suggesting title VI plus the Forand bill, then

these people I talked about, the individual below 65 who suffers from an illness all his years, or the individual whose income is low and is supporting a family and buying a home and doing all these other things, he has not one tax taken out of his payroll. He has two, one to support title VI and one to support the Forand bill.

Mr. CRUIKSHANK. Except that the cost of title VI would be greatly reduced by the extension of the social security principle, just as Dr. Larson pointed out, for example, in his testimony, that we had reduced public assistance from 22 percent down to 15 percent of the people. How did we do that, we did that because beginning in 1950, which was the base year that he presented, we greatly extended social insurance, and social insurance has absorbed a large part of the load which otherwise was public assistance.

Senator CURTIS. Well, that is part of it.

Mr. CRUIKSHANK. It's part of it. It is a major part, I believe, sir.

Senator CURTIS. Some of them die without ever getting the benefit, yet they purchased the necessities of life in an economy that was carrying the load of social security, and I do not feel this sort of an approach is meeting what the American public has in mind.

We are not thinking about the extreme destitute because we are committed to paying for those cases and we want to. They are thinking about what need is there beyond it, not in terms of taxing everybody, including those that it will be an extreme hardship upon, to give a benefit to people who do not want it. Together goes with it the defeat and suppression of private endeavors and voluntary endeavors and the surrender of the right of choice for many people. In reference to these people who are beneficiaries of OASI, when did the first ones qualify for benefits?

Mr. CRUIKSHANK. I believe 1940.

Senator CURTIS. 1940.

Suppose an individual, qualified for OASI benefits in 1940, and we will assume that he has not made or paid any social security taxes since then, how many raises has he received in benefits since 1940?

Mr. CRUIKSHANK. I don't know exactly how many but his average payment in 1940 was $22.60 and his average payment now is around $55.

Senator CURTIS. The difference between 22 and 55, did he ever pay any tax for it?

Mr. CRUIKSHANK. No, sir.

Senator CURTIS. Why are you denying the people outside the system in your Forand proposal which you propose, the benefits of this when you take the person who by happenstance retired in 1940, probably paid less than 1 month's benefits out of his payroll, in all probability paid less than 3 months' benefits if you count his employers' payments which are not credited to him. You have increased him on an average, more than doubled it, and now you are going to give him this. The individual who has been outside you now come here and say "He will still be outside of the medical benefits."

Mr. CRUIKSHANK. No, sir; they will be outside this particular method of paying for the benefits. But what you say, sir, is true of the whole social security system.

You can disagree with that whole social security system if you wish.

Senator CURTIS. No, no. All I have begged you people to change, to make it social, to make it humane, to make it fair.

Mr. CRUIKSHANK. We have tried to do that, sir, we have supported the extension.

Senator CURTIS. You have resisted it every time.

Mr. CRUIKSHANK. We have supported—the extension of coverage has meant payments out of relationship to an immediate payment of contributions which comes out of the pool which is created largely by taxes on industrial payrolls. Despite that we have argued for it, for the extension of coverage.

Senator CURTIS. That is true of everybody's benefits.

Mr. CRUIKSHANK. Yes, up to a certain point it is.

Senator CURTIS. Yes, the social security operates today because you are taxing the people who are working to take care of the people who are not, isn't that true?

Mr. CRUIKSHANK. That is true, but it is also true that every life insurance company today is paying its benefits out of its current premiums.

It operates exactly the same way.

Senator CURTIS. It is far, far different, and as I say, the time of this committee is too valuable to debate whether or not it is insurance. That is all, Mr. Chairman.

Senator DOUGLAS. Mr. Chairman, I would like to ask Mr. Cruikshank if it is not true that the vast majority of younger workers who pay in contributions have parents and grandparents over the age of 65 who are in need of hospitalization, nursing, and medical attention, and who, if these expenses were not met by some form would have to be borne in the main by these younger workers?

Mr. CRUIKSHANK. That is exactly true, and the question really is, when we challenge this program on the ground that it would mean that current workers are paying the bills of people who are over 65, who is paying them now? They are paying them now. It isn't the people that are beyond 65 who are in the hospital or needing medical care who are currently paying for these costs. To a very large extent they are paid by the younger children and often at very great family sacrifice. The choice often comes as to whether you properly take care of mother and father or whether you properly educate your children and this is a hard, cruel choice that is forced on many American families, and one which the social insurance mechanism would relieve them of.

I would like to point out that one of the real advantages of this approach is that it would strengthen the voluntary plans and enable them to grow. We have a witness to that, Dr. Basil C. McLean, who is the recently retired head of the national Blue Cross Association. He said and I quote, "Legislation along the lines of the Forand bill offers a means settling an area of difficulty and relieving the voluntary prepayment mechanism to concentrate on better programs within its areas of demonstrated competence."

Commercial insurance companies would still have an ample field of activity since they would be used to supplement a Government program just as life insurance and annuities have been purchased to supplement monthly cash benefits of social security.

Some people saw 25 years ago that or thought they saw the end of private commercial insurance in the life insurance field if social security were passed. But the total amount of life insurance in force today is a little over five times as much as it was when social security was passed.

As people get insurance conscious, whether it is in the health insurance field or the life insurance field they want to build more on their insurance rather than less once the basic needs are met.

Senator DOUGLAS. Hasn't that also happened in the development of private pension plans and the sale of annuities by life insurance companies?

Mr. CRUIKSHANK. That is quite true. There were very few scattered private pension plans in effect in 1935, and when the Social Security Act was passed, after that the private annuities and negotiated pension plans and those initiated by farsighted employers began to multiply so that today there is a hundredfold, at least, increase in the private pension plans.

There are a number of basic choices before anyone who wishes to approach this problem. You can have a very limited low-cost program, costing one-quarter percent of taxable payrolls, or an eighth of a percent each by employers and employees. Or an increase in the wage-base ceiling to $5,400, instead of $4,800, would produce an equal amount of revenue in the long run. An increase to $6,000 would produce a saving of one-half percent equivalent of one-half percent of payrolls in earlier years and 0.4 percent on a premium level basis. These are net savings, and with the funds thus obtained, it would be possible to pay very limited hospital benefits to all of the aged or, as another choice, more generous benefits to persons above the age of 68 or 72.

Now, you can start on that limited basis, conscious of the fact that these are costly programs in any event, however they are paid for, and start on an experimental basis. Or you can start on a broad spectrum of benefits, and say it is not only hospital, nursing home care, but doctor services at the home or the office, and home nursing services, diagnostic services, all those things which make a well-rounded health program, but the minute you do that, of course, you run into a much more costly program, and that is the choice that people have who are working on this kind of problem.

Now, the administration found a way out of this dilemma. It was the dilemma with which all students were confronted. We were confronted with it as we wrestled with it, talked about it with hospital administrators and with doctors and others, and with social security experts. The administration was confronted with it, and for over a year they wrestled with this problem. They found a way out and their way was to talk about a broad spectrum of benefits and list them—they call them the A to J benefits, 10 benefits, a really glittering array of hospital, home nursing, diagnostic, preventive, nursing home services, the works, everything—but then set them up under a mechanism such that very few people ever would be able to get them, a mechanism that would require not only action by the Congress, not only an appropriation by the Congress and signature by the President after approval by the Bureau of the Budget, assuming, Mr. Chairman, we have that approval, but then the adoption of this some pro-

gram by 50 State legislatures, each of which would have another veto. So there is a whole series of hurdles between the individual who is presumably covered and the actual receipt of the health benefits.

Now, this was a neat way out of a real dilemma, if it is a way out. It gets them out of the dilemma, but it does not help the old people who need medical care. You promise the works but under a mechanism that assures that your check will never have to be cashed.

Now, we just don't believe that that is dealing in a fair and square way with the problem. We think it is ducking the problem rather than really facing up to it.

Now, the bill for health care of the aged is going to be paid, we believe. That is, rich generous-hearted America is not going to ignore their needs. The whole question before this committee is how it is going to be done.

Families are not going to neglect their elder members, they are going to care for them to the limits of their ability, even though often at tragic cost to their younger members. It is precisely because health charges can be very heavy, and because you can never anticipate where they are going to fall or whom they are going to hit, that assured methods of payment through an insurance mechanism is the most practical approach.

It is partly because we believe that whatever Federal funds are available should be utilized most effectively that we object to costly administration by 50 separate State agencies and commercial insurance companies. We understand that Secretary Flemming himself told the House Ways and Means Committee that the per capita cost of administering his proposal would be $17 a year as compared with $6 under the Forand bill.

If the Secretary is worried about the regressive nature of the present payroll tax, as he indicated yesterday before this committee, he could join with us in raising the tax base from the present $4,800 to $6,000 or $9,000 or in removing it entirely as the late Prof. Sumner Slichter of Harvard University proposed. It is not difficult to introduce a substantial element of progressivity in the social security tax. But a payroll tax, even with the present overall earnings ceiling, is much less regressive, especially so far as retired people are concerned, than the sales taxes and other taxes on which States and localities rely for the major part of their revenues.

The Secretary's program would put half the cost on such regressive taxes.

The social insurance approach to health care of the aged can be based as the present program is on clearly defined contributions. As a matter of fact, better controls on costs are available under this mechanism than under the open end approach as authored by the administration or as built in to the House bill, because there is a commitment to meet whatever the States choose to do.

Now, it is perfectly possible to provide a separate fund for health benefits as in the case of the disability program. That was done, I believe, at the initiation of Senator Kerr, it was originally his suggestion in 1956, when criticisms of the disability proposal along the same lines that the Secretary made yesterday about an insurance approach to this were being offered, saying, "You never know how much it is going to cost, this would wreck the social security trust

fund. This could run us all into the red. It could be the end of our whole social security system." All right, Senator Kerr and his colleagues said, let's set it up as a separate fund, let's limit the liabilities of the fund to its assets. This was done, and now we find this was such a sound method of financing that we could eliminate the age provision and we can do as this committee and the Senate and the Congress concurred in 1958, in adding dependents to that. So that it is perfectly possible, in fact it is more possible, under this approach, to have the necessary fiscal controls on the problem than it is under the open end approach such as authored by the administration.

It seems to us that the administration proposal is fiscally irresponsible in this respect. In this regard, and Senator Douglas mentioned a moment ago, we recall Governor Rockefeller's criticism of the administration, he said, "while admirable in purpose," and we have agreed to that, "is basically unsound from a fiscal viewpoint." And I would suggest that Nelson Rockefeller knows something about the handling of money and is able to recognize a sound fiscal program.

Now, it is odd to us that this administration is constantly opposing programs—I understand today it is contemplating a veto of the raise for Government employees, because of the cost of around $700 million—but they come in with a program here with an open-end commitment around $600 million from the Federal Government, and say that is all right because the bill isn't going to come due until next year. It isn't in this year's budget, said Secretary Flemming, and so it is all right to commit ourselves to an open-end commitment of this kind.

Senator DOUGLAS. May I ask a question, Mr. Cruikshank. When you say the administration program is an open-end program I assume by that you mean there is no control over the ultimate costs?

Mr. CRUIKSHANK. That is correct.

Senator DOUGLAS. And whatever the ultimate costs would be you would have to have the States and the Federal Government meeting virtually seven-eighths of them?

Mr. CRUIKSHANK. That is correct; yes.

Now, we in the labor movement are confronted in this respect as we so often are with a practical choice, and we believe that what we are offering and what we espouse here is one that is fiscally responsible. I am proud of the fact that organized labor has never asked for an increase in coverage or in the amount of benefits under the social security system without proposing also the method of financing it on a sound long-term basis, and we are not proposing that this program, this extension of social security into a new type of protection be provided without also providing for the method of payment.

The whole social security system started on a relatively small start, it only covered about three-quarters of the workers in industry when it started, and now it is extended until it covers nine-tenths of the working people of the country. It has been built on, as Congress has had a chance to observe its practical operation. We believe there is the same situation here. If this bill can make a limited start, which admittedly doesn't meet all the problems and does not cover all the people, but makes a limited start, let Congress observe it, let the advisory committee study it and let them bring in their recommendations. If it starts to get out of hand it can be controlled and

it can be limited. If it proves sound, as the disability system has proven sound despite all the dire predictions, then we can build on this to meet some of the larger problems in some of the broader areas.

It is entirely feasible to work out a practical and sound program within the defined cost ceiling. For example, at a level premium cost of one-half of 1 percent of taxable payrolls, a plan can be developed which would make possible a good start for all beneficiaries 68 years of age and over. Payments could be made for up to 365 days of hospital care and subsequent skilled nursing home, recuperative care up to 180 days, and for visiting nursing service in the home. To provide these alternative forms of care, within this cost ceiling, two separate $75 deductible payments by the beneficiary would be necessary . Such a plan would be of enormous value in providing protection in long-continued illnesses without overloading hospitals.

We are informed that Senator Anderson and some of his associates are working out a proposal along these lines, designed to supplement the limited care provided in the House bill, with a basic plan of social insurance protection. The AFL–CIO will gladly support such a program and we hope this committee will incorporate it into the bill which is reported to the Senate.

There are other desirable features in H.R. 12580 which we approve. We regret they don't go further and we regret particularly that it doesn't do anything very substantial or anything really at all in the way of standards on unemployment compensation, and other provisions of the whole broad social security program that are so much needed.

The public assistance amendment included in the new title 16 are limited and we feel quite inadequate although they are a step in the right direction. But the great majority of aged should not have to turn to public assistance, whether it is dressed up in title 16 or in any other way, and an income test or a means test are not desirable as the basic form of protection. People do not want to have to swear to indigney, declare their resources, list relatives who might help them, and be subject to investigation, often by poorly trained and inexperienced people.

If the great majority of the aged can receive substantial protection as a matter of right through old-age, survivors, and disability insurance, the States and localities will be relieved of a tremendous financial responsibility which will otherwise increasingly overwhelm them. Without health benefits through social security, the House proposals for health care of the aged are like a roof without foundations. We urge your committee to add the foundations so that the aged may live out their lives constructively and with hope.

Mr. Chairman, and members, this concludes my prepared statement.

I should like, if I may, in addition to the editorials which I ask to be introduced and which you agreed to, to introduce two other things: an analysis dated April 12 of the Javits bill, S. 3350, and also ar analysis dated May 12, prepared by my department, of the administration plan. I would appreciate it, Mr. Chairman, if these could also be included in the record.

The CHAIRMAN. The insertions will be made.

Thank you very much, Mr. Cruikshank.
(The material referred to follows:)

STATEMENT OF NELSON CRUIKSHANK ON S. 3350, A HEALTH INSURANCE FOR THE AGED BILL, INTRODUCED APRIL 7, 1960, BY SENATOR JAVITS AND OTHERS

We have studied S. 3350, the health insurance for the aged bill, introduced last week by Senator Javits and several of his colleagues. The scope of benefits and the objectives described by Mr. Javits in introducing the bill are laudable. We have come to the conclusion, however, that the mechanisms provided in the bill cannot accomplish the fine things it aims to do.

1. State financing

We see virtually no possibility that each of the 50 States, many of which are already in substantial debt and financial difficulty, would raise the necessary funds to put this program into operation. By Senator Javits' own conservative estimate $640 million of State funds would be required.

There is no question but that the major legislative problem faced by the States today is that of raising funds to meet the growing needs for which the States have already assumed responsibility.

The States and localities are currently going deeper and deeper in debt. Between 1946 and 1958 their total debt increased from $16 billion to over $57 billion. By 1970, State and local outlays for programs to which the States and localities are already committed may well reach $85 billion—nearly twice the present level—according to projections of the National Bureau of Economic Research.

Most State tax structures already impose the heaviest burden on families least able to pay. Additional taxes would be most likely to take increasingly regressive forms.

2. Federal financing out of general revenues

The prospect of getting an appropriation of nearly half a billion dollars (again using Senator Javits' own estimate) out of general revenues for the health care of the aged, passed by Congress and signed by the President this year, is at best, remote.

3. Scope of benefits

Senator Javits' statement which accompanied the introduction of S. 3350 contained this hopeful description of benefits: "Generally, a 'service plan' would provide 60 days of full cost, semiprivate hospital care or the equivalent cost care in a nursing home for the aged and make satisfactory provision for surgery both in and out of the hospital, hospital medical care, visits to the doctor's office, along with necessary laboratory tests, diagnostic X-rays, specialist consultations, and visiting nurse service in the home."

There is nothing in the bill to justify such an optimistic view of the benefits which would be provided. The only benefit specifications which the bill contains are that each plan must provide outpatient care up to one-third of the premium cost, that coverage during an individual's temporary absence from the State must be included, and that plans of both the indemnity and the service variety must be offered in all of the States. This last provision is weakened by the qualification that service plans need only provide service benefits in part, with no limitation on how small the service part may be.

Thus, it is altogether possible that a plan could obtain approval to participate in the proposed program and receive Government subsidies under it while providing partial and inadequate indemnification for only a few of the services and only some of the care listed by Senator Javits.

4. Negotiations with carriers

The task set by S. 3350, for 50 State governments, to negotiate with a multitude of insurance carriers is not only formidable, it is most unlikely to be carried to a successful conclusion. Early this year, a crack task force of experts within the U.S. Civil Service Commission, trying valiantly to negotiate one similar program for far fewer people (U.S. Federal employees), was nearly overwhelmed by the complexity of the task.

The original authors of S. 3350 were perhaps not unaware of this difficulty, for the analysis which accompanies the bill states that "In instances where State cannot contract with a private carrier, State is permitted to provide the

coverage." At some stage, however, the provision of the bill to which this statement refers must have been deleted, for it can be found nowhere in the bill as introduced.

5. Income test

We cannot conceive of any way that the income test provided for in S. 3350 could be made to work with any degree of equity and some guarantee of the preservation of the dignity of the potential health plan subscriber. There is no indication in the bill as to whether it would be a State or Federal agency which would bear the responsibility of prying into the income of the elderly citizens of the Nation. The income test as proposed is clumsy and inequitable.

6. Use of commercial insurance carriers

Commercial insurance companies would be eligible, along with nonprofit health plans, to write Government subsidized health insurance for old people under this proposal. There is no evidence available to lead one to believe that a substantially greater part of the subsidy would go into benefits for old people than would go into insurance company profits.

Fifty years of practical experience in the field of workmen's compensation demonstrates that putting what is in essence a social insurance program in the hands of commercial carriers results in extravagance, waste, inefficiency, and deterioration of the basic purposes of the program. In 1958 employers in the United States paid $1,235 million to private insurance carriers to insure their risk under State workmen's compensation laws. In this same year the insurance carriers paid cash and medical benefits in the amount of $694,373,000; in other words, 56.2 cents out of every premium dollar went into benefits to injured workmen and their dependents that year.

The total benefits paid under all accident and sickness policies underwritten in the United States by commercial carriers in 1958 amounted to 71.2 cents out of each premium dollar. Under individual policies only 48.6 cents of each premium dollar went into benefits in 1958.

The record of commercial insurance carriers with individual noncancelable policies, to which the policies in the Javits bill would be most analogous, was even worse. Under these policies, during 1958, only 40.8 cents out of each premium dollar was paid in benefits.

We trust that the objective of Senator Javits and his colleagues who are cosponsors of S. 3350 is the same as ours: to find a way to lighten the financial burden of sickness in old age. We are dismayed that they should propose a route to this goal so circuitous that it cannot reach the goal at all.

There is a direct and workable method: the use of the social security system.

The use of the social security system would allow aged people to draw benefits as a simple matter of right, with their income or their poverty not at issue. The funds under a program like the Forand bill would go into health benefits for old people and not into insurance company profits. Financing would come from the contributions made by people during their working lives, with a matching contribution by employers. There would be no added financial burden on Federal or State Governments, or on the meager incomes of people who have retired.

The Forand bill would make it possible for voluntary insurance plans, both commercial and nonprofit, to grow and prosper by relieving them of a risk with which they cannot cope. It would provide health benefits to old people in an effective and economic way.

INHERENT DEFECTS OF THE TYPE OF HEALTH PLAN FOR THE AGED PROPOSED BY THE EISENHOWER ADMINISTRATION

The plan presented by Secretary of Health, Education, and Welfare Arthur S. Flemming to the House Ways and Means Committee on May 4 contains inherent shortcomings which cannot be overcome even by major modifications.

The executive council of the AFL–CIO on May 5 stated that "We are forced to conclude that this program has evidently been shaped to meet the political demands of an election year rather than the urgent needs of the aged." President Meany told the press that same day that his personal opinion was that the Flemming program would be worse than no bill at all.

The administration has not yet introduced a bill spelling out its proposal nor has it released to the public detailed information on its actual operation or cost. But enough is known to warrant conclusions on the serious disadvantages of this type of approach.

A. SHORTCOMINGS OF THE ADMINISTRATION PLAN

The major inherent defects are as follows:

1. The proposal rejects the most universal, economic, and dignified approach, namely the use of the old-age, survivors, and disability insurance system

Through social insurance, people can contribute during their working years and be assured benefits in their old age as a matter of right in whatever State they choose to live. After retirement, they need make no contribution.

2. The Federal Government abdicates its responsibilities to the aged by making the payment of any benefits completely dependent on action by each of 50 State legislatures and Governors

Even most of the decisions as to the nature of the program are left to the States, including, apparently, such important aspects as methods of assuring that individuals would actually get the benefits outlined, any minimum standards as to quality of care that would be paid for, any safeguards against excessive charges, and any regulation of the practices and profits of the commercial insurance companies involved.

Some $600 million or more of Federal funds would thus be made available to support State plans which could be highly inadequate and wasteful, with large sums going to subsidize commercial companies.

This abdication to the States flies in the face of known facts about the difficulties of securing effective and constructive State action. Many States are financially impoverished since they are having to meet ever-higher expenses for schools, health, and many other programs. Governor Rockefeller has undoubtedly expressed the views of many other State officials when he says that the administration plan could result in "a very serious fiscal situation, very high costs, and cumbersome administration."

Close to 60 percent of all State tax revenues come from regressive sales taxes levied on consumers, and the necessary $600 million of State funds would be largely raised through heavy levies on low-income people, including the aged themselves.

The AFL–CIO State labor organizations know from long experience the difficulties that they encounter in securing liberal social laws and adequate appropriations at the State level. The conservative elements which always oppose such legislation would either block any action or insist on the inclusion of damaging provisions directed toward the demands of the insurance industry rather than the needs of the aged.

3. The proposal would not in fact provide the real help that most aged persons require

The huge cash outlays that would have to be made by each before he could receive any benefits would mean that the majority of the aged who have incomes of $1,000 or less would not subscribe at all or would be forced to exist on still more meager budgets for food, rent, and other necessities. Only the aged who are on public assistance would not themselves have to make large payments before becoming entitled to benefits. The program is thus completely inadequate for the very group who must desire a constructive program, namely the people living independently on modest means who want security combined with dignity.

The financial barrier to seeking early, preventive care would remain. Medical costs would continue to be an ever-present threat and would in fact wipe out lifetime savings.

Some illustrations indicate the financial burden involved. A person with annual medical bills of $700 (and the Secretary indicated that 15 percent had average bills of this size) would have to pay more than half of this cost out of his own limited income.

Take the case of a widow over age 65 with an annual income of $880—which is the median income of all women over 65 with any money income at all. Let us assume she has a medical bill of $440—half of her annual income. Under the administration plan, she would have to pay herself $24 in enrollment fees for that year, plus $250 deductible, plus 20 percent of the remaining bill, or $38—a total of $312. Her total reimbursement would be only $152. She would have as net income for that year the sum of $568—less than $11 a week.

4. The proposal would not make benefits available as a matter of right but instead would require a yearly income test which is still uncertain in its content and inevitably confusing and inequitable in its application

Some persons with incomes just above $2,500 would not qualify while others with higher incomes would continue to be eligible for the subsidy once they had met the test. For elderly people not familiar with complicated forms, this type of requirement would lead to great confusion and anxiety. Millions of older people would thus suffer indignities, especially since Secretary Flemming contemplates that the program would be administered through the State welfare departments.

5. Administration would be costly and unnecessarily complicated, involving the use of at least 50 different State agencies as well as a Federal administrative agency, plus commercial insurance companies

As much as one-sixth of the total Federal-State appropriation might well be needed for administrative cost alone. This would mean an amount equal to one-third of the total Federal appropriation. Instead of utilizing the eligibility already established for old-age and survivors insurance benefits, the annual income test would in itself require a substantial staff if flagrant and widespread abuses were to be avoided.

In connection with the actual payment of claims by individuals, the State agencies and insurance companies would either have to have a large staff to substantiate evidence as to whether bills had actually been paid or would disburse huge sums without investigation.

6. The prospective use of commercial insurance carriers, both as agents under the State-run plan and as independent operators under the optional plan, introduces undesirable elements of many kinds

The AFL–CIO executive council stated: "52 years of experience in the field of workmen's compensation amply demonstrates that the use of commercial insurance in what is essentially a social insurance program is inefficient and extravagant. It inevitably results in channeling a large portion of the premium dollars away from the beneficiary and into the coffers of private insurance companies."

The administration proposal has apparently been shaped to meet the objectives of the commercial insurance carriers. It adopts one of their preferred patterns, namely major medical insurance, with a huge deductible amount and coinsurance. This is in contrast to the preferred policies of the leaders of the Blue Cross movement, who favor complete payment for early days of hospital care.

The possibility of overutilization of facilities should be avoided not by financial barriers, which keep people from receiving necessary care, but by hospital review committees and similar procedures which the leaders in the health professions already favor.

The administration proposal involves no Federal standards for commercial insurance companies, in spite of the wealth of evidence that State regulation has proved ineffective in protecting consumers from many abuses, such as cancellations, exclusion of persons with chronic ailments, excessive charges, and even loss of protection through bankruptcy.

7. The proposal is no more "voluntary" than use of the social insurance mechanism

As the New York Times editorial of May 10 points out, "the administration bill involves the same, but a less obvious, kind of compulsion. Taxpayers as a whole—including those not given protection—would be compelled to cover the costs of State and Federal subsidies."

Elderly persons themselves would have to pay taxes even though not protected in the State where they live or because of incomes above the level set. Younger persons would not be assured that when they reached age 65 they would get any benefits in the State in which they then resided.

Health benefits added to old-age and survivors insurance could be supplemented by private policies if the individual desired, just as present benefits are supplemented in many cases by annuities or life insurance. But the administration proposal would tend to impose the major medical approach, with its undesirable features, on the State programs and on Blue Cross. Thus, individuals would have a narrower choice, not a broader one, in terms of the type of protection available.

8. The wide variations in the State plans would create serious barriers to effective protection of the aged

Any State which attempted to finance and enforce an adequate program within the loose Federal framework provided would find itself at a competitive disadvantage in regard to taxes with States which had no programs at all or very poor ones. The very States which would receive a higher proportion of Federal assistance, because of their low per capita incomes, are often the same States which permit or encourage the movement of industries into their areas through the lure of low taxes. The higher income States, which would bear a larger portion of the Federal financial load, would receive proportionately less in return and encounter increasingly the contention of businessmen that they must reduce their taxes in order to retain and attract industry.

For the aged, the State-by-State approach would introduce great complexities and inefficiencies. It is by no means clear how a person who moved from one State to another within a year, or purchased medical services in the District of Columbia although living in Maryland or Virginia, would be assured of receiving full credit or repayment of the type theoretically promised. Difficulties and inefficiencies all too familiar in connection with unemployment compensation and public assistance would be accentuated under the administration proposal, with each State setting its own standards, if any, as to licensing requirements, maximum fees, and related specifications.

9. No provision is made for taxes to finance the Federal share

Under the Forand bill, sufficient funds are provided through the payroll tax as in other sections of the old-age, survivors, and disability program.

B. THE ALLEGED ADVANTAGES OF THE ADMINISTRATION PLAN

The above description of major shortcomings of the administration proposal is in itself a refutation of many of the arguments as to its advantages. Certain claims of Secretary Flemming and Vice President Nixon and others need further analysis.

1. The administration proposal does not "pinpoint the area of greatest need"

Unlike the Forand bill, it requires aged persons, with their low incomes, to pay large sums themselves before getting help with their medical bills. (See item 3 above.) Even Secretary Flemming estimates that only three-fourths of the theoretically eligible people not on public assistance would take advantage of the opportunity offered through paying the enrollment fee of $24 per person per year.

The Forand bill, as it now stands, would provide benefits to more aged persons in its first year of operation than would the Secretary's plan, according to his own estimates. For those on public assistance, the proposed use of the new system of benefits would result in less return per dollar expended insofar as the elderly themselves are concerned.

We understand that State welfare administrators oppose the Flemming proposal as a substitute for the social insurance approach.

An increasingly large proportion of older people will be entitled to old-age and survivors insurance benefits in the years ahead. A smaller and smaller proportion will be without such protection and, therefore, would need to have health protection furnished in some other way than through the inclusion of health benefits in the OASDI system.

Certain obvious steps can be taken immediately or in the near future to assist the one out of four aged persons who would not receive health benefits under H.R. 4700 as now written. About 1½ million of these persons are now covered under Government programs for their own employees, by the veterans' programs, or by the railroad retirement system. These groups could either have special legislation to provide them with health benefits or they could be included in the Forand type of bill, as the railroad unions have requested.

If health benefits are added to OASDI, the old-age assistance rolls will be reduced, since 700,000 of the old-age assistance recipients now also receive old-age benefits. In the years ahead an increasing proportion of the elderly would have their savings protected against heavy medical costs and not have to turn to public assistance at all.

For those who must turn to public assistance more effective methods of paying for health care are desirable. But Federal funds available for this purpose will be more effective if utilized in accordance with the recommendations of the

Advisory Council on Public Assistance than if used for the purchase of major medical insurance.

Another possible approach for those not already under any of the social insurance programs is to provide health benefits as a matter of right out of general revenues in a manner similar to that included in the McNamara bill, S. 3503.

2. If the Congress wishes to include a broader package of benefits in the legislation, additional types can be added to the Forand bill

The basic advantages of prepayment during working years and receiving benefits as a matter of right applies to any kind of benefit. In testimony before the Ways and Means Committee in July we indicated that it would be desirable to explore the possibility of adding outpatient diagnostic care and home-nursing care through a community agency.

3. The administration plan does not avoid the objections of those who fear that a Government program will mean "socialized medicine"

Like the Forand bill, it would require the use of fee schedules and negotiated rates. But instead of one Federal set agreed upon by each provider of service, there could theoretically be 50 different State schedules.

Actually, as the New York Times editorial points out, "under the Forand bill neither hospitals nor surgeons taking care of beneficiaries would be under Government control."

Senator FREAR. I would like to ask one question of Mr. Cruikshank.

I think you read a telegram or a statement made by the Governors, conference, and in it you said that recognition of need by States—was that a correct intrepretation?

Mr. CRUIKSHANK. If I said that, I think I was in error. What I meant was that the Governors now recognize the need to take action in this area.

Senator FREAR. Yes. Do you think that was meant that the Federal Government should take action in lieu of State action or action by Governors of different States?

Mr. CRUIKSHANK. Well, the resolution and the telegram, there were two actions from Glacier Park.

Senator FREAR. Yes.

Mr. CRUIKSHANK. Both asked the Federal Government to take action in this area.

Senator FREAR. Do you think that is a proper approach, and what I mean is to ask you this, do you think that the Governors of the States should ask the Federal Government to take action in this area when this, as the chief executives of their own States are or seem to be passing this problem on to the Federal Government when actually it is a part of each State?

Mr. CRUIKSHANK. Well, I think that the Governors are simply supporting the use of the social insurance mechanism here to meet this problem, and they are expressing a view with which I would agree, and I think many experts in social security would agree, and it was adopted as a basic policy in 1935 that these risks, the risks of old age are lifetime risks, and that they cannot be met by an insurance program on a State basis, that they are lifetime risks, with people moving all over the country, working in all parts of the country and that the only way that a social insurance mechanism can meet this is a Federal social insurance mechanism.

Now, I haven't read actually the telegram, but, while I have heard about their action it would indicate what they are supporting the social insurance approach to the problem.

Senator FREAR. You don't think, then, the Governors are shirking their responsibilities in taking care of the aged in their State in not proposing a plan in which the State in some form or another, either in conjunction with the Federal Government or on its own take care of its aged.

Mr. CRUIKSHANK. No, quite to the contrary, I think the Governors are making a deliberate decision as to what they consider an appropriate Federal function as against an appropriate State function.

Senator FREAR. In other words, it is your opinion then that the Governors have said this is purely a Federal function and is without the realm of the chief executives of the several States?

Mr. CRUIKSHANK. I don't believe I could quite interpret it that far. I don't think they have said this is purely a Federal function. I think they said, in fact I know they said, that the best mechanism meeting this, the major part of the problem, is through the social insurance mechanism which only the Federal Government can operate.

Now, they have a lot of the problem still with them, and they will have a considerable part of the problem still with them if our proposal is adopted, and I think they are prepared to carry that part of the problem under a Federal-State setup.

Senator FREAR. I think that is true, because if I understood your proposal correctly, those who are not covered by social security would not be protected.

Mr. CRUIKSHANK. Well, they would have the Federal-State protection as proposed now in the House bill.

Senator FREAR. What is Federal-State protection, is that a joint enterprise?

Mr. CRUIKSHANK. Yes, sir, just as public assistance is, sir.

Senator FREAR. Just as old age assistance is?

Mr. CRUIKSHANK. Yes, sir; that is correct.

Senator FREAR. Do you think that that is worked fairly satisfactorily?

Mr. CRUIKSHANK. I think it has worked quite satisfactorily on the whole. We certainly have made a great deal of progress from the days of the county courthouse, but we have always recognized, and I think that the Governors, and I think the States and the welfare people in the States have recognized, that since 1935 our national policy has been that the first line of protection is our social insurance system.

Now, they have always understood there would be some people who would fall between the meshes of this net and that you need a second line of protection. There will always be some people out of the social security system, whether it is a health system or whether it is an old-age, survivors and disability system. From the first, title I of the Social Security Act was a joint Federal-State old-age assistance program which would catch those people who fell through the meshes of the net of social insurance.

So if this provision of social insurance could be added to the provisions of the present House bill, it would be consistent with what Congress has done for the last 25 years: make its first line of defense its insurance system, its second line of defense a public assistance system shared by the State and the Federal Governments.

Senator FREAR. Well, you are giving me a pretty broad explanation that I really didn't ask for, but I am glad to have it. However, I

think, this is a personal point of view, I have a great admiration for those who want to protect and care for the aged, and especially the ill who are aged or the aged who are ill, and I am sympathetic with that type of program, although basically I feel as though the States, in their rights, should not ignore their responsibilities, and certainly one of the responsibilities of the States should be the protection and care of the aged. I, therefore, think we should not generate this into a purely Federal program but it should be a cooperative deal. As a matter of fact, I would be much happier if it were purely State, but I recognize the difficulties of that. But I do think the States should not give up their responsibility in the protection and care of these indigents and aged. Therefore, I feel as though they should have a part in it and the only way for them to have a part and to be responsible is to have a financial part.

Mr. CRUIKSHANK. Well, I don't think that the position of the Governors is one of abdicating their State responsibility.

Senator FREAR. Yes, abdicating you said?

Mr. CRUIKSHANK. Abdicating.

Senator FREAR. Yes, that is right.

The CHAIRMAN. Thank you very much.

Mr. CRUIKSHANK. Thank you, sir, and thank you, gentlemen.

Senator DOUGLAS. May I ask a question?

Mr. Cruikshank, I want to thank you for your very able testimony. There are two or three questions, however, that I should like to ask. The first is, is it not more desirable to have ample provision for nursing in the home for the aged than too much emphasis on hospital care? Is not the health problem of a great many of the aged a type of senility, which does not require hospital care, where, with practical nursing, or with supervised skilled nursing, the ordinary needs of the aged persons can be met in the home itself? If these benefits are not provided, but hospital benefits are, the tendency will be for the aged senile to go into the hospitals and to stay there. Will not the hospitals therefore become more or less warehouses for the aged senile? So the question I should like to raise is really this, Should we not develop the nursing in the home provision more fully than in the Forand bill because in the Forand bill I believe it is left out completely?

Mr. CRUIKSHANK. That is correct.

Senator DOUGLAS. And it seems to be somewhat skimped in your testimony where you provide, you say, "payment would be made up to 365 days of hospital care and subsequent skilled nursing home recuperative care for 180 days, for visiting nurses services in the home."

Now, in the shadings of emphasis, shouldn't we give a good deal of emphasis for nursing in the home even though we may provide the full provisions for hospital care?

Mr. CRUIKSHANK. I think that is a very sound position Senator.

In effect, you are doing that, I believe when you put in these two deductibles. You are in a sense thus discounting hospitalization, although, of course, we always have to remember that the decision to go to a hospital is not the inividual's decision. He can only go when his doctor sends him to the hospital, and doctors try, I am sure, to make that decision on a strictly medical basis, but doctors are human, too, and when they see a person who is in need of care, and there is not

proper care in the home, the doctor probably has a great deal of emotional pressure on him to send the person to the hospital.

Senator DOUGLAS. Exactly.

Mr. CRUIKSHANK. If there were home nursing services available and a method of paying for them such as we are proposing here, that doctor would not have that hard choice to make. Consequently, you could not only meet the humanitarian and social need here, you could meet part of your economic need. You can take care of a person at a home with a minimum home nursing service, at a fraction of the cost of what it needs to maintain him at an expensive hospital.

Senator DOUGLAS. I am very glad that you say that, Mr. Cruikshank, I am sure you have taken part in informal conversations about the drafting of the proper bill, and I would like to register my own very deep concern that adequate provisions be made for home nursing and also that if necessary to finance this, we could cut down somewhat on the amount of hospital care.

Mr. CRUIKSHANK. Yes, I think so. Actually, the nursing home services are a very small part of the financing those that could be provided under community visiting nurses associations, the cost estimate is one one-hundreth of 1 percent of payroll.

Senator DOUGLAS. Well, I don't mean to have merely visiting nurses, but practical nursing from people who come in for an hour or so a day, to help fix up the old person.

Mr. CRUIKSHANK. Yes, I think they should be under the supervision if they are practical nurses, of registered nurses and doctors.

Senator DOUGLAS. That is quite all right. But there is such a thing as overprofessionalizing the service, too, because you run up the costs under those conditions.

Mr. CRUIKSHANK. Yes, but we wouldn't want to be paying for poor medical care in any event.

Senator DOUGLAS. I am not proposing that we swamp the profession with Sarah Gants, but I do think that practical nursing has a distinct place.

Mr. CRUIKSHANK. Yes, I think this can be worked out, Senator.

Senator DOUGLAS. There is one final question. You say that you can have the social security approach used which would cover approximately 11½ million of the 16 million over the age of 65.

Mr. CRUIKSHANK. A little more than that. It would cover nearer 12½ million.

Senator DOUGLAS. 12½ million.

And those on public assistance could be covered under the title 6 of the House bill. That would be 1.8 million?

Mr. CRUIKSHANK. Roughly that; yes, sir. And then you would cover the railroad people in the——

Senator DOUGLAS. There is an intermediate group of people who are not on public assistance and not under social security. These are mostly the professional people who were not covered prior to the 1950 act, and who have limited incomes, who would never under any conditions submit themselves to the means test. Should there not be some intermediate method for caring for them? I though that one of the great merits of the McNamara bill was that it did include these people who number approximately, as I remember it, 1.3 million.

Mr. CRUIKSHANK. Yes; roughly that.

Well, there are various devices, of course, in which this problem can be met. Our immediate proposal is that with the addition of this, to which could very readily be added the railroad coverage, this proposal to the present House bill, I think you fill all the chinks in by one device or another.

Senator DOUGLAS. Well, but you still have a very large number of people who are not under social security, not under old age assistance, but who are in a zone of need.

Mr. CRUIKSHANK. Yes. You can meet them under the mechanism of the social security, but I don't think they should be charged to the trust fund.

Senator DOUGLAS. I agree with you.

Mr. CRUIKSHANK. The Federal Government, the mechanism of social security——

Senator DOUGLAS. Could you not provide a plan such as that which Senator McNamara proposes where these could be provided by Federal grant?

Mr. CRUIKSHANK. Yes; that is what I mean.

Senator DOUGLAS. Along the lines of the administration's plan?

Mr. CRUIKSHANK. Yes, or the House bill.

Senator DOUGLAS. Yes.

Mr. CRUIKSHANK. Any of these variants, and when you take out, say, the Government employees, which are a large group that are not in social security, and you take out the railroad groups, you have reduced that to a pretty small figure. There is now before the Congress a provision to provide care like this for the Government employees, and it would be very simple to amend the Railroad Retirement Act, to integrate that with the proposal your committee would bring out, to reduce that to a minimum. The minimum is very important, if you are one person who happens to be in that minimum. But that can be done as the McNamara bill proposes by bringing them in and making a payment out of grants by the Government to cover it.

Senator DOUGLAS. Thank you very much, and I want to congratulate you on the testimony.

Mr. CRUIKSHANK. Thank you, sir.

Senator HARTKE. Mr. Chairman, may I be permitted to ask a question or two.

The CHAIRMAN. Yes, sir.

Senator HARTKE. Thank you.

I would like to ask you, Mr. Cruikshank, as I understand it you represent wage earners; isn't that right?

Mr. CRUIKSHANK. Our members are mostly wage earners: yes, sir.

Senator HARTKE. And generally speaking, Secretary Flemming contends that the social security approach is detrimental to the wage earner's best interests, and he claims that the Federal-State approach would place the Federal cost onto a progressive tax base, rather than onto, as he claims, those people who are less able to support it, the wage earner.

I would like for you to comment, not at length, but on this contention of the Secretary of Health, Education, and Welfare.

Mr. CRUIKSHANK. I am surprised that the Secretary takes a position that you describe, because he administers this program and he

must know the history of this, that the wage earners themselves have been the first to say that this is the mechanism which we prefer. It is strange to us that the people who object to the payroll tax are not the people who pay it. Somebody is always coming in to protect our membership, our people against paying a tax which they themselves want to pay.

I think that when it was proposed back in 1953 that the social security contribution rate be held down to 1 percent, which it was at that time, and the scheduled rate which was then in the law, not be allowed to go into effect, there was one of the greatest outpourings of mail and telegrams from the very people who have been affected, saying, "Please allow this increase to go into effect." Working people know that money doesn't grow on bushes and if they want a sound insurance program that is soundly underwritten, they are going to have to pay their share of it, and they are the people who are wanting to extend this type of protection to the health bill, or to their health problem, so not only is there no objection on their part, there is an acceptance of this mechanism. They want it and they are willing to pay for it.

Senator HARTKE. Let me ask you another question.

The Secretary also contends that the administration proposal includes physicians' fees whereas most of the other proposals do not. Would you comment on the absence of the physicians' fees, and do you think it should be included in any bill?

Mr. CRUICKSHANK. Well, that, again, is something which we are confronted with. You can have this broad spectrum of benefits, you can cover everything you want to and every time you do you raise the costs, and the Secretary's proposal really in one way does not include the physicians' fees, anyway. It only authorizes States to pass appropriations which can include physicians' fees. That is they may or may not be included.

But we feel that it is a sounder approach to do just what Congress has been doing for 25 years, to start with a manageable part of this problem, explore it, develop our administrative techniques and expertise, see how it works and not try to bite off a whole thing at once. Take the things that are of the most urgent need and are manageable in size, undertake those, and see how we make out, and then let Congress look at it in another year or 2 years and see how this program is going. Services of the physician in the home and office are an important part of a health program. But they are not included in our proposal because we are just not consciously covering the whole thing. We are trying to take a manageable part of it and see how we make out with it.

Senator HARTKE. May I ask you this, sir, what about a separate fund not connected with the social security fund, would you care to comment upon such a proposal?

Mr. CRUIKSHANK. Well, I think it has distinct advantages. It would still permit you to use the social security mechanism. We did that with disability, and it has proven to have some advantages and I think it might be very well to have a separate fund in which the administrators of the program had to cut their cloth to the income of the funds, and they could not commit themselves beyond the income of the fund. I think it might have definite advantages in keeping the

public and Congress informed in clear bookkeeping, a simple way of just what this was costing, just what the income of this was without intermingling it with any other fund. I think there might be real advantages to this.

Senator HARTKE. Let me ask you this, Mr. Cruikshank, in regard to health care for the aged, even though it be charitable, somebody has to pay that bill; isn't that true?

Mr. CRUIKSHANK. Yes, sir.

Senator HARTKE. And the only way that you can cut down on the cost is to cut down on the care?

Mr. CRUIKSHANK. That is right.

Senator HARTKE. And the substance of this is for about 16 million people today that society, in one form or another, not Government, but society, is not providing for medical care and saving itself part of the cost.

Mr. CRUIKSHANK. That is correct.

Senator HARTKE. And——

Mr. CRUIKSHANK. At the cost of the old people themselves.

Senator HARTKE. At the cost of the old people in their minds as well as in their physical well-being.

Mr. CRUIKSHANK. That is correct, yes, sir.

Senator HARTKE. And that is why the Secretary, along with everyone else, I think, agrees that this is a present human need, national in scope, which a National Government should meet now in this Congress. I think that is why it is very important that we understand that the wage earners' representatives here agree to the general principle of the need.

I would like to point out to you, however, that in regard to your statement about the broad array of benefits which were provided, and then you say provide a mechanism which would prevent many of them from receiving their benefits. In other words, you said ducking the problem.

This situation, and not so uncommon, could develop under this proposal. Take a 66-year-old man earning $3,600 a year. He is single, he gets ill, he retires under social security at, say, $80 a month. He would be force to wait, first, in order to get on in the enrollment period, to pay that $24 fee, until his annual income was below $2,500 in any fiscal year, in order to be eligible to enroll, and under such a proposal it would be not unusual at all that he would probably have to wait as long as a year in order to get coverage, and in the meantime he could have hundreds and maybe thousands of dollars of expense.

Mr. CRUIKSHANK. That is quite true, yes, sir.

Senator HARTKE. In other words, this program as submitted by the administration is like a boy with a bad burn, and we put butter on it, it cooled it off for the moment, didn't do much good but made everybody feel like you have done something.

Mr. CRUIKSHANK. That is right. I believe that is a fair characterization of it.

Senator HARTKE. All right. Thank you, sir.

The CHAIRMAN. Thank you, sir.

Mr. CRUIKSHANK. Thank you very much.

The CHAIRMAN. The next witness will be presented by Senator Curtis.

Senator CURTIS. Mr. E. J. Faulkner.

Mr. Chairman, in presenting Mr. Faulkner to this committee I wish to present him not only as the president of the Woodman Accident Life Co. of Lincoln, Nebr., and representing three important associations, but I would like to present him as one of our outstanding citizens of Nebraska, an individual who has given much time to public service, serves on many community committees and commissions, and his views on this as well as other issues represent, reflect, rather, his devotion to the public good, and the interest of our economy and our people generally.

Mr. Faulkner?

STATEMENT OF E. J. FAULKNER, AMERICAN LIFE CONVENTION, HEALTH INSURANCE ASSOCIATION OF AMERICA AND LIFE INSURANCE ASSOCIATION OF AMERICA; ACCOMPANIED BY DAVID ROBBINS, ASSISTANT DIRECTOR OF RESEARCH, HEALTH INSURANCE ASSOCIATION

Mr. FAULKNER. Mr. Chairman, and gentlemen of the committee, I thank the Senator for his very gracious introduction. As he has told you, my name is E. J. Faulkner, I am the president of Woodmen Accident & Life Co. of Lincoln, Nebr., and I appear today in behalf of the American Life Convention, the Health Insurance Association of America and the Life Insurance Association of America.

The gentleman who sits beside me is Mr. David Robbins who is the assistant director of information and research of the Health Insurance Association.

The association for whom I speak today include in their membership insurance companies having in force approximately 90 percent of the voluntary health insurance underwritten by insurance companies in the United States and Canada.

My comments are directed particularly to title 6 of H.R. 12580, which would add to the Social Security Act a new "Title XVI—Medical Services for the Aged."

What action, if any, Congress should take to impose on the Federal Government greater responsibility for financing some health care costs for certain of the aged is a question that demands the most judicious and unhurried appraisal. Many proposals now pending on this subject would have the most profound and harmful effects on our economy and present arrangements for provision of health care. Particularly when it has not been established that any crisis exists in the financing of the health care of our senior citizens, when not a single substantiated case has been brought forward in which an aged person who needed and sought health care has been denied it because of inability to pay, and when the whole situation surrounding this question is characterized more by confusion than by clarity, we urge that you adhere to your tradition of high responsibility by avoiding action until the proper course is clear. The confusion and marked diversity of view pertinent to this subject are well illustrated by the large number of sharply varying proposals now pending before your committee. Within the limited time set for hearings and consideration, the multiple facets of this subject cannot be thoroughly evaluated.

The insurance business has made giant strides in providing voluntary protection for the whole American people including the aged. Specifically, several methods are being employed to provide the aged with protection against the costs of health care.

Under group health insurance there are three principal ways through which benefits are provided for older persons and their dependents.

The first is by continuance of their benefits while they remain in active employment past normal retirement age.

The second is through the continuation of their health insurance after they retire.

The third is by conversion of group benefits to individual policies at retirement, and I may say, sir, parenthetically, that in these devices the insured person frequently has the assistance of his employer in paying the premium.

Particularly in the short period since 1952 there has been a spectacular growth in group coverage of the aged—especially the retired aged. For example, the increasing effectiveness of voluntary programs is demonstrated in a recent survey of private employee benefit programs in New Jersey. Of the 538 plans reporting, 94.9 percent of today's employees will have hospitalization coverage available to them after retirement. This contrasts with 42.6 percent in 1950 and 17.5 percent in 1940.

Individual health insurance for retired persons providing lifetime coverage on a guaranteed renewal basis is widely available. This coverage can be purchased at advanced ages without evidence of good health. Contracts are now available to people at younger ages which become paid up at age 65 providing lifetime coverage without further premiums payments.

The insurance business is proud of this progress. It is in the public interest. It has brought the protection of voluntary health insurance to 130 million Americans of all ages. Certainly the Congress will not wish to take any action which would halt this progress and destroy voluntary health insurance for the aged.

Despite the remarkable progress made by voluntary insurance, there is doubtless a small residual group among the aged for whom costly illness may present a serious problem. However, the dimensions of this problem have never been adequately established. There is increasing evidence that the conclusions reached by some about the status of the aged and manner in which their health care is financed are not well grounded because they are premised on fragmentary, inadequate, and incomplete data. The most prevalent erroneous assumption or impression is that most of the aged of our country are not able to contribute to financing their own health care costs. Where adequate surveys have been made, the inaccuracy of such a presumption is established. For example, in Vermont, which has the highest portion of aged citizens of any State, a survey of aged patients showed that over 80 percent had the resources to pay their doctor bills from Blue Shield or insurance benefits, income, or savings. In the absence of positive proof that a majority of our aged are unable to provide for their own health care needs, we submit that it is socially and economically undesirable to adopt a Government plan providing health care coverage for all retired individuals as a class.

H.R. 12580 seeks—

to assist aged persons who are not eligible for public assistance, but do not have the means to pay their medical bills when illness occurs or continues.

The bill seeks to accomplish this objective within the framework of a Federal-State program with broad discretion allowed the States.

The insurance business has long supported the concept that older people who are unable to finance the cost of health care for themselves because of limited financial means should have assurance that health care is available to them when they need it. To that end, we have supported public assistance programs to supplement the efforts of private agencies. To the extent that this principle is embodied in H.R. 12580, we support the bill. However, H.R. 12580 could be implemented by the States through the use of such liberal eligibility tests as to provide health care assistance for individuals and families who might otherwise provide for their own health care through insurance. The insurance business opposes any program, at the Federal or State level, which would produce such a result.

In summary, the insurance business has examined all the proposals pending before Congress for financing health care costs of the aged. It is our considered opinion that all of them with the possible exception of H.R. 12580 would mean the end of voluntary health insurance of the senior citizens. Additionally, many of these proposals would impair or destroy the private practice of medicine, would add immeasurably to our already crushing tax burden, would aggravate our severe public fiscal problems, and would entail the other undesirable consequences pointed out in our testimony a year ago before the House Committee on Ways and Means, reference H.R. 4700.

We urge upon you the advisability of deferring action to place upon the Government further responsibility for the health care costs of the aged until more adequate and accurate information is available. Consequently, we strongly recommend that the committee withhold approval of any health care proposal. We feel that in no event should it go beyond reporting the House-approved measure, H.R. 12580.

Thank you, sir.

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

Any questions?

Senator DOUGLAS. Mr. Chairman, may I ask Mr. Faulkner, did I understand him to say that he would prefer that we should not pass title VI of the House bill, that title being medical services for the aged? Your preference would be that that title not be passed, is that correct?

Mr. FAULKNER. It is my judgment, Senator Douglas, that the confusion rampant on this whole subject is such that the course that is in the public interest is the course of unhurried appraisal and deliberation. Let us get the facts. Let us view the problem carefully and in an unhurried way, and then I believe that the proper course in the public interest will be clear.

Senator DOUGLAS. If I may translate into immediate legislative action, do I understand that you oppose the passage of title VI at this session of Congress or this year?

Mr. FAULKNER. My position, sir, is that the Congress will serve the public interest by taking no action on a health-care proposal at this time.

Senator DOUGLAS. Therefore, you do not believe we should pass title VI?

Mr. FAULKNER. That is correct.

Senator DOUGLAS. Thank you.

May I ask other factual questions, and especially those covered in your testimony? Do you have in your association any statistics indicating how many workers below the age of 65 are entitled to hospital or medical benefits, if they retire after the age of 65?

Mr. FAULKNER. At the present time, Senator, there are 130 million Americans who have the benefit of voluntary health insurance. Probably on the order of 40 percent of that number could be classified in the worker category. Well over half of workers who are insured under voluntary health insurance will carry into the period of their retirement the benefits or some part of the benefits that they enjoyed during their working years.

Senator DOUGLAS. The question is, What part of the benefits will it carry?

Mr. FAULKNER. The tendency, sir, is toward a very substantial part of the benefits.

Senator DOUGLAS. Can you furnish figures on that?

Mr. FAULKNER. We will be glad to supply documentation, Senator. (See p. 271.)

Senator DOUGLAS. Now, the next question I want to ask is about the sale to people who have already retired, of health insurance by individual companies. May I ask how many of these companies do provide such policies?

Mr. FAULKNER. There are more than 1,00 companies active in the health insurance business today, Senator, and I would say to you that probably on the order of 150 or 200 companies operating nationally make available this protection to anyone who wishes to purchase them.

Senator DOUGLAS. This is very interesting because yesterday Secretary Flemming testified before us, and I asked him this specific question, and I think the record will bear out my memory, he said there were about four companies which sold health insurance to people over the age of 65, one of them a very well known company from your city, Mutual of Omaha.

Mr. FAULKNER. I am from Lincoln, Senator, not Omaha.

Senator DOUGLAS. Your neighbor.

Mr. FAULKNER. We have the highest regard for our friendly competitor in Omaha.

Senator, you appreciate, of course, that the Secretary is a very busy many, he has problems of enormous complexity and perhaps he was not adequately briefed in anticipation of the question that you asked.

Senator DOUGLAS. Could you supply a list of the number of these which do? (See p. 271.)

Mr. FAULKNER. Yes, we will be very glad to.

Senator DOUGLAS. What will be the monthly and yearly premium costs under these private plans for those over the age of 65?

Mr. FAULKNER. Part of the genius of private enterprise in the insurance business, Senator, is that it permits individuals to select the type of kind of coverage best suited to their needs. It permits labor unions and employers and associations of people to select that type,

amount of coverage that they figure in their own interest is appropriate and proper. So it is very difficult, sir, to generalize on the subject of cost. You can get inexpensive insurance that provides minor benefits. You can get more expensive insurance that provides adequate benefits.

Senator DOUGLAS. First let me ask about your own company. Do you sell insurance to people over the age of 65?

Mr. FAULKNER. Yes, sir.

Senator DOUGLAS. What are the benefits which you provide and what are the premiums?

Mr. FAULKNER. I can describe a typical plan, sir. We will be delighted to provide an applicant hospital benefits on the order of $20 per day, which in a reasonably low-cost medical area such as Nebraska, is quite adequate.

Senator DOUGLAS. For how many days?

Mr. FAULKNER. One hundred days for any one confinement to a hospital because of a simple injury or illness. On the order of $300 maximum in a surgical schedule, on the order of $200 to cover the miscellaneous costs of hospital care, and at a premium of $12 to $13 per month.

Senator DOUGLAS. What would be your monthly premium for this?

Mr. FAULKNER. $12 to $13 per month.

Senator DOUGLAS. $12 to $13 per month. Now, there are 12 months a year, that would be from $144 to $156 a year?

Mr. FAULKNER. Correct.

Senator DOUGLAS. Are you familiar with the testimony of Secretary Flemming that 60 percent of the aged over 65 have incomes of less than $1,000 a year?

Mr. FAULKNER. I did not have the privilege, Senator Douglas, of hearing the Secretary.

Senator DOUGLAS. That was his statement.

Mr. FAULKNER. But I am familiar with that statistic. I would comment on it to the effect that this statement that a certain spectrum of the aged per capita only enjoy an income of $1,000 a year or less is not significant of the capacity of aged people to pay for their own health care costs.

Senator DOUGLAS. You mean that they have prior savings which they can use?

Mr. FAULKNER. I mean, sir, that they have available to them a variety of resources.

Senator DOUGLAS. Prior savings plus contributions by children?

Mr. FAULKNER. One should not deny the child the opportunity to take care of his father and mother. [Laughter.]

Senator DOUGLAS. I mean those would be the two sources outside of current income.

Mr. FAULKNER. Sir, there are many, many resources.

Senator DOUGLAS. I mean prior savings would be one, certainly. Contributions of children would be another. What would be other sources?

Mr. FAULKNER. Entitlement to pension benefits, entitlement to social security benefits.

Senator DOUGLAS. I think in his statement that includes incomes from those payments.

Mr. FAULKNER. The figure of $1,000 annual income, of course, goes to the individual. This does not apply to the family circle. It melds into the whole thing individuals with no income of their own. A woman over 65, for example, would be reported as having no income but would normally be supported by the income or assets of her husband. There are 127 million Americans who own life insurance; most of these life insurance policies have cash values. We know that the economic status of the aged, as a class, has improved more than any other age bracket in our population in terms of current liquid assets. We must not forget that the aged have less need in terms of current income than many other segments of the population. The aged, for example, are no longer raising their children.

Senator DOUGLAS. Excuse me, but do you think $1,000 cash income of $20 a week gives them much of a surplus with which to purchase a $144 or $156 insurance policy?

Mr. FAULKNER. Here, again, it is a question of the individual having the opportunity to pick and choose those things out of life for which he is willing to pay.

Senator DOUGLAS. If he pays $144 to $156 for a policy practically he would do so at the expense of adequate food or clothing or housing accommodations.

Mr. FAULKNER. Well, it is a matter of personal preference. If people wish to put a high priority of desirability on protection against the cost of health care, certainly that is their privilege.

Senator DOUGLAS. And society should not help them to meet this problem?

Mr. FAULKNER. Senator, the position of the associations for which I speak is that those of our aged who need help are entitled to it from society.

Senator DOUGLAS. But under a means test.

Mr. FAULKNER. On the basis of need. If there is a demonstrable need then society certainly should step in.

Senator DOUGLAS. Which they would have to prove.

Mr. FAULKNER. But society has a responsibility also, not to so encumber people in their working years as to make American life a sham.

Senator DOUGLAS. May I ask this: What percentage of your premiums go for administrative costs rather than for the payment of benefits?

Mr. FAULKNER. This, again, is a question that cannot be answered with a quick generalization, Senator Douglas. Insofar as group insurance is concerned, insurance in which the benefits are provided, many under one cotract, the cost of administration is substantially less tha 8 or 9 percent. When it is necessary for the insurer to go to individual people and solicit their patronage one at a time the expenses are higher, obviously.

Senator DOUGLAS. Yes.

Well, now, on your policies, which you sell to those over the age of 65, individual policies, you do have to go to them, don't you?

Mr. FAULKNER. Yes. The majority, however, of the insurance in force on the aged, sir, is under group contracts of various kinds.

Senator DOUGLAS. Well, I am speaking of the policies sold to people who already are of the age of 65. Have you figured out what the administrative costs are as a percentage of the premiums?

Mr. FAULKNER. The insurers, recognizing that aged people may find it somewhat more difficult than those in their working years to pay insurance premiums, have devised various means by which the administrative costs of policies, especially designed for older people, are less. Specifically, the commissions paid to insurance salesmen on these contracts especially designed for older people is less.

Senator DOUGLAS. I wondered if you would be willing to state for the record the administrative costs as a percentage of the premiums paid in by those over the age of 65 who take out individual policies?

Mr. FAULKNER. Sir, I will be glad to supply documentation for the record, and I ask leave to do that, because I don't want to mislead the committee. But I would say to you that since there are so many different kinds of plans, you can't just say it is 20 percent, or that it is 25 percent. (See p. 271.)

Senator DOUGLAS. But you were able to segregate the costs, the administrative costs when you dealt with group policies. You said there your administrative costs were 8 to 9 percent.

Mr. FAULKNER. That is correct, sir.

Senator DOUGLAS. Haven't you been able to segregate the costs on these individual policies?

Mr. FAULKNER. The costs, if you are speaking of the health insurance business overall, individual contract, yes.

Senator DOUGLAS. Well, then, suppose we start with that.

Mr. FAULKNER. All right, sir. Overall, people of all ages, the administrative costs of individual contracts would range somewhere, depending on the company, from 20 to 35 percent.

Senator DOUGLAS. What would be an average figure?

Mr. FAULKNER. I would say 30.

Senator DOUGLAS. I see you have your statistician with you, and I am sure that the Health Insurance Association of America has figures on this, and so I think you should feel free to consult your statistician.

Mr. FAULKNER. Thank you, sir. I have done that. It is our judgment that the average would be 30 percent on individual contracts.

Now, it should be recognized, Senator, that the vast majority of health insurance in force in this country is under group coverages on which the administrative costs are on the order of 8 or 9 percent.

Senator HARTKE. Will the Senator yield at that point?

Senator DOUGLAS. Yes, certainly.

Senator HARTKE. I am interested in this same thing. Let's get at it in a different way. What are the loss ratios under the health insurance for those individuals?

Mr. FAULKNER. Here, again, Senator, we are confronted with a question that cannot be answered with a pat generalization because of the very heterogeneity of coverage. To give you an example——

Senator HARTKE. Let's not get out, I went through this yesterday with long speeches to every question and it took quite a bit of time. If you can't give an answer, it is all right. But what I am trying to find out is the loss ratio. These figures are available as I understand from the examination which your statistican has of the reports made to the State regulatory agencies.

Mr. FAULKNER. Senator, I will give you——

Senator HARTKE. If we can't get an answer to it——

Mr. FAULKNER. I will give you a quick number.

Senator HARTKE. All right.

Mr. FAULKNER. The overall loss ratio on individual health insurance in the United States today is on the order of 66 percent, but that number obscures more than it discloses.

Senator HARTKE. And it is not more nearly 50 percent?

Mr. FAULKNER. No.

Senator DOUGLAS. May I follow up? Does that mean that two-thirds of the policies taken out are lapsed before they become effective?

Mr. FAULKNER. I am sorry, sir, I don't believe that is factually correct.

Senator HARTKE. I think I would like to ask the other question to which I will get equally an obscure answer, but that is what is it for the group, for group policies?

Mr. FAULKNER. Ninety-one percent, Senator, 91 cents out of the premium dollar is returned in benefits.

Senator HARTKE. And if, perchance we can supply figures which might correct that, you would be willing to correct the testimony?

Mr. FAULKNER. Certainly.

Senator HARTKE. All right.

Senator CURTIS. Mr. Chairman, Mr. Faulkner, I noticed particularly what you had to say on page 3 about your experience in New Jersey, 538 plans reporting 94.9 of today's employees will have hospitalization coverage available to them after retirement. This contrasts with 42.6 percent in 1950, and 17.5 percent in 1940.

In general, the progress of medical and hospital insurance has been quite phenomenal in the last 5 or 6 years has it not?

Mr. FAULKNER. That is correct. Since 1934, the volume of voluntary health insurance in force in the United States has increased by 3,200 percent, indicative of the facts that the American people like it and want it and will have it.

Senator CURTIS. If we proceed with this system what do you anticipate for the next few years?

Mr. FAULKNER. Looking ahead, unless the field is preempted by Government, unless the voluntary health insurers are handicapped in their job of doing a job for the American people, we would anticipate that by 1970, 90 percent of the aged who need and want coverage will have the benefit of voluntary health insurance.

Senator CURTIS. The payment of this health insurance for an aged person by himself is a tax deduction, is it not?

Mr. FAULKNER. Yes, sir.

Senator CURTIS. That lessens his tax.

Mr. FAULKNER. Yes, sir.

Senator CURTIS. The payment for hospital and medical insurance by other than the aged if the aged person is his dependent, likewise a tax deduction, is it not?

Mr. FAULKNER. Yes, sir.

Senator CURTIS. Personally, in view of the progress that has been made in the last 4 or 5 or 6 years and what is bound to happen, if the Government does not prevent it, in the next few years, I would like to see the tax benefit further extended so that if an individual paid a hospital and medical insurance premium for an aged person, and the

aged person did not have income so that he could realistically deduct the premium himself, the payor can.

In other words, I believe there might be a great, or a sizable rather, group of individuals in categories such as this, perhaps the mother and father have an income of $2,000 or $3,000, they are not dependent on the child, but the child is concerned as well as the parents about catastrophic illness, and with an income of that size they would not have any taxable income.

The chances are they would have their double exemption for the two, they would have the standard deduction for paying taxes on their home or whatnot, and if that son or daughter paid a premium to take care of the catastrophic illness or other kind rather than add to his tax burden it would be lessened.

Mr. FAULKNER. That is correct.

Senator CURTIS. Mr. Faulkner, you serve on a hospital board or two, don't you?

Mr. FAULKNER. Yes.

Senator CURTIS. And you have for some time.

Mr. FAULKNER. For more than 12 years, Senator.

Senator CURTIS. What are some of the factors that make medical care costly?

Mr. FAULKNER. Probably the predominant factor in the cost of health care of all kinds and especially hospital care is the general inflation of the price level.

All right, sir. A second factor is that the health care available to the American people today is immeasurably finer in terms of quality than it was even 10 years ago. So that health care costs have risen, yes, but health care today in America is still one of the greatest bargains that any people has ever enjoyed.

Senator CURTIS. Is there an area of improvement that would be desirable in the improvement of the management of hospitals, in the efficient running of hospitals in your opinion?

Mr. FAULKNER. Yes, sir, and I am delighted to be able to state to you, Senator, that hospital administrators are becoming more proficient. I hope you will excuse the reference to an institution for which I have the greatest respect, and which I serve on, Bryan Memorial Hospital in Lincoln, Nebr., a relatively small hospital, 130-bed hospital, and yet that hospital, while carrying on a teaching program, while taking care of its proportionate amount of the indigent cases is still able to operate on such a basis that it can generate the cash for depreciation and it can operate in the black.

Senator CURTIS. Would you care to give us the costs of various room accommodations there?

Mr. FAULKNER. At the present time a private room is available at Bryan Hospital from $20, $22, and $23 a day, depending on the location of the room. A two-bed ward accommodation is available, at $14 and $15 a day. The hospital, at the present time is about to undertake a construction and rehabilitation program that will incorporate the procedure known as progressive patient care. This assigns to the patient accommodations suited to his particular need. The patient who has just emerged from surgery is accommodated in the intensive care area, and there, with all of the concentration of facilities, and skills the cost would be on the order of $30 per day.

Then when he moves down after a period of 36 hours, perhaps, or even less, to an area in which less intensive care is indicated he goes into what we call the intermediate department, and there the costs would probably be, in Lincoln, on the order of $16 or $17 a day. Finally he moves to the self-care area, at which the cost per day will be on the order of $9 or $10, substantially less, sir, than one would be charged in a first-class hotel, only for the right to place his head on a pillow at night.

Senator CURTIS. That of course includes meals.

Mr. FAULKNER. Yes, sir.

Senator CURTIS. There is no such thing as tipping as in a hotel, as a general practice. In other words, it is your feeling that, in addition to the voluntary insurance making strides, from the standpoint of good hospital administrators likewise a great deal of progress is being made.

Mr. FAULKNER. That is correct.

Senator CURTIS. In a period where the resources of the retired people are on the increase?

Mr. FAULKNER. Yes, sir.

Senator CURTIS. If our present system operates as it does now, do you feel that a great many people, not only in the insurance field, but elsewhere, share your view that in the next very few years this voluntary system will make strides comparable to the last 5 or 6 years?

Mr. FAULKNER. If we can reason from the progress that has been made over the last quarter of a century, particularly over the last decade, sir, there is no question in my mind of the competence of the voluntary system to take care of the vast majority of all Americans insofar as the costs of their health care are concerned.

Senator CURTIS. That is all, Mr. Chairman.

Senator HARTKE. Mr. Chairman, I interrupted Senator Douglas.

Senator DOUGLAS. Please go ahead. I have just two or three more questions. You go ahead now.

Senator HARTKE. Go ahead now.

Senator DOUGLAS. I have simply three statistical questions to ask.

How many people over the age of 65 are now under group contracts?

Mr. FAULKNER. Group contracts of all kinds of insurance service plans as well as insurance companies is that the question?

Senator DOUGLAS. No, just of insurance companies.

Mr. FAULKNER. They are on the order of 7½ million over age 65 who are insured for, under all kinds of arrangements. On the order of 3 million are insured by insurance companies.

Senator DOUGLAS. Under group contracts.

Mr. FAULKNER. And of that number, on the order of probably 1 million to 1,250,000 under group contracts.

Senator DOUGLAS. About 1 to 1¼ million.

Mr. FAULKNER. Yes, sir.

Senator DOUGLAS. Under group contracts, those now over the age of 65.

Mr. FAULKNER. Issued by insurance companies.

Senator DOUGLAS. And 1¾ million to 2 million under individual contracts.

Mr. FAULKNER. That is correct, sir.

Senator DOUGLAS. May I ask, how much does it cost for a person who retires to convert from a group policy to an individual policy?

Mr. FAULKNER. Well, the cost of conversion ordinarily is nil. The rate that he would pay under the individual policy would be according to the amount of benefit under the contract that he buys provides and as I have suggested to you, in my example out of my own company, the premium for the benefits I described would be on the order of about $13.

Senator DOUGLAS. Suppose you have identical benefits under the individual policies as provided under the group policy and under the group policy of course the cost is borne partially by the contributions of the younger workers although their incidence of disease is not as great.

Now when the aged person departs from the protection of the group policy, and has to get the protection of the individual policy, the premiums for that group are supposed to meet the costs for that group without being contributed to by the younger group. How much will the policy rate increase as he converts from a group to an individual policy? If you cannot give it in dollar terms, I suppose you could in percentage terms.

How much do you have to raise the rate in order to meet the specific costs of this upper age group as compared to the general average?

Mr. FAULKNER. Here again, we are confronted with a difficult generalization, sir, but I can give you a figure. While it is true, as you have suggested that the incidence of disease among the aged is considerably more than among the younger, the incidence of maternity is considerably less.

Senator DOUGLAS. I think that is indisputable. [Laughter.]

Mr. FAULKNER. In New York State the premium for the benefits under the converted policy cannot exceed the premium for the benefits prior to conversion by more than 20 percent. So it would be in the range from 0 to 20 percent more.

Senator DOUGLAS. And not above 20 percent?

Mr. FAULKNER. That is the New York law.

Senator DOUGLAS. Yes, but what about the practices over the rest of the country?

Mr. FAULKNER. Here again we are confronted with the difficulty of attempting to generalize about something that is not succeptible to easy generalization.

I would say to you that probably the increase in premium over the rate charged for the worker during his active years would be in the range of 0 to 33⅓ percent.

Senator DOUGLAS. Excuse me, Senator Hartke. You have been very gracious and I regret my taking the time.

Senator HARTKE. Let me ask you, you are acquainted with the fact that the Secretary of Health, Education, and Welfare in his testimony here yesterday stated, asserted quite strongly that private insurance companies cannot meet this need.

Mr. FAULKNER. I have been told that that was the Secretary's assertion. I reserve the right to differ strongly with the Secretary on that score.

Senator HARTKE. I think this is a great American right to differ with people.

Mr. FAULKNER. Thank you, sir.

Senator HARTKE. Do you know any other insurance company which approves of the social security approach which I disapprove of?

Mr. FAULKNER. I know of only one, a company whose philosophy is, well, shall we say, somewhat at variance with the other companies in the business?

Senator HARTKE. That is nationwide, is that right?

Mr. FAULKNER. That is correct.

Senator HARTKE. And with the permission of the chairman I would like to insert this resolution into the hearings in this place under date of April 7 in which they do adopt the policy to support the use of social insurance principle to meet the health needs of older citizens and for further detail.

(The document referred to follows:)

RESOLUTION ADOPTED BY NATIONSIDE INSURANCE BOARD OF DIRECTORS, APRIL 7, 1960

Whereas the Nationwide Insurance Cos. are deeply committed to the principle of helping people to meet their social and economic needs; and the health needs of their older citizens are among the most urgent and pressing social problems remaining unsolved; and

Whereas most of the health costs of older people are not being met by insurance as evidenced by certain statistics which indicate that 86 percent of couples receiving social security benefits in 1957 had none of their medical care costs met by insurance; and

Whereas certain statistics indicate that most older people had neither the income nor the assets to meet such expenses as evidenced by the figures that nearly 4 out of 10 couples over 65 years of age had total income of less than $2,000 in 1958: Be it

Resolved, That it be the policy of the Nationwide Insurance Cos.—

(*a*) To support the use of the social insurance principle to meet the health needs of older citizens;

(*b*) To support the application of this principle in appropriate legislation to provide basic health insurance to those eligible for old-age, survivors, and disability benefits as a feasible and desirable step in this direction; and

(*c*) To continue our efforts in our own insurance program, in conjunction with cooperative health plans, and as members of the private insurance industry to provide further health care through voluntary coverage in addition to that which may be furnished through government programs.

Mr. FAULKNER. Senator, even in this insurance business it is permissible to have differences of viewpoint.

Senator HARTKE. That is good, too, sometimes.

Mr. FAULKNER. Indeed it is.

Senator HARTKE. In competition and for the price of premiums.

Mr. FAULKNER. One of the great and virile characteristics of the health insurance business in this country is the keen free competition that characterizes it. It has been an enormous force for progress and it has made possible situations in which the American people can pick and choose the kind of coverage that they need and want.

Senator HARTKE. I would like to comment briefly here on one of the statements. You say health care is still one of the greatest bargains enjoyed by Americans, is that right?

Mr. FAULKNER. The quality of the health care, yes, I subscribe to that.

Senator HARTKE. How about the quantity?

Mr. FAULKNER. The quantity is of such character, Senator, in my judgment, that anyone who needs health care and seeks it has it available to him irrespective of his ability to pay.

Senator HARTKE. Would it make any real difference to you, and I assume the truthfulness of your statement, if actual cases were brought to your attention and you could see and visit some of these people——

Mr. FAULKNER. I would welcome the opportunity to be brought up to date, if you please, on that score.

Senator HARTKE. Let me say, sir, to you, I don't want to go into detail, if you would accompany me rather than elicit your information from black-and-white sheets, I would be happy to accompany you and show you the deplorable condition of the health of some of these people, which I personally have witnessed, and it is a sorry sight.

Mr. FAULKNER. Senator——

Senator HARTKE. They are not going to buy insurance policies from your insurance company or any others.

Mr. FAULKNER. Sir, on no less than three occasions over a period of that many years I have asked, in the position of a witness, I have made the statement that I have made to this committee, and to my knowledge there has never been brought forward the case of an aged person who needed and who sought health care and has been denied it because he could not pay for it.

Senator HARTKE. Well, you should go to Evansville, Ind., where they play it on the front page of the Evansville newspapers.

Mr. FAULKNER. In California, as my colleague reminds me, the Los Angeles County Medical Society periodically inserts a display advertisement in the newspaper requesting people, who are in need of health care and who are unable to pay for it, to call the number and a doctor will be sent, and there is no response.

Senator HARTKE. All right. Let me say to you for information that that might be misinterpreted, I don't think this is applying particularly to Evansville, I just mentioned that because that is where my home city is, but I think this is true in every other city and here again I respect your right to disagree with me.

You have made one other statement I want to get to just quite hurriedly, in which you comment upon the strides which insurance companies made for the protection of the whole American people including aged for which I congratulate you for the good work you have done, and I would imagine then that you would dispute the contention of the Senate subcommittee on the problems of the aging in which they point out that in 1958 about 3 million families headed by individuals over 65 received less than $2,500 in income, and this makes about 6 million men and women with incomes of this amount or less, and that we have to add to this about 2 million unrelated aged individuals who received less than $1,500, a figures which is considered quite low in terms of adequacy.

In other words, there are about 8 million aged citizens living in what at today's prices would almost have to be called poverty and that, in fact, if you go into the absolute figures and the overall position, the Federal Reserve Board consumers finance survey for early 1959, among spending units with aged heads who have incomes of less than $3,000, 56 percent have liquid assets of less than $500, among those units with incomes of $3,000 to $5,000 only 30 percent had liquid assets of less than $500, and also that in the 10 years since 1949, there

has been no more progress in the proportion of aged heads of spending units with no liquid assets at all.

In 1949 there were 32 percent; in 1959, 29 percent. An absolute figure is there was actually a retrogression because in 1949 there were 3.9 million, almost 4 million spending units with aged heads who had no liquid assets, but by 1959, 10 years later, there were at least 4.6 million an increase almost of 700,000 people of spending units with no liquid assets at all.

An additional 3 million have no liquid assets of more than $500. In other words, there are about 7.6 million or 7,600,000 people, who have liquid assets of less than $500, in other words, there are more than 7.6 million aged spending units with between zero, not $500, but between zero and $500 and these do not take into account the fact that there has been an increase in medical costs and other costs of living since 1948, in the last 10 years.

In substance what you are contending is that these figures leave a false impression or are in fact false.

Mr. FAULKNER. May I have the privilege to comment, sir?

Senator HARTKE. Oh, yes, that is what I asked for.

Mr. FAULKNER. I am reminded of the remark attributed to the late great Lord Beaconfield, Disraeli who is purported to have said "There are liars, damn liars, and statisticians."

The comment that the learned gentleman from Indiana has offered, I think substantiates the principal contention that I attempted to make in my testimony, and that is that here is so much confusion, there is so much lack of sound and adequate information about this problem, that it would be deplorable for the Congress to take precipitate action in this area at this time.

Senator DOUGLAS. In what ways are the figures that the Senator from Indiana quoted false?

Mr. FAULKNER. Senator, I certainly didn't mean to imply that, and I hope you did not interpret that I suggested that the statistics quoted by Senator Hartke were false. I simply suggest to you that they are conclusive of nothing. I suggest to you, sir, that an isolated statistic does not prove the case. I suggest to you that there are statistics available that would lead to the contrary point of view.

Senator HARTKE. Let me point out to you, sir, that these are not my statistics, nor the committee on the aged, problems of the aged, these are the statistics of the Federal Reserve Board Consumer Finance Survey, a fairly reputable outfit in this world today, I think, sir.

Mr. FAULKNER. Yes, indeed, sir.

Senator HARTKE. And I hope we don't ascribe to them that they are liars, damn liars.

Mr. FAULKNER. Or statisticians.

Senator HARTKE. Or statisticians in the terms in which you described it.

Mr. FAULKNER. We don't ascribe anything to anybody. We simply suggest to you that it is a futile endeavor to attempt to arrive at a total picture of varying needs on the basis of unrelated statistics.

Senator DOUGLAS. I would suggest that these are related. I don't see how you can sweep these figures under the rug, if they are true. Now if they are not true, why, of course, we should know about them, excuse me, Senator Hartke.

Mr. FAULKNER. Well, if we are going to consider statistics, should we not consider the fact that two-thirds of the aged own their own homes, according to the Department of Health, ducation, and Welfare.

Senator HARTKE. That is fine, I am in favor of home ownership and I am sure the Senator from Illinois is.

Mr. FAULKNER. I am sure we are all in favor of it.

Senator HARTKE. I am in favor of the other third owning their own homes.

Mr. FAULKNER. I agree with you, sir, and I suggest to you that the way to permit them to own their own homes is to do things which will keep our economy from want and to keep our democracy from the burdens of Government and free from the fetters of big Government as much as possible.

Senator HARTKE. You do use statistics in operation as an insurance company, I hope.

Mr. FAULKNER. Yes, sir.

Senator HARTKE. Because I have a few policies of my own and if you don't I want to know about it.

Mr. FAULKNER. If it is legal reserve company you are pretty well protected.

Senator HARTKE. You are familiar with the fact and I hope your actuary there or your statistician, would agree that one out of every four people born today has a right to expect to live to be 83 years of age.

Mr. FAULKNER. I think that is the fact according to the modern mortality table.

Senator HARTKE. And that the other three have a right to expect and can expect to live to be in their 60's, probably 63 years of age.

Mr. FAULKNER. I believe that is so.

Senator HARTKE. This is a wonderful tribute to American progress, so by 1960, we have this situation for every 100 persons whose age is 60 to 64, there are 34 who now are 80. And these are primarily the parents and older relatives of those who are 60 to 64, the ones who were 80.

By the year 2000, for every 100 persons between 60 and 64 there are going to be 67 people over the age of 80. And I want to know just how we can expect this working population to provide for most of the medical costs of the parents as well as grandparents, not to mention the increased costs of raising their own families.

Mr. FAULKNER. Well, one of the ways is to permit the older person to continue to be productive.

Senator HARTKE. Productive. I am in favor of that. You mean to take off the $1,200 limitation on earning on social security?

Mr. FAULKNER. That undoubtedly is an inhibiting factor.

Senator HARTKE. I would like to subscribe that to my bill if you would like, I introduced that bill so I am in favor of that. That is fine.

You know, I am going to quit with this, I think that this is a good statement, pardon me, I think it is a remarkable statement that you made that one should not deny the right of a child to take care of his parents. You see I have six children.

Mr. FAULKNER. You are going to be well cared for, Senator.

Senator HARTKE. And I have therefore six definite and distinct opportunities for them to take care of me in my old age, and I am going to try to instill them with this doctrine, and I hope that they will acquire this particular doctrine at an early age in life so that I can start my old age at the present age of 41. [Laughter.]

Mr. FAULKNER. Well, in the process of indoctrinating them, sir, you will build a stronger America.

Senator HARTKE. One other thing if I could, then: You say "Certainly the Congress will not wish to take any action which would halt this progress," and you speak of the progress of the voluntary health insurance program. "And destroy voluntary health insurance for the aged."

If you have any statistics or any information which would substantiate this generalization I am sure this committee would certainly like to know about it.

Mr. FAULKNER. Well, perhaps we can reason from the experience as to this in Canada. Health insurance is not like other kinds of insurance where it is possible for government and private insurers to coexist in the same field. To the extent that the Government provides a benefit in the health care area, it preempts the field, there is certainly no merit in having entitlement to a benefit at the public expense and then going out and buying the same benefit from a private insurer, and so it is our feeling, Senator, that to the extent that Government moves into this area the service of private insurers is precluded.

Senator HARTKE. But there is no really, you have no real facts or real anything to back this up?

Mr. FAULKNER. Well, in Canada, when they passed the national hospitalization program.

Senator HARTKE. For the aged?

Mr. FAULKNER. No, for the whole population.

Senator HARTKE. Well, now, we are talking about two different things. I don't want to beg words with you but we are talking about legislation that deals with the problems of health insurance for the aged.

Mr. FAULKNER. Would an aged person, who is entitled to certain benefits from Government expend the money to duplicate those benefits from a private insurer?

I think not.

Senator HARTKE. If he had an income of less than a thousand dollars, I would think they would.

Mr. FAULKNER. I am quite certain even if his income was $100,000 a month he would not do it.

Why buy again what is handed to you? So in this area, when government moves in the private insurer is excluded. And there is a proclivity, Senator, as you must recognize from your study of social benefit programs in other countries, there is a proclivity of all of these social benefit schemes to burgeon to the point where they become universal.

Senator HARTKE. In other words, social benefits schemes implies a sinister meaning. Would you tell us what you have in mind?

I had in mind operation, operational here in the United States.

Mr. FAULKNER. Well, sir, one cannot fail to observe that once the seed is planted of government's acceptance of responsibility for doing

some part of a social benefit job, that Congress is under an enormous pressure to accept for the Government responsibility for that same job for all the people.

Senator HARTKE. All I asked you was whether you would identify one social benefit scheme, I think that is the word you used, "scheme," which has had this disastrous effect, for the American people. Let's take the social security program as it has been instituted. Do you feel that is a scheme which reacted detrimentally?

Mr. FAULKNER. Well, I used the word "scheme," in its dictionary sense. There is no implication derogatory.

Senator HARTKE. It certainly has not destroyed the private pension programs of the insurance companies. In fact they have multiplied out of all proportion tremendously.

Mr. FAULKNER. Let's not confuse cause and effect, Senator.

Senator HARTKE. I am not saying cause and effect, I am saying as a practical matter since social security the private pension plans have expanded.

Mr. FAULKNER. Because during the period that we are considering private enterprise in the United States has moved ahead enormously, and it has provided our people with a higher standard of living, it has provided them with an income with which to secure for themselves all of these things.

Senator HARTKE. Yes, that is what I said.

Mr. FAULKNER. But life insurance is not health insurance, and that the value of a human life is without limit, and so it is quite possible for a man to be entitled to social security, and still if he has the competence to secure large amounts of life insurance, whereas if you are talking about health insurance if Government is providing him the benefit he has no need to secure it from private insurance.

Senator HARTKE. I want to get back to these social benefit schemes, I mean where is one of them?

How about unemployment insurance? That is considered a social benefit scheme. Is that what you mean by scheme?

Mr. FAULKNER. The scheme, sir, according to Mr. Webster, is simply an arrangement, and a device or a plan.

Senator HARTKE. All right, fine. Let's use whatever you want to use for the terminology and semantics. What social benefit program has been detrimental to the American people?

Mr. FAULKNER. I haven't implied, sir, that any existing social benefit scheme has been deleterious.

Senator HARTKE. If you stated this to me I have to recognize this and if I recognize this, I just want to know what it is I have to recognize.

Mr. FAULKNER. Potentially if Government accepts increasing responsibilities for the welfare of the individual person, the time will come when the tax burden will be such that your six children and the other youngsters of the next generation will say "Pop voted himself too much."

Senator HARTKE. Well, in other words, we really don't have any of these so-called schemes that we can point to, is that what you are telling me?

Let's forget about the potential and about Pop and those things.

I am talking about now, do we have any of these programs that you feel are detrimental?

In other words, possibly the Congress, if they are of such nature should consider repealing them.

Mr. FAULKNER. I am not suggesting that.

Senator HARTKE. Are there any of these schemes then as you indicated a while ago or is this something on which you ask me to just assume a general principle which you have enunciated?

Mr. FAULKNER. I am suggesting that as thinking people, part of our obligation is to look ahead, to anticipate consequences, and to so order our conduct as not to fall into boobytraps, as not to make life more difficult or impossible or not to burden our economy in such a way that the Americans cannt endure as a free people.

Senator HARTKE. I don't think anyone in the United States would so disagree with that statement.

Mr. FAULKNER. Good.

Senator HARTKE. When you come down to saying these schemes again, I can't get you to talk about them, and all I am asking you, and I am not trying in any way to take away from your testimony, but I would just like to know where these schemes are, and if we can agree that there are none to date, so then it is pretty good because the Congress and the United States have done fairly well so far.

Mr. FAULKNER. There is no argument about that, Senator, life is full of schemes, private insurance schemes, social benefit schemes, all kinds of schemes.

Senator HARTKE. I guess I am belaboring the point. Let me take one thing which I did forget. You talked about the hospital budgets, is that right, and how efficiently they are able to operate?

Mr. FAULKNER. I spoke, sir, only out of my experience in connection with one hospital, and a rather broad knowledge of the problems of hospitals generally.

Senator HARTKE. Recognizing their social benefit and their need for the people, the truth of it is that they do have certain tax benefits, do they not? I am not saying it is wrong, I just say they do have.

Mr. FAULKNER. Yes.

Senator HARTKE. And the pay on a comparable basis as compared to the standing of nurses for the amount of education they required is not really in accordance with the general standard of comparable people is it?

Mr. FAULKNER. I could not agree to that, sir. I think the pay enjoyed by most registered nurses has been improved considerably and while they are certainly not overpaid, the pay scales for registered nurses broadly are not miserable.

Senator HARTKE. Those are all the questions.

Senator DOUGLAS (presiding). Thank you very much. The committee will recess until 2:30 this afternoon, when hearings will be resumed in the same room.

Mr. FAULKNER. Thank you, gentlemen.

(The following was subsequently received for the record:)

AMERICAN LIFE CONVENTION,
Chicago, Ill.
LIFE INSURANCE ASSOCIATION OF AMERICA,
New York, N.Y.
HEALTH INSURANCE ASSOCIATION OF AMERICA,
Washington, D.C., July 5, 1960.

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

DEAR SENATOR BYRD: During the course of testimony by Mr. E. J. Faulkner on behalf of the American Life Convention, the Health Insurance Association of America and the Life Insurance Association of America on H.R. 12580, Mr. Faulkner was asked to supply certain additional information for the record.

1. Attached hereto is a list of 162 companies which sell policies of insurance to those aged 65 and above to assist in meeting the costs of health care. These coverages are diversified. Of recent origin are the mass enrollment 65-plus coverages which provide around $10 a day for room and board charges up to 31 or 60 days per confinement, plus hospital extras of up to $100 (or in the case of one company 80 percent of charges above a $100 deductible up to a maximum of $1,000), plus a surgical schedule with a $200 or $225 maximum. One company offers $5,000 major medical after a $500 deductible which can be used to supplement basic coverage. The cost of these coverages is approximately $7 to $8.50 per month. However, other individual policies offer a choice of benefit levels, some going up to $25 for daily room and board charges.

2. With reference to a question by Senator Douglas as to the proportion of benefits which present workers will carry into retirement, there is no specific documentation available on this point. In group insurance the general pattern among insured plans is to reduce benefits on retirement. In most instances, the benefits on retirement take the form of reduced maximum durations for hospital benefits or the imposition of calendar year or lifetime maximum benefits. The continuing coverage is substantial. For those individuals whose coverages are not continued, or who wish to supplement that which is continued into retirement, there is available the mass enrollment coverages referred to above.

3. During the course of testimony, Mr. Faulkner responded that loss ratio on individual policies would equal 66⅔ percent. Mr. Faulkner appears to have misspoken himself because a more nearly correct figure for 1959 is estimated to be 56 percent, an increase of four to five points over 1958 for which year the loss ratio for individual hospital and surgical-medical insurance was 51.2 percent.

In considering the ratio of losses incurred to earned income, it should be recognized that the percentage of premiums retained is no measure of the insurer's profit. For example, the hospital surgical-medical loss ratio for individual insurance for 1958 was 51.2 percent and for group insurance 91.8 percent. For 25 leading insurance companies these loss ratios resulted in an underwriting profit for the year 1958 of six-tenths of 1 percent of the premiums earned. Divided between group and individual, the results were an underwriting loss of approximately 1 percent of premiums earned on group and a profit of approximately 4 percent on individual policies.

Out of the percentage not paid out in claims, the insurers were required to set up reserves, pay taxes, dividends to policyholders, and expenses, including the cost of claim administration in the health insurance field. The expense is relatively higher in the individual policy coverages than in the case of group coverage. Individual contracts are sold through the agency system, premiums are collected on an individual basis and greater care must be exercised in underwriting to avoid antiselection.

According to the 13th annual survey of the health insurance council on the extent of voluntary health insurance coverage, of the persons covered by insurance companies at the end of 1958, 72 million persons had hospital expense insurance, 63 percent being on a group basis and 37 percent on the individual basis. In other words, almost 7 out of 10 persons were covered under group plans.

Very truly yours,

AMERICAN LIFE CONVENTION,
RICHARD E. VEBNOR,
Counsel.
HEALTH INSURANCE ASSOCIATION OF AMERICA,
ROBERT R. NEAL,
General Manager.
LIFE INSURANCE ASSOCIATION OF AMERICA,
EUGENE M. THORE,
Vice President and General Counsel.

COMPANIES WHICH ISSUE NEW POLICIES ON AN INDIVIDUAL BASIS TO PERSONS 65 YEARS OF AGE OR OLDER

Accredited Hospital & Life Insurance Co.
Aetna Life Insurance Co.
All American Life & Casualty Co.
Allied Reserve Life Insurance Co.
Allstate Insurance Co.
Allstate Life Insurance Co.
American Benefit Association.
American Casualty Insurance Co.
American Guarantee & Liability Insurance Co.
American Hardware Mutual Insurance Co.
American Health Insurance Corp.
American Hospital & Life Insurance Co.
American Life Insurance Co. of New York.
American Life & Casualty Co.
American Manufacturers Mutual Insurance Co.
American Motorists Insurance Co.
American Mutual Liability Insurance Co.
American National Insurance Co.
American Policyholders' Insurance Co.
American Progressive Health Insurance Co. of New York.
American Republic.
American United Life Insurance Co.
Atlantic Life Insurance Co.
Atlas Life Insurance Co.
Austin Life Insurance Co.
Bankers Life & Casualty Co.
Bankers Life Insurance Co. of Nebraska.
Beneficial Standard Life Insurance Co.
Benefit Association of Railway Employees.
Berkshire Life Insurance Co.
Brotherhood Mutual Life Insurance Co.
Business Men's Assurance Co. of America.
California Life Insurance Co.
California-Western States Life Insurance Co.
Carolina Home Life Insurance Co.
Celina Mutual Insurance Co.
Central Assurance Co.
Central Standard Indemnity Co.
Central Standard Life Insurance Co.
Central States Health & Life Co. of Omaha.
Colorado Credit Life, Inc.
Columbian Mutual Life Insurance Co.
Combined American Insurance Co.
Combined Insurance Co. of Newark.
Commonwealth Mutual Insurance Co. of America.

COMPANIES WHICH ISSUE NEW POLICIES ON AN INDIVIDUAL BASIS TO PERSONS 65 YEARS OF AGE OR OLDER—Continued

Combined Insurance Co. of America.
Companion Life Insurance Co.
Connecticut General Life Insurance Co.
Constitution Life Insurance Co.
Continental Casualty Co.
Countryside Casualty.
Craftsman Insurance Co.
Detroit Mutual Insurance Co.
Educators Mutual Life Insurance Co.
Empire State Mutual Life Insurance Co.
Employers Mutual Liability Insurance Co.
Farmers & Traders Life Insurance Co.
Federal Life & Casualty Co.
Federal Life Insurance Co.
Federal Mutual Insurance Co.
Fireman's Fund Insurance Co.
First National Casualty Co.
Girardian Insurance Co.
Globe Assurance Co.
Globe Life Insurance Co.
Great American Reserve Insurance Co.
Great Southwest Life Insurance Co.
Guardian Life Insurance Co. of America.
Guarantee Reserve Insurance of Indiana.
Guarantee Trust Life.
Hartford Accident & Indemnity Co.
Hearthstone Insurance Co.
Home Fire & Marine Insurance Co.
Hoosier Casualty Co.
Illinois Mutual Life & Casualty Co.
Independence Life & Accident Insurance Co.
Inter-Ocean Insurance Co.
Inter-State Insurance Co.
International Fidelity Insurance Co.
Jefferson Life & Casualty Co.
Jefferson National Life Insurance Co.
Life Insurance Co. of Georgia.
Life Insurance Co. of Virginia.
Lincoln Liberty Life Insurance Co.
Lincoln Mutual Life & Casualty Co.
Lincoln National Life Insurance Co.
Lumbermens Mutual Casualty Co.
Maryland Casualty Co.
Massachusetts Bonding & Insurance Co.
Metropolitan Casualty Co. of New York.
Metropolitan Life Insurance Co.
Michigan Life Insurance Co.
Midwest Life Insurance Co.
Minnesota Commercial Men's Association.
Missouri National Life Insurance Co.
Monarch Life Insurance Co.
Municipal Insurance Co. of America.
Mutual Life Insurance Co. of New York.
Mutual of Omaha.
M.F.A. Mutual Insurance Co.
National Accident & Health Insurance Co.
National Casualty Co.
National Fidelity Life Insurance Co.
National Home Life Assurance Co.
National Surety Corp.
National Travelers Life Co.
Nationwide Mutual Insurance Co.
New York Life Insurance Co.
North American Assurance Society of Virginia.

COMPANIES WHICH ISSUE NEW POLICIES ON AN INDIVIDUAL BASIS TO PERSONS 65 YEARS OF AGE OR OLDER—Continued

North American Life Insurance Co. of Chicago.
North American Life & Casualty Co.
North Central Life Insurance Co.
Northern Life Insurance Co.
Northwestern Life Insurance Co.
Occidental Life Insurance Co. of California.
Ohio State Life Insurance Co.
Old American Insurance Co.
Old Equity Life Insurance Co.
Old Line Life Insurance Co. of America.
Olympic National Life Insurance Co.
Pacific Mutual Life Insurance Co.
Paramount Mutual Life Insurance Co.
Pennsylvania Life Insurance Co.
Pilot Life Insurance Co.
Postal Life & Casualty Insurance Co.
Professional Insurance Corp.
Protective Security Life Insurance Co.
Provident Life & Accident Insurance Co.
Prudence Life Insurance Co.
Prudential Insurance Co. of America.
Republic National Life Insurance Co.
Reserve Life Insurance Co.
Secured Insurance Co.
Security Mutual Life Insurance Co. of New York.
Security Mutual Life Insurance Co. of Nebraska.
Security Life & Accident Co.
Service Life Insurance Co.
Sovereign States Insurance Co.
Standard Insurance Co.
Standard Life & Accident Insurance Co.
State Automobile & Casualty Underwriters.
State Mutual Life Assurance Co. of America.
State National Life Insurance Co.
Sunset Life Insurance Co.
Teachers Protective Mutual Life Insurance Co.
Texas Reserve Life Insurance Co.
Time Insurance Co.
Transportation Insurance Co.
Travelers Insurance Co.
Union Life Insurance Co., Inc., of Virginia.
United American Insurance Co.
United Insurance Co. of America.
United States Life Insurance Co.
Wabash Life Insurance Co.
Washington National Insurance Co.
West Coast Life Insurance Co.
Westland Life Insurance Co.
Wilson National Life Insurance Co.
Wisconsin National Life Insurance Co.
Woodmen Accident & Life Co.
World Insurance Co.
Zurich Insurance Co.

(Whereupon, at 1:15 p.m. the hearing was recessed, to reconvene at 2:30 p.m. of the same day.)

AFTERNOON SESSION

The CHAIRMAN. The committee will come to order.

Senator Hartke is anxious to be here when Mr. John W. Nagle testifies. I understand that Dr. Schamberg has a plane to catch. So if he wants to come forward.

Is he in the room? I understand you had a plane to catch.
Dr. SCHAMBERG. Yes; I do, sir.
Thank you very much.
The CHAIRMAN. We will be glad to hear you.

STATEMENT OF DR. I. L. SCHAMBERG, COMMITTEE ON SOCIAL SECURITY FOR PHYSICIANS; ACCOMPANIED BY HARRY KELBER, SECRETARY

Dr. SCHAMBERG. Thank you very much indeed.

I am Ira Leo Schamberg. Dr. Harold Aaron, the chairman of the committee is unfortunately unable to attend this meeting and I am very happy to appear and to read his statement for him.

I am a dermatologist, a skin specialist, practicing in Elkins Park, Pa. I am a member of the Philadelphia County Medical Society, the Pennsylvania State Medical Society and the American Medical Association. I am also a member of the Committee on Legislation of the Philadelphia County Medical Society.

I would like to confine my remarks today to the provision in the act which has been passed by the House of Representatives, and is up for consideration before this committee, for inclusion of physicians in social security.

I would like to further confine my remarks to two points: One, do physicians want social security? And two, do physicians need social security?

In answer to the first point, I would like to read the statement which Dr. Aaron prepared. A letter prepared by the president-elect of the American Medical Association dated today, June 30, 1960, states that the majority of physicians in this country do not want social security. There is no documentation by the president-elect of this statement. I believe that I can document adequately a contradiction to that statement.

Dr. Aaron's statement reads:

We are glad to have this opportunity to present up-to-date evidence to prove that a substantial majority of the Nation's self-employed physicians want to be included under social security.

A tally of the 27 statewide polls on social security held in the past 2 years shows: 19 States, representing 126,462 physicians, or 64 percent of the Nation's total, are in favor of physician coverage; 6 States, representing 18,266 physicians, or 9 percent of the Nation's total, are opposed to coverage; 2 States, representing 4,531 physicians, or 2 percent of the Nation's total, are in favor of voluntary coverage only.

We have enclosed a tabulated breakdown of these various polls for the examination of members of the committee.

There are several significant factors about these polls to which we would like to call your attention:

(1) Twenty-four of these polls were official surveys conducted by State medical societies, most of whose delegates to AMA conventions had consistently opposed social security coverage for physicians.

(2) Two independent polls among Illinois and California physicians, conducted by the Honest Ballot Association as recently as May and June of this year, show majorities of 67 percent and 62 percent respectively, in favor of social security coverage. These polls included not only physicians affiliated with the AMA but all physicians.

(3) You will note that substantial majorities, ranging from 57 percent to as high as 77 percent, were piled up in States which favored coverage.

(4) All of these latest figures confirm the trend observed in the nationwide independent poll conducted by the authoritative publication, Medical Economics, which showed a nearly 2-to-1 majority in favor of coverage.

Attached to this statement is a tabulated breakdown of these polls for the examination by members of the committee, and I would like to read briefly to you the 19 States whose physicians have spoken in favor of social security and also the percentage of physicians in those States who want social security coverage.

California, 62 percent; Connecticut, 73 percent want social security; Delaware, 61 percent; District of Columbia, 74 percent; Florida, 57 percent; Illinois, 67 percent; Maine, 64 percent; Massachusetts, 77 percent; Michigan, 63 percent; New Jersey, 70 percent; New York, I don't have a percentage here; Ohio, 60 percent; Pennsylvania, 63 percent; Rhode Island, 70 percent; South Dakota, 63 percent; Utah, 60 percent; Vermont, 65 percent; West Virginia, 57 percent.

And the poll in the State of Washington which was just completed yesterday, I believe, 60 percent.

One hundred thirty-one thousand physicians, 64 percent of the Nation's 204,000 physicians reside in these States, practice in these States which have filed for social security.

In the fall of 1958 we showed a nearly 2-to-1 majority in favor of coverage.

For years now physicians have been virtually the only self-employed group to be denied the benefits and protection of social security coverage. On the basis of the evidence we have presented, we sincerely hope that Congress will remedy this injustice to members of the medical profession and their families.

I would like to interject for a moment and speak of the patient I had in my office who was the widow of a physician, her husband died of leukemia when he was 41. She has three small children to bring up. When I mentioned social security she had a great deal to say. She is one of the few widows in the country who is denied social security protection when her husband dies at the age of 41.

The CHAIRMAN. Have you got the figures here of how many physicians voted in these different polls? You have the total number of physicians but it does not say how many.

Dr. SCHAMBERG. I don't believe I have that, Mr. Chairman. Possibly Mr. Kelber—approximately on an average of 50 percent of the physicians in each State responded to these polls.

The CHAIRMAN. In other words, taking California, only 10,000 voted, a little over 10,000, is that correct?

Dr. SCHAMBERG. Harry Kelber, secretary of the committee.

Mr. KELBER. The Honest Ballot Association conducted this poll, which was a 1-in-10 survey, and about 2,100 ballots were sent out and 1,012 were returned.

I have the other poll, for instance, in Illinois which was conducted by the Honest Ballot Association and I have a signed affidavit here from the Honest Ballot Association which says that 11,942 ballots were mailed, as certified by the U.S. Post Office Department, and of those 5,967 ballots were returned and tabulated. Of these, yes votes were 3,986, no votes 1,962, blank 41, so there you have actually a little more than 50 percent——

The CHAIRMAN. Just 1 second. I think you should take each State up. You can't do it now but if you, for the record, show how many voted in each State—all you have here is the total number of physicians, I understand, so in order to complete the record I would like

to know when you put it on a percentage basis how many actually voted.

Mr. KELBER. We will be glad to have that sent to the committee by tomorrow, if that will be all right with the chairman.

The CHAIRMAN. If you will insert that in the record.

Mr. KELBER. All right; we'll have that inserted in the record.

(The following was subsequently received for the record:)

Information requested by Senator Byrd at Senate Finance Committee hearings on Thursday, June 30, 1960, is herewith supplied by the Committee on Social Security for Physicians as an addition to the oral testimony of Dr. Ira L. Schamberg:

Dr. SCHAMBERG. The Committee on Social Security for Physicians, in reply to your request, Mr. Chairman, is happy to submit the following supplementary data pertaining to statewide social security polls among physicians. These figures have been compiled from reports appearing in State medical society journals and independent medical publications, from our communication, by letter and phone, with a number of executive secretaries of State medical societies, from reports by members of our committee, and from affidavits of the Honest Ballot Association.

Results of 18 State polls of physicians on the issue of social security coverage

State	For coverage	Against coverage	Total voting	Number of physicians in the State
Arkansas	167	596	763	1,533
California [1]	635	372	1,007	[1] 2,104
Connecticut	1,391	504	1,895	3,782
Delaware	135	85	220	522
District of Columbia	550	192	742	2,252
Florida	957	714	1,671	4,613
Georgia	496	539	1,035	3,288
Illinois	3,964	1,962	5,926	11,624
Maine	369	210	579	888
Massachusetts	3,253	988	4,241	8,274
Michigan	1,781	1,048	2,829	7,823
Minnesota	817	1,030	1,847	4,089
New Jersey	2,174	916	3,090	6,694
Ohio	4,095	2,737	6,832	10,616
Oklahoma	446	761	1,207	1,999
Pennsylvania	5,605	3,335	8,940	13,821
South Dakota	155	104	259	456
West Virginia	436	237	673	1,582
Total	27,426	16,330	43,756	95,951

[1] The California poll is a 1-in-10 poll of the State's 21,045 physicians, conducted by the Honest Ballot Association.

SUMMARY OF 18 POLLS

27,426 physicians favor coverage: 62.5 percent of all physicians voting.
16,330 physicians oppose coverage: 37.5 percent of all physicians voting.
The 43,756 physicians who cast yes or no votes represent 46 percent of all physicians in these States.

In two State society polls—Maryland and Montana—the vote was mixed and inconclusive. In Maryland, physicians opposed "compulsory" coverage 853 to 368, but favored "voluntary coverage for themselves" by a vote of 741 to 571. In Montana, the physicians opposed compulsory coverage 256 to 65, but approved voluntary coverage 195 to 133.

In the case of four State medical societies, only percentage figures were available: Rhode Island, 70 percent for, 30 percent against; Utah, 60 percent for, 40 percent against; Vermont, 65 percent for, 35 percent against; Washington State, 60 percent for, 40 percent against.

In two States—Virginia and Wisconsin—no figures or percentages have as yet been released, although the State medical societies have informed our committee that a majority of the physicians voted against social security coverage. The two States have been listed accordingly in our tabulation.

We have also leaned backward, Mr. Chairman, in estimating the ratio of physicians who returned yes or no ballots as against the total number of physicians in these States. Our figure of slightly more than 46 percent is obviously

conservative as it does not take into account the following categories: physicians who cast blank or "undecided" ballots; those who are not members of the AMA; those who did not receive ballots because of change of address; those who sent in ballots after the poll was closed; and so forth.

To conclude this point, Mr. Chairman, we sincerely believe that these figures, in addition to the data we have already presented at these hearings, provide clear-cut evidence that a substantial majority of the Nation's self-employed physicians want social security coverage.

The CHAIRMAN. Have you got anything else to say, sir?

Dr. SCHAMBERG. Yes, sir, I do. To complete Dr. Aaron's statement:

In conclusion, we would like to state our approval of the provision passed by the House, which would indicate not only self-employed physicians but also interns under the social security law.

I believe that this statement indicates clearly the desire of the physicians for social security. I would like, with your indulgence, Mr. Chairman, to spend just a moment indicating the need that physicians have for social security and I would like to read from an article in Medical Economics dated February 29, 1960 entitled "Two hundred Destitute Physicians Found in Six States." I quote:

Physicians may earn more money during their lifetime than men in many other professions, yet a surprising number of doctors die broke. According to Dr. Beverly C. Smith of New York City there is far more indigency among doctors than many medical men realize. Medical societies of six States have told him that they consider the problem of major concern. These six States reported a total contribution last year for the support of needy physicians of $180,000. In many instances physicians relied entirely on the Society for subsistence.

I would also like to read to you a letter which I received from Jeanes Hospital of which I am senior dermatologist dated November 11, 1959, and I will be happy to submit this for the record if you so desire:

"Dear Doctor." This was mailed to every member of the staff.

As you undoubtedly know, Doctor So-and-so died last Friday morning; due to his recent condition he incurred many bills, canceled most of his life insurance, and left his wife and four children in severe financial straits.

Mrs. So-and-so has certainly been in questionable physical condition along with her husband.

I am writing this letter in the hope that you would be willing to write a check for any amount you desire in order to assist in straightening out some of the financial needs that are urgent for the family. To date we have been given $15 from each of nine members of the courtesy staff and larger gifts from more active members of our regular staff.

If you will write your check to me and leave it at the hospital or mail it to my home, I will see that it is properly used for the purposes intended—

and so on.

I would also like to present and put in the record two brochures, official publications entitled "The Aid Association of the Philadelphia County Medical Society." This is the most recent one, dated 1959, and this one is dated 1956.

The preamble to this states:

Object: The object of the aid association is benevolent, and the purpose for which it is formed is to afford aid to needy physicians and their families.

The CHAIRMAN. That was in 1956?

Dr. SCHOMBERG. And 1959. I just received this 1959 one last week.

Doctors are no different from anyone else, Mr. Chairman, they may be needy as are others.

The CHAIRMAN. We will examine them and we will either make them a part of the record or keep it in the files.

Dr. SCHOMBERG. Yes I will be happy to leave them here. I would like to read you two paragraphs from this report.

Our clients—

meaning the needy physicians aided by the Aid Association of the Philadelphia County Medical Society—

however, practically never complain nor voluntarily ask for an increase in their allotment. Their inate pride and sincere desire not to be a further burden to the association was the reason given for not asking for more aid even when the need was great.

This, Mr. Chairman, is a physician, one of the group whom the American Medical Association claims does not need any help in handling its financial security. Another paragraph:

The problem of caring for elderly physician clients who now live alone and who are rapidly becoming so incapacitated that they are unable to take care of their physical needs is a serious one. Finding good nursing homes for them within our means is difficult.

I would also like to read excerpts of two letters from beneficiaries which appear in 1956 issue, and I quote:

May I try to express from my mother and myself our most grateful appreciation for your most generous holiday gift and all the help you have given us. With humble thanks and may God bless you.

And the second letter:

I want to thank you again for all your kindness, it has been a godsend, particularly the past 6 months for me.

This is apparently written by the doctor's wife—

has given up the few patients he attended, and your check is his entire income.

The CHAIRMAN. Thank you very much, Doctor.

(The documents referred to will be found in the files of the committee.)

The CHAIRMAN. The next witness is Senator Harrison A. Williams, Jr., of New Jersey.

All right, Senator, we are glad to have you, sir, and you may proceed.

STATEMENT OF HON. HARRISON A. WILLIAMS, JR., U.S. SENATOR FROM THE STATE OF NEW JERSEY

Senator WILLIAMS. Mr. Chairman, I appreciate this opportunity to present an explanation of the amendment I introduced June 24, to-together with Senator Case of New Jersey, relating to the social security bill, H.R. 12580, pending before your committee.

I earnestly hope the committee will give its most serious consideration to this amendment or similar language, for if the present bill is enacted in its present form it will dash the hopes, the expectations and financial security of thousands of dedicated teachers and public employees in the State of New Jersey.

The bill now before you would, because of the interlocking nature of New Jersey law, reduce the retirement allowances of approximately 2,130 retired New Jersey teachers and 1,300 other retired New Jersey

public employees by an average of $1,300 a year for the teachers and $960 for the public employees.

It is an unusual and unfortunate fact that a bill which is intended to improve our social security system for the general population by reducing the number of quarters necessary to achieve fully insured status will, paradoxically, have a serious adverse effect on thousands of New Jersey teachers and public employees.

I would like to emphasize that this amendment does not add or detract from the cost of the social security bill. Nor does it affect any other beneficiaries of the legislation than those specific groups in New Jersey that I have mentioned.

It merely seeks to preserve the existing schedule of eligibility for these people who would be seriously hurt if the new reduced eligibility requirements come into effect.

It seeks to insure that these groups will be permitted to receive the benefits to which they are fully entitled, which they have been led to expect, and for which they have made important plans in their careers that cannot be changed easily or at all.

I will try to explain as simply as possible how this adverse effect can occur.

Because the laws of New Jersey provide for the integration of the Federal Social Security System with the New Jersey Teachers' Pension and Annuity Fund and the New Jersey Public Employees' Retirement System, the State is permitted to reduce the amount of pension it owes to these groups of people by the amount of social security benefit for which the individual becomes eligible through New Jersey public employment.

Because of this provision, many teachers and public employees have retired or have planned their retirements in advance of the date on which they would become eligible for social security benefits as public employees, thus avoiding the reduction in their retirement allowances that would result if they earned the necessary number of quarters as public employees that would make them eligible for social security benefits.

They have retired early and have collected their pensions from the State of New Jersey with the expectation of seeking private employment for a time long enough to become eligible for social security.

Now, however, the pending bill proposes to reduce the number of quarters necessary for eligibility. So that, if the bill is passed in its present form a teacher who has retired, for example, having worked for only 19 quarters and needing 20 quarters to become fully insured as a public employee will now find that he needs only 10 quarters to become eligible or fully insured. Because he has worked 19 quarters as a public employee in New Jersey, he suddenly finds himself subject to the "offset" provision which permits the State to reduce his pension by the amount of his social security benefit.

Thus because of the changes in the Federal law and the interlocking nature of New Jersey law, 2,130 teachers who thought they were ineligible for social security as public employees when they retired will now find that they are eligible and thus subject to an average reduction of $1,300 in their retirement allowances when they reach the age of 65. The same holds true for a smaller number of public employees.

It is important to point out, Mr. Chairman, that these people have retired or planned their retirements early in accordance with well-publicized instructions from the State itself in official retirement manuals.

These teachers were encouraged to join in this integrated system in 1955 on the basis that they would be able to collect their full benefits from both the State's retirement programs and the Federal Social Security. They were led to believe this, and they were quoted specific retirement allowances predicated upon carefully arranged retirement schedules. And, of course, not being intimately aware of the intricate ramifications of this problem, they did not anticipate that changes in the Federal law would jeopardize their expectations and financial security.

To demonstrate the situation as it actually exists, I would like to point out that in the manual prepared in 1957 by the Division of Pensions of the New Jersey Department of Treasury, entitled "Public Employees' Retirement System of New Jersey" there appears this notation:

> No reduction is made in the Public Employees' Retirement System allowance at age 65 if the member does not qualify for social security benefits as a result of public employment alone. Generally, the ability to avoid this reduction depends upon the member's age and date of retirement. Separate "avoid" dates may be obtained from the personnel office of each employer.

Likewise, the State's manual on the Teachers' Pension and Annuity Fund, dated September 1, 1959, states that:

> When a member retired (after December 1954) reaches age 65, or upon retirement of a member age 65 or beyond, the fund will reduce the pension portion of his retirement allowance by the amount of social security he is entitled to receive by virtue of his public employment in the State of New Jersey after January 1, 1955. (See the schedule which indicates the number of years needed in New Jersey public employment after January 1, 1955, before a pension allowance becomes subject to offset (reduction), also example of how the offset is applied.)

Mr. Chairman, I would like to request that the retirement schedule, as it appears in both the publications I have mentioned, be included in the record with my remarks so that committee members might see how explicit the instructions are that the teachers and public employees have been encouraged to follow in order that they might avoid this serious reduction in their anticipated retirement allowance.

Let me just express my earnest hope, Mr. Chairman, that this committee will act favorably on the proposal suggested by the amendment Senator Case and I have introduced to prevent a beneficial change in the existing law from inflicting a severe injustice on two of the most important segments of New Jersey's citizenry—its teachers and public servants.

(The table accompanying Senator Williams' remarks follows:)

THE SOCIAL SECURITY OFFSET SCHEDULE

The following table applies to all active members in the retirement system who were in public employment on January 1, 1955.

If you were born before these dates—	Men		Women	
	Number of quarters needed for social security coverage after Jan. 1, 1955	Retirement system will reduce your pension allowance if you retire after—	Number of quarters needed for social security coverage after Jan. 1, 1955	Retirement system will reduce your pension allowance if you retire after—
Before Oct. 1, 1892	6	Apr. 1, 1956	6	
Oct. 2, 1892 to Jan. 1, 1893	7	July 1, 1956	6	
Jan. 2 to Apr. 1, 1893	8	Oct. 1, 1956	6	
Apr. 2 to July 1, 1893	9	Jan. 1, 1957	6	
Jul. 2 to Oct. 1, 1893	10	Apr. 1, 1957	6	
Oct. 2, 1893 to Jan. 1, 1894	11	July 1, 1957	6	
Jan. 2 to Apr. 1, 1894	12	Oct. 1, 1957	6	Apr. 1, 1956
Apr. 2 to July 1, 1894	13	Jan. 1, 1958	6	
July 2 to Oct. 1, 1894	14	Apr. 1, 1958	6	
Oct. 2, 1894 to Jan. 1, 1895	15	July 1, 1958	6	
Jan. 2 to Apr. 1, 1895	16	Oct. 1, 1958	6	
Apr. 2 to July 1, 1895	17	Jan. 1, 1959	6	
July 2 to Oct. 1, 1895	18	Apr. 1, 1959	6	
Oct. 2, 1895 to Jan. 1, 1896	19	July 1, 1959	7	July 1, 1956
Jan. 2 to Apr. 1, 1896	20	Oct. 1, 1959	8	Oct. 1, 1956
Apr. 2 to July 1, 1896	20	do	9	Jan. 1, 1957
July 2 to Oct. 1, 1896	21	Jan. 1, 1960	10	Apr. 1, 1957
Oct. 2, 1896 to Jan. 1, 1897	21	do	11	July 1, 1957
Jan. 2 to Apr. 1, 1897	22	Apr. 1, 1960	12	Oct. 1, 1957
Apr. 2 to July 1, 1897	22	do	13	Jan. 1, 1958
July 2 to Oct. 1, 1897	23	July 1, 1960	14	Apr. 1, 1958
Oct. 2, 1897 to Jan. 1, 1898	23	do	15	July 1, 1958
Jan. 2 to Apr. 1, 1898	24	Oct. 1, 1960	16	Oct. 1, 1958
Apr. 2 to July 1, 1898	24	do	17	Jan. 1, 1959
July 2 to Oct. 1, 1898	25	Jan. 1, 1961	18	Apr. 1, 1959
Oct. 2, 1898, to Jan. 1, 1899	25	do	19	July 1, 1959
Jan. 2 to July 1, 1899	26	Apr. 1, 1961	20	Oct. 1, 1959
July 2, 1899, to Jan. 1, 1900	27	July 1, 1961	21	Jan. 1, 1960
Jan. 2 to July 1, 1900	28	Oct. 1, 1961	22	Apr. 1, 1960
July 2, 1900, to Jan. 1, 1901	29	Jan. 1, 1962	23	July 1, 1960
Jan. 2 to July 1, 1901	30	Apr. 1, 1962	24	Oct. 1, 1960
July 1, 1901, to Jan. 1, 1902	31	July 1, 1962	25	Jan. 1, 1961
Jan. 2 to July 1, 1902	32	Oct. 1, 1962	26	Apr. 1, 1961
July 2, 1902, to Jan. 1, 1903	33	Jan. 1, 1963	27	July 1, 1961
Jan. 2 to July 1, 1903	34	Apr. 1, 1963	28	Oct. 1, 1961
July 2, 1903, to Jan. 1, 1904	35	July 1, 1963	29	Jan. 1, 1962
Jan. 2 to July 1, 1904	36	Oct. 1, 1963	30	Apr. 1, 1962
July 2, 1904, to Jan. 1, 1905	37	Jan. 1, 1964	31	July 1, 1962
Jan. 2 to July 1, 1905	38	Apr. 1, 1964	32	Oct. 1, 1962
July 2, 1905, to Jan. 1, 1906	39	July 1, 1964	33	Jan. 1, 1963
Jan. 2 to July 1, 1906	40	Oct. 1, 1964	34	Apr. 1, 1963
July 2, 1906, to Jan. 1, 1907	40	do	35	July 1, 1963
Jan. 2 to July 1, 1907	40	do	36	Oct. 1, 1963
July 2, 1907, to Jan. 1, 1908	40	do	37	Jan. 1, 1964
Jan. 2 to July 1, 1908	40	do	38	Apr. 1, 1964
July 2, 1908, to Jan. 1, 1909	40	do	39	July 1, 1964
Jan. 2, 1909, or thereafter	40	do	40	Oct. 1, 1964

NOTE.—The above table does not consider the problem of those individuals who may earn $4,800 during the final year in which they will achieve the number of quarters needed for social security coverage. Anyone whose earnings reach $4,800 during the final year is automatically credited with 4 quarters for that year under social security.

The CHAIRMAN. Thank you, Senator Williams.

The next witness is Senator Warren G. Magnuson, U.S. Senator from the State of Washington.

Senator, please take a seat.

STATEMENT OF SENATOR WARREN G. MAGNUSON, U.S. SENATOR FROM THE STATE OF WASHINGTON

Senator MAGNUSON. Mr. Chairman and members of the committee, I appreciate the opportunity to appear before you to speak briefly about one of the most important subjects of the day which demands the full attention of our minds and energies in this session of the Congress. This is the problem of adequate and reasonable medical care for the aged and aging population of our country.

We are living in an age of amazing technological progress. The pace is so swift and so varied as to distract and confuse all of us at times. We talk in terms of outer space, of planetary exploration, of moon shoots, of supersonic jet transportation and other subjects that previously existed only in the pages of the uninhibited fiction writers or in the vocabularies of isolated students of esoteric phenomena. While our attention is necessarily attracted to these new horizons, I think, many of us tend to forget that we have a few, simple but difficult problems of mankind right on this planet which require attention and immediate action. One of them involves the health of our aged who, in this surging, changing world, are oft lost sight of or forgotten.

What does it profit us as a Nation if we solve these problems of outer space and in so doing, ignore such basic needs as the health of our aged.

We have a beacon to guide us in our approach to this problem. Let me quote from the Charter of the World Health Organization:

> Enjoyment of the highest attainable standard of health is one of the fundamental rights of every human being without distinction of race, religion, political beliefs, or economic and social condition.

Good health is a "state of complete physical, mental, and social well-being and not merely the absence of disease or infirmity."

Medicine, like the other sciences, has not stood still in recent years. Our problem, however, is to harness it, for the benefit of the greatest possible number of our fellow citizens—to employ it for the advancement of the common good of this country. During the past half century, this Nation has witnessed the realization of astonishing advances in the field of medical science. Diseases formerly thought incurable have been conquered. Longevity has markedly increased. With the benefits achieved by these medical advances, however, there has arisen simultaneously a great new challenge—utilizing the additional years of life with purpose * * * happily and usefully. Certainly this challenge requires the resolution of a host of problems but I think no problem is more demanding of solution than that involving the health of our aged—providing them with the means of maintaining good health.

Consider just a few of the many facts which demonstrate this need. Our aged population is increasing by 1,000 per day. Today there are approximately 16 million people age 65 and over. By 1980 there will be nearly 25 million. Yet 60 percent of our aged population have money incomes of less than $1,000 annually. Cost of living has continually risen—medical costs have risen twice as fast. Our aged require nearly 2½ times more hospital care than do those under 65. Yet less than half of our aged have medical insurance—and those who have such insurance generally find it inadequate.

Medical science has given us the precious gift of added life but it has been accompanied by a feeling of profound insecurity in many of our aged. A constituent wrote me recently, saying, "We are two old people, living in fear" * * * fear of being unable to financially meet their medical needs. There are those of course who would answer by saying that free medical aid is available to the indigent. This may be true. But to assume this questionable status and therefore qualify, one must sacrifice nearly every asset which took a lifetime to accumulate and literally, take a pauper's oath. Good health should be a matter of right, not charitable caprice. If a right exists, the fear is dispelled and a sense of security restored. By providing such security, we enable our aged to live their remaining years with dignity. The blessing of medical science should not be bestowed on the arbitrary basis of ability to pay. Our aged have contributed immeasurably in achieving the standard of living which this Nation enjoys today. In so doing, they have guided us through periods of economic insecurity, a catastrophic depression, World Wars and vast economic and social changes. These events, coupled with such factors as increased living costs, have rendered it impossible for many to adequately provide for their remaining years despite their thrift and frugality.

We know the problem—we see it on every hand. The question then is how to meet and solve it. I am convinced that only through an insurance system, utilizing the existing social security machinery, can this problem best be met. The social security system is well established—it is sound, efficient, successful, and economical. The advantages of improving this existing structure are manifold. For example, the additional number of personnel which would be required, would not be large. The insurance would be noncancelable. A change in employment or retirement would not affect one's rights. The financial strain on hospitals would be decreased since the requirement for indigent care would be less. The coverage would almost be universal—eventually 9 out of 10 persons presently employed would be covered.

Some may say "Why not let private insurance companies solve the problem through conventional private insurance channels?" The answer is that private insurance has not demonstrated its ability to adequately provide for the medical needs of the aged at premiums which they can afford. This is not meant as an adverse reflection on the private insurance companies. I think they have accomplished a great deal and they are to be commended for their efforts. But they do not have the means of doing as an effective job as can be accomplished through a federally sponsored program. Private insurance companies need have no fear of being replaced in the health field. A Federal program will simply provide a firm basis upon which they can build and supplement with additional coverage.

I find it regrettable that this plan of health insurance which I, and so many others, envision, is labeled by some as "socialism." This label is misleading and false. I have no sympathy with those who approach a great humanitarian cause as a game in semantics. The plan is strictly one of insurance, under Federal auspices, extended to cover a much larger number of persons, than would be feasible under a privately sponsored program. It would be financed by individual and employer contributions and served by private medical personnel and

facilities. The Government would not interfere in the administration of a hospital and would not attempt in any way to prescribe the manner in which a physician conducts his practice.

To date no satisfactory alternative to a federally sponsored insurance program has been proposed. If there had been, I would have been the first to support it. But we have reached a point where the problem grows more acute each day. We are aware of the need and we cannot in conscience adopt the expediency of head-in-the-sand ignorance.

S. 3503 introduced by the very able and distinguished Senator from Michigan, Mr. McNamara, is a forward-looking and constructive bill. It is an excellent bill and one which I am privileged to cosponsor. I am hopeful that this committee will give serious consideration to the measure and that it will act favorably thereon. I cannot emphasize too strongly my conviction that this legislation is vital and that it should be enacted during this session of Congress. We cannot cure tomorrow the disease which must be cured today. We cannot save tomorrow the life which must be saved today.

The CHAIRMAN. Thank you, Senator Magnuson.

The next witness is John W. Nagle of the National Federation of the Blind.

All right, Mr. Nagle, we are glad to have you, sir, and you proceed.

STATEMENT OF JOHN W. NAGLE, NATIONAL FEDERATION OF THE BLIND

Mr. NAGLE. Thank you, Mr. Chairman.

Mr. Chairman and members of the committee, my name is John F. Nagle. I am the representative of the National Federation of the Blind in Washington. According to figures contained in the May–June Social Security Bulletin, a publication of the Department of Health, Education, and Welfare, there were 108,644 blind aid recipients in the United States in February of this year.

How many of these men and women, though blind, though able and willing to work, will be on public assistance the rest of their lives?

How many of them, physically able to work, filled with the overwhelming desire to work, must continue on the public aid rolls because they must eat, must feed their families, because they lack the opportunity to work, are denied the incentive and the encouragement to work?

We of the National Federation of the Blind believe that at least one quarter of these people and perhaps more could and should be working; could be and should be earning their living, supporting themselves and their families contributing by their tax paid dollars to assist in meeting the needs of those less fortunate than themselves—those physically unable to work.

Mr. Chairman, the bill S. 3449—introduced into the Senate by Hon. Vance Hartke, of Indiana, a member of this committee, and cosponsored by Hon. Paul Douglas, of Illinois, also a member of this committee, and 15 other distinguished members of the Senate—this bill, S. 3449, would amend title X of the Social Security Act so as to make of this title, the blind aid section of the social security law, a

means by which those dependent upon public aid may work their way off public aid and into employment and economic self-sufficiency.

Although I urge that all provisions of this bill be adopted by your committee as amendments to the social security law, I particularly urge that you adopt the first portion of S. 3449 which would exempt $1,000 plus 50 percent of the yearly net earned income of a blind aid recipient from meeting his living expenses.

Why do this?

Why shouldn't every cent a blind aid recipient earns be used by him to live on, and if he doesn't have enough, then the difference be met by a public assistance grant?

Why treat needy blind persons different from other aid categories?

The answer is a simple one: Because blindness can strike at any time in a person's life, when he is old and infirmed or when he is young and vigorous and prepared to meet head on the challenges of life, because many blind persons have an employment potential, and if given the opportunity and the encouragement will transform this work potential into wages and salaries.

This very committee recognized the significance of this difference when it includes the exempt earnings concept in its amendments to title X of the Social Security Act in 1950.

Senator George, then chairman of this committee, recognized this difference by his stanch support of the exempt earnings principle in 1950 and because of this support, because of the enlightened leadership given by this man it became a part of the social security amendments enacted into law in that year, and this, in spite of the refusal of the House originally to accept this principle, in spite of the active and vigorous opposition of the administration to the inclusion of the exempt earnings principle into the law.

I would like to read briefly from the report of this committee made in 1950 with reference to H.R. 6000:

> Under title X of the Social Security Act the States are required, in determining the need for assistance, to take into account the income and resources of claimants of aid to the blind. Your committee believes this requirement stifles incentive and discourages the needy blind from becoming self-supporting and that therefore it should be replaced by a requirement that would assist blind individuals in becoming self-supporting and that therefore it should be replaced by a requirement that would assist blind individuals in becoming useful and productive members of their communities. Accordingly the committee-approved bill would require all States administering federally approved aid to the blind programs to disregard earned income up to $50 per month of claimants of aid to the blind.
>
> Aid to the needy blind, in the judgment of your committee, is not in the same category with assistance programs for other needy individuals. Opportunities for gainful employment for blind individuals are limited and their necessary expenditures are increased by the need for special books, for special medical treatment in some cases, and for guide service and readers. As with concessions and special provisions for the blind in other laws, the exemption of earnings up to $50 is not regarded by your committee as a precedent for similar treatment for individuals who are not blind.

For 10 years, the earned income concept has been in operation in the Federal-State aid to the blind programs—but as the years have passed, as costs of living have soared higher and ever higher, the $50 monthly limit on exempt earned income has decreased in value as a means by which a man may cross over from dependence to independence.

More and more this provision has become a tantalizing symbol of the good intentions of a day long since passed; it has become a symbol to the ambitious blind person of the futility of effort, a mockery of his struggle for economic self-sufficiency, and a steel-jawed trap for the profits of his labors—for each dollar he earns above $12 a week reduced his aid grant by that amount.

Though he works steadily and tirelessly in a profession or business, trade, or common calling, to acquire stability and solvency in his endeavors, he is stifled by the restrictiveness of the $50 monthly limit placed upon his earnings—and though he may work hard and long, though he may sacrifice, struggle, and strive, he is like a man on a treadmill, going round and round in the same small circle: If he earns more than $12 a week, his aid check is reduced by the amount of the excess; but to get established in his small variety store, in his backyard chicken business, he needs far more than $50 a month—and to prosper in his small store or business he needs more than this amount.

Thus, however much he may try, he remains permanently on public assistance, courageously, stubbornly, trying to work his way off, but never quite succeeding, and finally he has no more heart for the uneven struggle and one more chance is lost to return a man to the normal productive channels of community life.

Mr. Chairman, I urge you and the members of this committee not to abandon the work so finely begun in 1950—the conversion of the aid to the blind title from a program offering bare subsistence, to a program by which men who are blind, who are in need of financial help, may receive help in their valiant efforts to rebuild their lives.

S. 3067, too, is a bill which merits your most careful consideration. Introduced into the Senate by Hon. Hubert Humphrey, of Minnesota, and cosponsored by Hon. Jacob Javits, of New York, this bill would liberalize the disability insurance provisions of the Social Security Act.

It would make disability cash benefits available as an absolute right, without regard to age, income or employment status, related exclusively to the establishment of the disability of blindness within the generally accepted definition of blindness; it would reduce the minimum requirement of coverage from 20 quarters to 1 quarter in covered employment; the present provision of compulsory acceptance of vocational rehabilitation would be abolished, and disability insurance benfits would be made available to persons who have earned coverage after the onset of blindness on the same basis as set forth above. Finally, I urge that you adopt the provisions of S. 3470, and incorporate them into title X of the Social Security Act.

This bill, introduced into the Senate by Hon. Eugene McCarthy, of Minnesota, a member of this committee, would prohibit the States from imposing a residence requirement for eligibility to receive aid to the blind payments, and further, would provide that should an applicant for such aid not be a resident of the State of application for a certain length of time, then the entire cost of such person's aid grant would be met by Federal funds until the person resided in the State the required period of time.

I thank you, Mr. Chairman, members of the committee, for allowing me the opportunity of making known to you the views of the Na-

tional Federation of the Blind with regard to certain bills now before you for consideration.

Thank you.

The CHAIRMAN. Mr. Nagle, I want to congratulate you in the way you read your address. You have done much better than those who can see every word. You didn't hesitate on a single word.

Mr. NAGLE. Mr. Chairman, I would like permission to submit for the record a statement by a Mr. Perry Sundquist. This program that I speak of, the earned income exemption of $1,000 plus 50 percent above that, has been in operation in a program in California functioning entirely through State funds for the past 19 years, and I believe that a statement from the person who is director of this program would be of benefit to the gentlemen of the committee.

It would give much more ample information about this operation than I have provided in my statement.

The CHAIRMAN. The insertion will be made in the record.

(The document referred to follows:)

STATEMENT PREPARED AND SUBMITTED BY PERRY SUNDQUIST, CHIEF, DIVISION FOR THE BLIND, DEPARTMENT OF SOCIAL WELFARE, CALIFORNIA IN SUPPORT OF S. 3449

CALIFORNIA'S AID TO POTENTIALLY SELF-SUPPORTING BLIND RESIDENTS STATUTE

I. Purpose

California has two public assistance programs for the blind—aid to needy blind and aid to potentially self-supporting blind residents. The aid to needy blind program was enacted by the legislature in 1929. In March 1960, there were 13,486 recipients receiving aid to needy blind and the average grant was $100.32, excluding medical care.

The aid to potentially self-supporting blind residents statute was enacted by the legislature effective July 1, 1941, and in March of 1960 the statewide caseload was 302 and the average grant was $114.41. This second program of public assistance for the blind in this State, which is distinct from the older category of aid to needy blind, resulted clearly from recognition on the part of the legislature of the fact that relief from the distress of poverty alone is not sufficient for those blind persons who wish to have an opportunity to achieve self-support.

The constructive purposes of the aid to potential self-supporting blind residents law are eloquently set forth in section 3400 of the statute. "The purpose of this chapter is to provide a plan for this State whereby the blind residents of this State may be encouraged to take advantage of and to enlarge their economic opportunities to the end that they may render themselves independent of public assistance and become entirely self-supporting. To achieve this objective, resources and income beyond the necessities of bare decency and subsistence are required. This chapter, by allowing the retention of necessary income and resources by those of the blind showing a reasonable probability of being able and willing to undertake the acquisition of resources and income necessary for self-support will encourage them in their efforts to become self-supporting." This program is financed entirely by the State and county governments since the Federal Government will not participate because of the liberal provisions for exempt income and property in the statute. The rehabilitative aspects of the program, however, seemed ample recompense for loss of Federal funds.

In aid to potentially self-supporting blind residents the eligibility requirements are the same as for the federally reimbursed aid to needly blind program, except that: (1) a maximum of $1,200 a year of net income from all sources is allowed without deduction from the maximum monthly grant of $115 a month, plus 50 percent of all net income above $1,200; (2) a maximum of $5,000 in assessed value of real and/or personal property, less encumbrances, is allowed together with and additional $5,00 in such property if needed as an integral part of the plan for self-support; and (3) the recipient of aid to potentially self-supporting blind residents must have a reasonably adequate plant for self-support and must give evidence that he is attempting to carry out that plan through a sincere and sustained effort.

II. Operation and results of the program

Since the aid to potentially self-supporting blind residents program began in 1941, the State social welfare board has provided two criteria for eligibility in addition to the usual requirements with respect to property, income, degree of blindness, etc. The criteria are (1) a reasonably adequate plan which may lead to self-support; and (2) a sincere and sustained effort to further that plan. Evaluation of a plan for self-support by the county social worker is, of necessity, anticipatory in nature if the individual is just embarking on a plan the adequacy of which can only become apparent with the passage of time. However, reevaluation of a current plan for self-support is usually slanted toward its success as shown by progress made toward achieving self-support. Experience has indicated that even though originally a plan may have been subject to some question, the encouragement given the blind person often leads him to more satisfactory results than originally appeared possible. The amount of money earned by an individual is only one factor in determining adequacy of a plan. It is the probability of future earnings sufficient for self-support which is a more final determinant. It is important to consider the length of time a given plan has been in effect. However, a plan which requires a long period of preparation and training may be acceptable even though it may not produce immediate income, as for example, university training which experience has proved to be perhaps the best type of plan for self-support of all.

Whenever a blind person is a recipient of aid to potentially self-supporting blind residents, or applies for aid under the program, it is crucial that a very thorough and intensive and individual examination be made of his particular situation. It is, of course, up to the blind person himself—with such help, consultation and advice as he can secure—to determine his own plan which he hopes will lead him to self-support. But whether the plan is one which is likely to eventuate in complete self-support or not, is a matter of his judgment and the judgment of the county social worker and the employer. In order to make this judgment a sound one it is indispensable that a very intensive examination be made of the individual situation. It is not simply enough to say, if a blind man wants to go into a certain occupation, that that occupation is one in which few blind persons have succeeded. It very well could be an occupation in which that particular individual can succeed. This is the clear-cut illustration which is most sharply made by a case like that of Dr. Bradley Burson. Dr. Burson is a blind man, totally blind, who is a nuclear physicist, an experimental nuclear physicist. If he had offered as a plan for self-support going to a university and becoming a nuclear physicist, in all likelihood most persons might have said that this was not a plan likely to lead to self-support, but this would be a generalized conclusion about a plan and in this area it is extremely important to avoid generalized conclusions. As a matter of fact, someone who examined Dr. Burson's talents and his individual situation might very well have concluded that his was a good plan even before he demonstrated that it was by succeeding at it.

In 1955 the department prepared for and submitted to the legislative auditor a study of the aid to potentially self-supporting blind residents program. In that study a comparison was made of the caseload as of December 1950, June 1953, and September 1954. Since December 1950, and aid to potentially self-supporting blind residents program has been administered with increasing emphasis on demonstrated progress in the achievement of self-support by recipients and transfer to aid to needy blind of those who did not meet this criterion, or who could not develop a more adequate plan. The result has been a progressive reduction in caseload, but also a caseload of much greater potentiality for eventual self-support.

This study also showed an increase in the number of students aided by the aid to partially self-supporting blind residents program, both numerically and proportionately. It should be noted again that this group of recipients (students) is known to have a much higher potential for eventual self-support than any other group.

The substantial success of this department and of the counties to weeding out recipients with low potential for self-support from the aid to potentially self-supporting blind residents program was made very apparent by the tabular material included in this study. The number of recipients with annual earnings of less than $100 declined from 21.6 percent in December 1950 to 5.3 percent in September 1954. The number with annual earnings of less than $600 declined from 71.6 percent in December 1950 to 32.6 percent in September 1954.

On the other hand, only 5.6 percent of the recipients had earnings of $1,000 or more in December 1950, compared with 25.7 percent in September 1954. Median earnings reported in December 1950 report were about $380, in June 1953 about $740, and in September 1954 about $820.

By December 31, 1947—6½ years after the program began—a total of 847 blind men and women had been granted aid under the aid to potentially self-supporting blind residents statute. There were 173 of these individuals, or approximately 20 percent who had become self-supporting.

As of June 30, 1949—after 8 years of operation of the program—933 different blind men and women had been granted aid under the program. There were 316 persons, or almost 32 percent of the total who had achieved self-support for periods of time varying from several months to permanent self-maintenance.

During the fiscal year ending June 30, 1953, almost 25 percent of all cases discontinued were due to income from earnings of the individual.

During the fiscal year ending June 30, 1954, a total of 173 recipients of aid to potentially self-supporting blind residents had their aid discontinued for various reasons, and 32 percent of this number were discontinued because of earnings.

During the fiscal year ending June 30, 1955, a total of 155 recipients of aid to potentially self-supporting blind residents were discontinued, 49.1 percent because of earnings.

During the fiscal year ending June 30, 1956, a total of 137 recipients were discontinued for all causes. Of this number, 33 percent were discontinued because of earnings. Stated in another way, there were 46 persons discontinued due to earnings. Since the statewide caseload during that fiscal year was 391 cases, this means that almost 12 percent were discontinued because of earnings.

During the fiscal year ending June 30, 1957, 11.5 percent of all aid to potentially self-supporting blind residents cases became self-supporting for periods of time varying from several months to presumably complete self-maintenance.

During the calendar year of 1958 a total of 174 recipients of aid to potentially self-supporting blind residents were discontinued for all causes. Of this total, 30 percent were discontinued because of earnings. Some of these will have their aid restored while others have achieved permanent self-support. The rehabitative values of the aid to potentially self-supporting blind residents program can be seen by comparison with the results under aid to needy blind. During this same period only 2 percent of all discontinuances were due to the earnings of the recipient.

In other words, during the calendar year of 1958 some 52 recipients of aid to potentially self-supporting blind residents were discontinued because of earnings. This means that over 17 percent of the caseload achieved self-support for varying periods of time. It should be noted that for every recipient under the program who achieves permanent self-maintenance, there is a saving in public funds of approximately $1,475 every year. Thus, if 52 blind persons achieved full self-support during the calendar year 1958 (and some of these may have reapplied after several months) it would mean an annual saving in public assistance funds of over $76,000.

III. Summary and conclusions

The number of recipients under aid to potentially self-supporting blind residents who have achieved full self-support during the past 19 years is most encouraging and constitutes a tribute to the courage of these blind persons. We do not feel that this happy result could possibly have been achieved under the small amounts of exempt income and property permitted under the aid to needy blind program. This is particularly true in those many instances where the blind recipient moves gradually toward full self-support through the practice of a trade or profession or an operation of a business or agricultural enterprise.

One of the basic objectives in the social welfare programs for the blind in California is to assist blind persons to decrease dependency in all of its many forms. Self-support and self-care have recently been incorporated in title X of the Federal Social Security Act as basic objectives of aid to the blind. The provision of liberal exemptions of earned income and property ownership under the aid to potentially self-supporting blind residents statute have undoubtedly been powerful incentives to many blind men and women in their quest for economic independence since 1941. If the self-support objective of title X is to become at all meaningful, far more liberal exemptions of income and property must be permitted by the Federal Government in the States' aid to needy blind programs.

(The following letter was also recorded for the record:)

MISSOURI FEDERATION OF THE BLIND, INC.,
AFFILIATE OF NATIONAL FEDERATION OF THE BLIND, INC.,
St. Louis, Mo., June 26, 1960.

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

DEAR SENATOR BYRD: Long before Congress passed the Social Security Act, both Missouri and Pennsylvania maintained their own entirely State financed aid to the blind programs. Designed to encourage their clients to strive for rehabilitation, leading to partial or full self-support, these programs have been of incalculable social and economic value. Moreover, since Congress provided for Federal aid to the blind, these State programs have saved the Federal Treasury a very considerable sum by bearing the full expense of all grants-in-aid to blind Missourians and Pennsylvanians whose "estimated need" disqualified them from maximum assistance under the Federal plan. In other words, these States continued to assume full responsibility for the grants-in-aid to all their blind citizens who could qualify for some, but not maximum, Federal assistance.

Strange as it may seem, ever since the Social Security Act became law, the Federal Department of Health, Education, and Welfare has tried to destroy these splendid programs. At first, HEW withheld Federal participating funds in aid to the blind pending elimination of these State-financed plans. In 1950 however, the ban on such funds was temporarily lifted. Since then, four special acts of Congress have mercifully extended the cutoff date originally set by the Department of HEW as a deadline for Missouri and Pennsylvania to choose between abandoning their incomparable programs or forfeiting Federal participating funds in aid to the blind.

The current cutoff date is June 30, 1961; but H.R. 12580 provides for 3-year extension to 1964. Although this bill will undoubtedly undergo many changes before meeting with Senate approval, please give your full support to the 3-year extension of the cutoff date on Federal participating funds in aid to the blind of Missouri and Pennsylvania. By protecting these State-financed programs, you will be protecting the Federal Treasury as well. And through helping us to thwart unjust pressure from the Department of Health, Education, and Welfare, you may be instrumental in helping other States to see the folly of bartering their rights and duties in exchange for administrative funds from powerful Federal Bureaus.

Cordially yours,

ALMA MURPHEY, *President.*

Senator HARTKE. I just want to say I agree with the statement with regard to the statement by Mr. Nagle and also the fact that one of the most serious problems that the blind people have today is not the question of whether or not they can do the job but some of the prejudices against hiring them in the first place.

Thank you, sir.

Mr. NAGLE. Thank you.

The CHAIRMAN. The next witness is Dr. Eugene McCrary, American Optometric Association.

Doctor, have a seat, sir, and proceed.

STATEMENT OF DR. V. EUGENE McCRARY ON BEHALF OF THE AMERICAN OPTOMETRIC ASSOCIATION

Dr. MCCRARY. Mr. Chairman, and members of the committee, my name is Eugene McCrary and I am an optometrist practicing in College Park, Md.; for the past 3 years I have been a member of the Department of National Affairs of the American Optometric Association. I am also president of the Maryland Association of Optometrists, and a member of the Maryland State Board of Examiners (in optometry).

The legislation being considered by the committee is to be known as "The Social Security Amendments of 1960."

The bill, H.R. 12580, covers many phases of our social security program, but the one to which I will confine my remarks is known as title VI of the bill which would add a new title to the act to be known as "title XVI—Medical Services for the Aged."

It is my understanding that there is a possibility that the language of some of the other bills which have been introduced, dealing with this subject, may be substituted by way of an amendment for that contained in title VI of this particular bill.

In view of the time limitation, I have attached to my prepared statement suggested amendments for H.R. 12580, H.R. 4700 known as the Forand bill, and S. 3503 sometimes referred to as the McNamara bill.

My first recommendation is that any legislation enacted by Congress should, wherever possible use the word "health" rather than "medical."

This would mean that the title of the particular bill under consideration would be amended to read "Health Services for the Aged."

There are many disciplines besides medicine which render professional services to the American people and particularly to the aged.

The profession of optometry to which I belong is one of the most important if not the most important, discipline outside of medicine and dentistry.

Practically all of our older citizens who are beneficiaries of the social security system have vision problems. The vast majority of these are patients of optometrists. Because this bill is designed to provide assistance in a field that is frequently referred to as "major medical" and deals particularly with cases involving surgery, some of you may question the necessity of providing optometric services for the beneficiaries of the proposed law.

One of the most common surgical operations performed on our older citizens is that for the removal of cataract. Well over 50 percent of the cataract cases are detected by optometrists and referred to ophthalmologists for surgical care.

Notwithstanding the fact that the American Medical Association has declared that it is unethical for a doctor of medicine to confer on a professional basis with optometrists, or to teach in the schools and colleges of optometry, nevertheless, a substantial number of these patients are sent back by the surgeon to the referring optometrists for postoperative refraction and the furnishing of corrective eye wear.

Were it not for the hostile attitude of the American Medical Association toward optometry, and particularly its section on ophthalomology, more of these patients would be referred back to the optometrists. In many instances it is much more convenient and results in a smaller expenditure of time and money for the patient to go to an optometrist for postoperative refraction and for his lenses.

Under these circumstances it is imperative that the language of the bill be broadened.

Senator DOUGLAS. Mr. Chairman, may I ask the witness a question?

Doctor, you speak of the American Medical Association policy in terms of it being unethical for an M.D. to confer on a professional basis with optometrists?

Dr. McCRARY. Yes, sir.

Senator DOUGLAS. Does that mean a doctor who confers with you would be liable for expulsion from the medical association?

Dr. McCRARY. He would be liable to discipline which may include expulsion.

Senator DOUGLAS. Do you know of any cases where doctors have been disciplined?

Dr. McCRARY. I do not personally know of any cases.

Senator DOUGLAS. Do you think it exists?

Dr. McCRARY. Yes, sir; I do.

Senator BENNETT. Have you ever had a doctor confer with you?

Dr. McCRARY. Yes, sir.

Senator BENNETT. Do you know whether he was disciplined for that conferring?

Dr. McCRARY. No, I do not. My personal relations on a community basis with physicians is quite good, but this apparently in some areas it is my understanding that there is practically no interprofessional relationship due to this resolution.

Senator BENNETT. It isn't nationwide and it isn't automatic.

This punishment or disciplne is neither nationwide nor automatic?

Dr. McCRARY. It is not automatic, I don't think. It is my understanding that this was a resolution adopted by the AMA house of delegates. Therefore it probably is nationwide.

Senator BENNETT. Do you have the text of the resolution?

Dr. McCRARY. No, sir, but I will be happy to furnish it to the committee.

(The resolution referred to follows:)

RESOLUTION 77 OF THE AMERICAN MEDICAL ASSOCIATION, ADOPTED BY THE HOUSE OF DELEGATES IN ATLANTIC CITY, JUNE 1955

Resolved, That it is unethical for any doctor of medicine to teach in any school or college of optometry, or to lecture to any optometric organization, or to contribute scientific material to the optometric literature, or in any way to impart technical medical knowledge to nonmedical practitioners.

Senator DOUGLAS. Well, such advice as you get is bootleg advice, is it not, that is it is advice which they offer you contrary to the declaration of the AMA.

Dr. McCRARY. Yes, sir, I would say that is correct.

The CHAIRMAN. Any further questions?

Dr. McCRARY. If I may continue, sir. We would like to recommend that the beneficiaries of the program regardless of the form it takes, be accorded the freedom of choice of any practitioner duly licensed by the State to render the service to which the individual is entitled. We know only too well from past experience that an express mandate by Congress to this effect is indispensable if the individual is to possess this right.

As an example, permit me to remind you that by administrative action optometrists were originally excluded from participating in the aid to the blind program established by title X of the social security law.

In the interest of the beneficiaries of that title Congress by the 1950 amendments of that law, expressly required that State plans to be approved must make available the services of optometrists to the beneficiaries who desired to utilize them.

This has been of real benefit, particularly to beneficiaries living in smaller communities or rural areas where, in order to obtain services of opthalmologists or physicians skilled in diseases of the eye, the beneficiary must travel a distance of anywhere from 100 to 200 or 300 miles, while an optometrist might be his next-door neighbor.

To assure the beneficiary of this right, we respectfully recommend that there be added to H.R. 12580, title VI, section 601, "SEC. 1602(a)(6)" the following language:

* * * and shall accord the individual freedom of choice of any practitioner duly licensed to render the service to which the individual is entitled.

This follows the same pattern as the 1950 amendment to the aid to the blind program except that it includes all duly licensed health disciplines.

The Senate on Friday of last week, by unanimous action passed H.R. 7966, the sole purpose of which was to accord a similar privilege to veterans entitled to outpatient vision care.

The same reasons which prompted both the House and the Senate to pass this bill without a dissenting vote, are equally applicable to the proposed amendment to the pending legislation.

The American Medical Association is a great advocate of freedom of choice among physicians. At the same time they advocate limiting the choice of the patient to members of the medical profession, even though other professions in the health field are regulated and licensed by the States, and their services utilized extensively by those who are free to choose.

When Henry Ford, Sr., was first approached about offering the public a choice of colors in Ford cars, he is reputed to have said: "The purchaser is free to select any color he desires so long as it is black." That is the way the medical profession regards the entire field of health care the individual should be free to select the practitioner of his choice so long as he is an M.D.

It is contrary to the public interest and American tradition for Congress to pass legislation providing health care for any group of our citizens, and leave it in the power of the executive departments of the Government to require the beneficiaries to select only members of the medical profession to render a service which can be provided by another profession in the health field which is duly licensed and regulated by State law.

If our aged citizens are to have the same freedom of choice of practitioner under Government-sponsored health care programs that they do prior to the time they reach the qualifying age, the amendments attached hereto as exhibits, or comparable amendments, are indispensable.

I have referred to our experience under the aid to the blind program and vision care for the veterans. In conclusion I would like to mention briefly the experience of our profession in connection with our national defense.

The Army during World War II refused to commission optometrists and permit them to practice their profession. In the interest of the visual welfare of the Army (the Navy was commissioning optometrists and utilizing their professional services) Congress passed the Optometry Corps bill in May of 1945, over the strenuous opposition of the War Department and the American Medical Association.

While this bill was vetoed because World War II was drawing to a close, the administration because of this congressional action agreed to and did sponsor the Medical Service Corps law of 1947. This resulted in the commissioning of optometrists in the Regular Army, Navy, and Air Force.

There are now some 350 optometry officers on active duty in our Armed Forces, with ranks ranging from second lieutenant to colonel or the equivalent ranks in the Navy.

Even the Army Medical Corps now recognizes the invaluable services which optometrists are performing in caring for the vision of the man and woman in uniform and their dependents.

When some of the States have what are referred to as antidiscrimination laws, our National Government should not attempt to discriminate between professions that are duly licensed and regulated by State laws. The individual is entitled not only to assistance when needed but to freedom of choice as to who shall provide the health care services.

The detailed amendments are attached hereto as exhibits.

(The amendments referred to follow:)

PROPOSED AMENDMENTS TO H.R. 12580 TO ACCOMPANY THE STATEMENT OF DR. V. EUGENE MCCRARY, REPRESENTING THE AMERICAN OPTOMETRIC ASSOCIATION, JUNE 30, 1960

(Note: The page and line references are to the bill as introduced in the House on June 9, 1960)

Page 154, line 1, strike out the word "MEDICAL" and insert in lieu thereof the word "HEALTH"; line 5, strike out the word "MEDICAL" and insert "HEALTH"; line 9, strike out the word "medical" and insert "health"; line 15, same amendment; line 17, same amendment.

Page 155, line 3, same amendment; line 5, same amendment; line 8, same amendment; line 13, same amendment; line 16, same amendment; line 17, strike out the semicolon and insert the following: "* * * and shall accord the individual freedom of choice of any practitioner duly licensed to render the service to which the individual is entitled;".

Page 156, line 6, strike out the word "medical" and insert "health"; line 21, same amendment.

Page 157, line 7, same amendment; line 10, same amendment.

Page 158, line 13, same amendment; line 18, same amendment.

Page 159, line 4, same amendment; line 12, same amendment.

Page 160, line 5, same amendment; line 10, same amendment.

Page 162, line 4, same amendment.

Page 163, line 14, same amendment; line 15, same amendment; line 18, same amendment

Page 163, line 19, strike out the word "physician" and insert in lieu thereof the words "a duly licensed practitioner"; strike out the word "medically."

Page 164, line 6, strike out the word "medical" and insert "health"; line 8, same amendment; line 12, same amendment.

Page 165, line 8, same amendment; line 12, strike out the words "physicians' services" and insert in lieu thereof "health services"; line 13, strike out "a" and insert "an"; line 14, strike out "physician" and insert in lieu thereof "individual" and after the word "licensed" insert the words "to practice in the field of health care."

Page 166, line 9, strike out the words "a physician" and insert in lieu thereof the words "an individual duly licensed to practice by the State in the field of health care."

Page 167, line 18, strike out the word "Medical" and insert in lieu thereof the word "Health."

Page 168, line 2, strike out the word "medical" and insert in lieu thereof the word "health"; line 22, same amendment.

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Page 169, line 3, strike out the word "medical" and insert "health"; line 8, same amendment; line 24, same amendment.
Page 170, line 7, same amendment; line 23, same amendment.
Page 171, line 13, same amendment.
Page 178, line 5, strike out the word "Medical" and insert "Health"; line 6, same amendment; line 9, same amendment; line 10, same amendment; line 12, strike out the word "medical" and insert "health"; line 13, same amendment; line 16, strike out "medical" twice and insert "health" twice; line 19, same amendment; line 21, strike out "medical" and insert "health"; line 22, same amendment; line 24, strike out "medical" twice and insert "health" twice.

SUGGESTED AMENDMENTS TO H.R. 4700 (FORAND BILL—FEBRUARY 1959)

Page 7, line 10, strike out the period and add the following: "and except that in prescribing and furnishing corrective eye wear or lenses following eye surgery, such individual may select a duly licensed optometrist."
Page 11, line 16, after the word "dentists" insert "optometrists."
Page 12, line 8, after the word "dentist" insert "optometrist."
Page 16, line 11, after the word "homes" insert "optometrists."
Page 17, line 3, after the word "physicians" insert "optometrists."
Page 18, line 14, after the word "physician" insert "optometrist"; line 15, after the word "home" insert the words "postoperative."

PROPOSED AMENDMENTS TO S. 3503 (SOMETIMES REFERRED TO AS THE MCNAMARA BILL)

Page 1, line 3, strike out the word "Medical" and insert in lieu thereof the word "Health".
Page 2, lines 6, 13, 20, 25, strike out the word "Medical" and insert in lieu thereof the word "health".
Page 3, line 7, same amendment.
Page 4, lines 5 and 16, same amendment.
Page 5, lines 14 and 21, same amendment; line 24, strike out the word "physician" and insert in lieu thereof "duly licensed practitioner".
Page 6, line 1, strike out the word "physician" and insert in lieu thereof the word "practitioner"; line 3, strike out "medical" and insert "health".
Page 7, line 25, strike out "medical" and insert "health".
Page 10, line 5, after the word "homes" insert "(iv) clinics" after "and" strike out "(iv)" and insert in lieu thereof "(v)"; line 8, before the word "and" insert the word "clinics"; line 19, before the word "or" insert the word "clinic"; line 24, strike out "medical" and insert "health".
Page 11, lines 6, 16 and 22, same amendment; line 13, after "hospital," insert "clinic"; line 25, after the word "hospitals" insert "or clinics".
Page 12, line 22, strike out the word "and". After the word "services" insert "and clinics".
Page 14, line 3, after the word "agency," insert "clinic," line 6, before the word "or" insert the word "clinics"; line 14, strike out "medical" and insert "health".
Page 15, line 4, and in the balance of the bill, wherever the word "medical" appears, strike out the word and insert in lieu thereof the word "health"; line 10, before the word "or" insert "clinical services".

Dr. MCCRARY. Mr. Chairman, I want to thank you for this opportunity to express the views of our profession, and to assure you I will be happy to answer any questions you or the members of your committee may wish to ask.

The CHAIRMAN. Any questions.

Senator DOUGLAS. Doctor, I take it you object to being placed in a medical leper colony.

Dr. MCCRARY. Well, let me say we feel that it is important for the health and welfare of the American people to have all disciplines who work in the health care field to be heard and to cooperate together in carrying on and caring for the health needs of the American people.

Senator DOUGLAS. How long a period of study do the optometrists have to have?

Dr. McCRARY. The present requirements are 6 years at college level in some of our schools, and 5 years in the others.

Five years is the minimum.

Senator DOUGLAS. That includes liberal arts and then medicine, too; I mean optometry, too?

Dr. McCRARY. Yes, sir.

Senator DOUGLAS. Courses in physics and in vision and so forth?

Dr. McCRARY. Yes, sir; the subject matter in the preoptometry, premedicine, predentist is basically the same for the 2 years and then as you study in a more particular area of the field, we cover physiology and anatomy, psychology, physics, pathology, all of the various aspects.

Senator DOUGLAS. So you are not corresponding school doctors?

Dr. McCRARY. Positively no, to my knowledge.

Senator DOUGLAS. How do you account for the attitude of the American Medical Association?

Dr. McCRARY. Well, sir, that is a big question. I think frankly that there is basically an economic reason for it. I think basically that is the segment of vision care rendered the American public; there are two groups which render this care and that as a result of this there is some economic rivalry existing. This is my personal opinion, and I am speaking now as an individual giving his personal opinion.

This is my feelng, and this seems to be the basis.

Now to point up an illustration; In the Armed Forces, I had the privilege of holding a commission in the Medical Service Corps of the Navy.

I have served 2 years on active duty from 1951 to 1953. There is no problem with any professional cooperation when the economic factor is removed. I would say that interprofessional relationships were beautifully cooperative and I might add, too, for the benefit of the patient because when these differences take place, it is the patient ultimately who loses.

Senator DOUGLAS. You make a very serious charge, sir.

Dr. McCRARY. Well, we are quite concerned about this. We in optometry are quite anxious to resolve these differences because we feel it is in the public interest to do so.

Senator DOUGLAS. Have you tried to adjust this by conciliation with the AMA?

Dr. McCRARY. Yes; there has been in past years a committee known as the Interprofessional Committee on Eye Care which had representatives from medicine, optometry and opticianry, this committee operated, I believe, lived about 6 years and was disbanded about 5 years ago; it was disbanded in 1955, as a result of the action of the house of delegates of the AMA.

We would like to see this problem resolved and we would like to make every effort to do so.

Senator DOUGLAS. So you resort to legislation only as a last resort.

Dr. McCRARY. Yes; we feel that the optometrist is well trained to render the unique services which he offers to the public and he should not be disenfranchised from rendering this service.

Senator DOUGLAS. Thank you.

The CHAIRMAN. Any further questions?

Thank you, Doctor.

Senator HARTKE. Mr. Chairman, before the next witness is called I would like permission of the committee to insert in the hearings at this time a resolution approved by the Governors' Conference on June 29, 1960, advocating the medical care under the framework of the old age survivors and disability system and recording the vote of 30 for and 13 against with 11 not voting and also, not a part of the resolution but the statement that all the Governors present indicated they were for the principle of national health insurance plan for the aged although they voted, some voting against disapproved of OASDI financing.

The CHAIRMAN. Without objection, the insertion will be made a part of the record.

(The document referred to follows:)

TEXT OF RESOLUTION APPROVED BY GOVERNORS' CONFERENCE, JUNE 29, 1960

PROBLEMS OF THE AGING

Whereas the Governors' Conference for many years has been acutely aware of the growing number and complexity of problems faced by our increasing population of senior citizens, including health and medical care, employment and income maintenance, provision of suitable housing, and enrichment of leisure time activities; and

"Whereas the most pressing of these problems is the financing of adequate health and medical care; now, therefore, be it

Resolved by the 52d annual meeting of the Governors' Conference, That Congress be urged to enact legislation providing for a health insurance plan for persons 65 years of age and over to be financed principally through the contributory plan and framework of the old age survivors and disability insurance system; and be it further

Resolved, That the States support and participate actively in the forthcoming White House Conference on Aging to the end that public and private agencies be stimulated and encouraged to develop approaches to all the problems of the aging.

Vote: 30 for; 13 against; 11 absent or not voting.

Vote for (30): Alabama; Egan, Alaska; Arizona; Faubus, Arkansas; Brown, California; McNichols, Colorado; Ribicoff, Connecticut; Collins, Florida; Docking, Kansas; Combs, Kentucky; Maine; Furcolo, Massachusetts; Williams, Michigan; Freeman, Minnesota; Blair, Missouri; Montana; Nebraska; Sawyer, Nevada; Meyner, New Jersey; New Mexico; Rockefeller, New York; DiSalle, Ohio; Oklahoma; Rhode Island; Herseth, South Dakota; Tennessee; Texas; Vermont; Rossellini, Washington; Nelson, Wisconsin.

Vote against (13): Delaware; Georgia; Idaho; Illinois; Indiana; New Hampshire; North Carolina; South Carolina; Utah; Virginia; West Virginia; American Samoa; Virgin Islands.

Absent or not voting (11): Hawaii; Loveless, Iowa; Louisiana; Maryland; Mississippi; North Dakota; Oregon; Pennsylvania; Wyoming; Guam; Puerto Rico.

The CHAIRMAN. The next witness is Dr. Hugh E. Chance, International Chiropractors Association.

Dr. Chance, take a seat, sir.

STATEMENT OF DR. HUGH E. CHANCE, INTERNATIONAL CHIROPRACTORS ASSOCIATION; ACCOMPANIED BY DR. S. K. KEISER, LANCASTER, PA.

Dr. CHANCE. Mr. Chairman and members of the committee, I have with me Dr. S. K. Keiser of Lancaster, Pa., chairmen of our committee on legislation; previously in the room but he had to leave was Dr. John Thaxton, our vice president, from Raton, N. Mex.

I wish to correct an impression that may have occurred because of the reference to the title Doctor which appears on the witness list. I have a J.D. degree in law, and it should be, perhaps, Mister instead of Doctor.

My name is Hugh E. Chance. I am executive director and general counsel of the International Chiropractors Association with headquarters in Davenport, Iowa. Its membership represents a nonprofit professional association of thousands of practicing chiropractors throughout the United States.

First of all I wish to express appreciation to the committee for making time available to call attention to the significant fact that H.R. 12580, title VI in its present form does not permit the eligible individuals; namely, those over 65 who qualify for benefits, to use or employ chiropractic services.

This, notwithstanding the fact that chiropractic is the second-largest healing art in the United States (estimated at over 20,000 now in practice); notwithstanding the fact that chiropractors are licensed to practice in 46 of the 50 States; and notwithstanding the fact that between 30 and 40 percent of the family groups in the United States make some use of chiropractic services each year. It is also significant that more people in the older age brackets go to chiropractors than do people in other age groups.

We wish to urge that the people who are to be the beneficiaries of this legislation should have freedom to choose the doctor and the method of health services; that those who are chiropractic patients should not be completely discriminated against.

We are not involved here with any consideration of the relative merits of one system of healing versus another system. Nor are we concerned with legal recognition of chiropractic. That matter is for the several States to consider and, as we have already indicated, 46 of them have granted legal status to the chiropractic profession.

What we are concerned with here is permitting the beneficiaries under this proposal to make use of services already recognized by the vast majority of States.

For this reason, it is proposed that title XVI, Medical Services for the Aged, section 1606(e), H.R. 12580, be amended as follows:

(e) The term "physicians' services" means services provided in the exercise of his profession in any State by a physician, osteopath, or chiropractor, licensed in such State; and the term "physician" includes a physician, osteopath, or chiropractor licensed in such State. * * *

This amendment as presented would guarantee the continuance of benefits already offered through most State old-age assistance programs successfully operating today. To fail to include chiropractic in some manner in this legislation presently before your committee, or other legislation now before the Congress, would in effect cancel or abrogate the right of a potential of several million citizens to use a healing service proven to be of great personal value.

In conclusion and on behalf of the members of the International Chiropractors Association I again wish to express appreciation to the distinguished members of this committee and the honorable chairman for the courtesy of granting time for this presentation.

The CHAIRMAN. Thank you. Any questions?

Senator HARTKE. What I would like to ask, implied in your statement is that you approve, generally speaking, of the type of legislation which would give care in problems of health as I understand it to the aging; is that right?

Mr. CHANCE. Yes, the association is sympathetic to this move. It has not, however, taken any definitive action on any particular proposal.

Senator HARTKE. Nor on the method of financing?

Mr. CHANCE. No.

Senator HARTKE. Your sole concern at this time is that when and if legislation is approved that it be amended generally along the lines which you have indicated?

Mr. CHANCE. That is correct.

Senator HARTKE. Thank you.

Senator CURTIS. I am trying to locate section 1606(e).

Mr. CHANCE. It is on page 165, down about the middle of the page.

Senator CURTIS. Of this publication?

Mr. CHANCE. No, of the House bill, H.R. 12580, it is on lines 12 to 16.

Senator CURTIS. Is that term defined in the present law relating to medical assistance for old age assistance?

Mr. CHANCE. The reference is back to section 1101, subparagraph (a)(7) in the 1956 social security law, and all that that says on reference is that osteopaths are included in the term "physician," so by using——

Senator CURTIS. In other words, does this take a different definition of physician here than existing law?

Mr. CHANCE. Yes, properly speaking, although this is not up for amendment at this time, and that is the reason we did not ask for it as only this particular bill is up for consideration at this time.

Senator CURTIS. But are we going to have—here is the social security law, which is quite a volume in itself—are we going to have under the social security system, under the various titles more than one definition of physician? I am not quarreling with your position.

I am trying to get the thing straight. I notice that in the compilation of the social security law, section 1101, paragraph 7(a)(7), the term "physician" and "medical care" and "hospitalization" includes osteopathic practitioners and the services of osteopathic practitioners and hospitals within the scope of the practice as defined by State law.

Are chiropractors excluded under this?

Mr. CHANCE. Yes, they are.

Senator CURTIS. Osteopaths are included?

Mr. CHANCE. Correct.

Senator CURTIS. Do you know what the legislative history of that was?

Mr. CHANCE. No, I am sorry, I do not.

Senator CURTIS. You are speaking now of the definition if the new title is accepted?

Mr. CHANCE. Yes.

Senator CURTIS. Is that what you would like to have?

Mr. CHANCE. Yes, sir.

Senator CURTIS. You are not making that recommendation as to the existing law elsewhere unless the draftsmen say that is the way to do it?

Mr. CHANCE. Yes, we have no particular choice of wording or choice of location on this section but we say when services are provided for the aged qualifying under this bill or any other bill which the Congress might choose to pass that the chiropractors should be included.

Senator CURTIS. Thank you.

The CHAIRMAN. Senator Curtis, do you have any further questions?

Senator CURTIS. No.

The CHAIRMAN. Thank you very much.

The next witness is Mr. Wilbur J. Cohen.

Senator DOUGLAS. Mr. Chairman, I think is it well known that Dr. Cohen is one of the leading authorities in the Nation on the whole subject of social security. He was a distinguished member of the Social Security Administration for many years and has now for some years been at the University of Michigan. I don't know anyone in the country who knows more about the problems of social security and old age than does Dr. Cohen.

I must say I await his testimony with great interest.

Dr. COHEN. Thank you, Senator Douglas.

STATEMENT OF WILBUR J. COHEN, PROFESSOR OF PUBLIC WELFARE ADMINISTRATION, UNIVERSITY OF MICHIGAN

Mr. COHEN. I had at this late hour thought that I might forgo my testimony and spare the committee this extra labor. But as I sat in the back of the room, thinking that it was only Senator Byrd and myself here today who 25 years ago sat in the Finance Committee when it was first considering social security I thought I ought to take advantage of this historic occasion to say a few words to the committee.

This is the 25th year, Senator Byrd, of the Social Security Act. A lot has transpired in that time, and I think it is well worth an opportunity to reflect on some of that experience.

I am testifying here in several capacities. I was a member of the Advisory Council on Public Assistance appointed by the Secretary of Health, Education, and Welfare pursuant to the amendments adopted by this committee in 1958, which requested that a thorough evaluation be made of the public assistance program. Some of the amendments in the House-passed bill, reflect the views of this Advisory Council on Public Assistance, whose report has been made to you, but the recommendations of which have not yet been put into the record.

In part, the House Committee on Ways and Means did consider some of the recommendations of the Advisory Committee, and I should like to comment briefly upon them.

I should like to ask permission first to insert in the record a statement of the American Public Welfare Association on this bill since as a member of their welfare policy committee, I have been asked to represent them here today, too. I should like to summarize, after putting the statement in the record, their main views.

The CHAIRMAN. Without objection.
(The document referred to follows:)

STATEMENT OF THE AMERICAN PUBLIC WELFARE ASSOCIATION ON H.R. 12580, SOCIAL SECURITY AMENDMENTS OF 1960, TO THE SENATE COMMITTEE OF FINANCE

This statement presents the views of the American Public Welfare Association on H.R. 12580, the Social Security Amendments of 1960, as passed by the House of Representatives.

The American Public Welfare Association is the only national organization of local and State public welfare departments and of individuals engaged in public welfare at all levels of government. Its membership includes Federal, State, and local welfare administrators, board members and welfare workers from every jurisdiction. As the result of the discussions in our councils, committees and conferences, our board of directors of 27 persons, representing all parts of the country, adopts official policy positions on issues of current significance. These policy positions govern the association's testimony on proposed legislation relevant to the field of public welfare.

Over the years the association has supported strongly all sound recommendations which have advocated broadening and strengthening the social insurance programs of our country. We have talked many times with the Senate Committee on Finance about our observations of the social insurance and public welfare programs and believe that we have unique background for evaluating the interrelationship of social insurance and public asssitance.

COMMENTS ON TITLE XVI

For more than 20 years, the association's medical care committee, made up of persons knowledgeable in health and welfare programs throughout the country, has studied the medical care problems of needy and low-income individuals and families and methods of administering and financing medical services required by them. The medical care committee is fully familiar with the present extent of medical care programs in public welfare and with the gaps which still remain. Despite the fact that the association, since its inception almost 30 years ago, has considered as a major responsibility the stimulation and promotion of programs of medical care of adequate quality and quantity in the public assistance programs, and although there have been very large expenditures for medical care in these programs, we find that there are gaps and deficiencies still existing in many States with respect to the provision of medical care for the needy aged and other needy persons. We do not believe there are more than 15 to 20 States in which needy persons, including the aged, can receive all the medical care they require with the assistance of public funds. We are in full agreement with the decision of the House Ways and Means Committee, therefore, that there must be action taken to improve the provision of medical care for aged persons, although we are not in complete agreement with the method suggested, nor do we believe that the proposal fully meets the need.

H.R. 12580 proposes that a new Title XVI, Medical Services for the Aged, be added to the Social Security Act. We have studied this title with care and have certain comments which we would like to submit for consideration.

We approve:

1. The prohibition in title XVI against the imposition of residence requirements as an eligibility factor in determining eligibility of low-income aged persons for medical care;

2. The fact that the bill recognizes the broad scope of services needed by the aged (although we do disagree with the limitations in amount placed on certain essential services and supplies);

3. The requirement that both institutional and noninstitutional services be provided to the aged. This, we believe, will serve to reduce unnecessary institutionalization of older persons;

4. The prohibition against an enrollment fee premium or similar charge to be imposed as a condition of any individual's eligibility for medical benefits under the plan. (We believe that there should also be a prohibition against any deductible or coinsurance feature since this is a needs program and not an insurance program.)

DOVETAILING TITLE XVI INTO TITLE I

We question whether there is actual need for this new title, even though we agree with the intent and the provisions we have commented on. Essentially the program described in title XVI is part of the old-age assistance program and a number of States are already assisting medically needy aged persons under title I. We believe that the same ends could be achieved by amending title I to make clear the intent of Congress that old-age assistance should include aged persons of low income who are unable to finance their full medical care requirements. It appears to us, from the viewpoint of economical and sound administration, that this revision of title I would be more satisfactory than the establishment of a wholly new title. We believe, too, from our observation of State legislative activities, that most States would find it more possible to obtain authorization, if needed, to expand services and assistance under title I than to obtain legislation establishing a "new" program. As one example, we would point out that Texas would undoubtedly need a constitutional amendment in order to participate in title XVI.

COMMENTS OF SECTION 602 OF THE BILL

In this connection we would like to comment on section 602 of H.R. 12580 which proposes somewhat more favorable Federal matching for States (an increase in the matching ratio of 5 percent) contingent upon a showing of an improvement in their old-age assistance medical care program. There are both inequities and problems in this provision since it would provide no additional funds in OAA medical care to those States that have, at great State expense and with very limited Federal matching, financed broad programs of medical services and supplies for aged persons. These States, of course, could show no improvement in their medical care programs since they already include all essential medical requirements. We are in full agreement that the poorer States need additional help but we think that this can be accomplished through further modifications of the matching formula based upon per capita income in the States. The improvement grants suggested in section 602 would, in fact, reward a number of average or high income States that have been backward in meeting the medical care requirements of their aged persons. Our suggestion that title XVI be included in title I would do away with this provision and would make it possible, through an appropriate modification of the matching formula, to establish a more equitable method of Federal participation for both the higher and lower income States.

COMMENTS ON SECTION 705 OF THE BILL

The association is pleased to note section 705 of H.R. 12580, which would amend the general provisions of the Social Security Act to require the Secretary to develop and revise from time to time guides or recommended standards as to the level, content, and quality of medical care and medical services to be used in evaluating and improving the public assistance medical care programs, including programs of medical services for the aged. We have long felt that the Department, through its Bureau of Public Assistance, should provide more

leadership to the States in this connection. We are pleased to see a recommendation of this kind in the recent report of the Advisory Council on Public Assistance. We would suggest that in addition to this provision there be a requirement that the Secretary establish a broadly constituted medical advisory committee, as was also recommended in the report of the Advisory Council on Public Assistance.

HEALTH INSURANCE FOR OASDI BENEFICIARIES

We believe, however, that even with the changes we have suggested in title XVI and related portions of H.R. 12580, our country would be far from meeting the health needs of all aged persons. In our opinion this can only be done through an extension of the old-age, survivors, and disability insurance program to include health service benefits. We will still need provisions under public assistance for those persons who do not qualify under OASDI, but we are fully convinced that the social insurance mechanism is the soundest approach to meeting medical need for the great bulk of aged persons.

The association, as a result of its studies, has included in its Federal legislative objectives, which are reviewed each year by the association's board of directors, the following statement:

"Health costs of old-age, survivors, and disability insurance beneficiaries should be financed through the OASDI program. Arrangements for achieving this objective should take into account the priority needs of the groups to be served; availability of facilities, personnel and services; and protection and encouragement of high quality of care, including the organization of health and related services to effect appropriate utilization of services and facilities."

As this policy statement indicates, we are in full accord with the principle of amending the OASDI program to include the financing of certain health benefits for social security beneficiaries. We believe that it is not the wish of the American people that substantial numbers of our aged citizens be required to turn to public assistance for help with their medical needs. Whereas cash benefits under the OASDI program in many instances may be sufficient for the individual's average maintenance requirements, it is rare that medical costs of an unpredictable or large character can be met unless the aged or disabled person has considerable other income and resources. It has been established that only a small proportion of aged and disabled people fall into this fortunate group.

We strongly urge, therefore, the establishment of a program of health benefits for social security beneficaries as part of OASDI. This program, together with the expansion of OAA to provide better for the medical needs of persons not eligible under social insurance or whose needs cannot be fully met in that way, would give to all aged persons the assurance that they will not have to go without essential medical care when their working years are over. We subscribe to the principle of financing the costs of any health insurance benefits to OASDI beneficaries through the contributory social insurance program so widely accepted by the American people. We believe that it is both proper and desirable for all employers, employees, and the self-employed to finance the costs so that individuals during their working years will build for themselves health insurance coverage which will meet their needs after retirement. It appears that voluntary insurance cannot accomplish this for any large number of persons within the reasonably near future.

SUPPORT FOR OTHER PROVISIONS IN THE BILL

We should like to comment briefly on some of the social insurance provisions in H.R. 12580. It appears to us that the recommendations for change, both major and minor, are in the right direction. We are particularly pleased with the removal of the age 50 limitation for disability insurance benefits. We support strongly, too, the measure which would strengthen the rehabilitation aspects of the disability program by providing a 12-month period of trial work during

which benefits would be continued for all disabled workers who attempt any planned rehabilitation rather than limiting this trial work period to those receiving services under the official Federal, State vocational rehabilitation program, as at present.

We support the change in the insured status requirement for retired workers, the new benefit protection provisions for widows and children, and the extension of coverage to self-employed physicians and to a number of other groups.

We are pleased to note that the authorization for appropriation for the maternal and child health services program would be increased to $25 million and the services for crippled children authorization to $25 million. We are disappointed that the bill proposes that the authorization for appropriation for the child welfare program be increased only to $20 million. Our studies of needs in this program indicate that this authorization, too, should be increased to $25 million and we have previously recommended this to the Congress. The new authorization for research and demonstration projects in the child welfare services program, which would permit grants to public and other nonprofit institutions and agencies for this purpose, would meet an existing need for further study in the child welfare field.

Mr. COHEN. I might say that the State welfare administrators as a whole, and those persons who make up the American Public Welfare Association, after considering the proposal of the Secretary of Health, Education, and Welfare, and conferences with him at which we attended at his request, we come to the conclusion that the plan he presented to the committee yesterday from the standpoint of State and local administration is not a realistic plan that can or should be adopted at this time.

Senator DOUGLAS. That is the opinion of the American Public Welfare Association.

Mr. COHEN. That is correct, Senator.

Senator DOUGLAS. Consisting of State directors of public welfare.

Mr. COHEN. Yes, sir.

Senator DOUGLAS. And who are in the public welfare field.

Mr. COHEN. That is correct.

Senator CURTIS. Just for the record when did they arrive at that conclusion?

Mr. COHEN. First, the Secretary called the executive committee of the State administrators in for a conference.

Senator CURTIS. Yes, sir.

Mr. COHEN. I can't remember the date but it was at the time the Ways and Means Committee was considering the legislation and the chairman of the Ways and Means Committee asked that they consult the Senate welfare administrators, which was done.

Senator CURTIS. How large is the executive committee?

Mr. COHEN. At that time it was 6, 8, or 10.

Senator CURTIS. How many attended?

Mr. COHEN. About that number, I would say maybe eight, and since that time, Senator, the board of directors of the American Public Welfare Association has met to discuss this. I don't want to imply that this represents the view of every single State administrator because they were not consulted individually.

Senator CURTIS. I am not quarreling with you, but I think we should keep this in mind, with reference to these telegrams of Governors, and others, if we put them in the proper perspective.

How many people have seen the formalized plan developed by Flemming?

Mr. COHEN. Well——

Senator CURTIS. At the time you take the action?

Mr. COHEN. At the time they took the action Secretary Flemming presented to us a summary of his proposal, cost estimates State by State which were probably the same ones that were discussed here yesterday, and the details of the plan but not a specific bill. There was no bill at that time, but the main elements, including the matter of deductibles, coinsurance and use of the State agency——

Senator CURTIS. So this is the action of the executive board?

Mr. COHEN. Yes, sir.

Senator HARTKE. If you will permit me to interrupt and if you will yield at that point, there is no bill embodying the Flemming proposal today.

Mr. COHEN. We did not see one at the time.

Senator HARTKE. There isn't any.

Senator DOUGLAS. It was more than the executive committee, was it not? The board of directors approved this statement.

Mr. COHEN. The board of directors did not formally approve this statement which I submitted to you. They discussed it. It was not formally presented to them at that time for their endorsement.

The second point I want to make is a rather important point, that all of the objectives of this new title 16 that are in the House bill, could be achieved by dovetailing them into the provisions of title 1 into the present act without the need of setting up an entirely different or new category of grants, with separate plan requirements.

In other words, insofar as there are good purposes, objectives, and provisions in the new title 16, why not put them directly into title 1?

Senator CURTIS. Are you saying that by revising the eligibility, so far as the means test is concerned, you can carry out title 1?

Mr. COHEN. Yes, every single new provision that is in title 16 could be inserted into title 1 because the objective of title 16 is nothing more than saying "We wish to broaden the concept of medical care more explicitly in title 1 for needy aged persons." So there is absolutely no reason why there needs to be a whole new title, a wholly new set of plan requirements asking the Governors, the budget directors, the legislatures to give authorization to a whole new program, when that program already exists under title 1 and if you want to say that you think the provision should be more liberal or changed, the committee could well insert that into title 1.

There is absolutely no reason that there needs to be the whole new title.

Senator CURTIS. All of these recent remarks are in reference to a bill that passed the House.

Mr. COHEN. Yes.

Senator CURTIS. Not as to Mr. Flemming?

Mr. COHEN. No, I am speaking now of the more limited plan of what might be called the medically indigent proposal in title 16.

Senator CURTIS. What are you say—a big change in that in existing law is a definition of who is in need?

Mr. COHEN. Absolutely. All really title 16 does is create a legislative history that says "The definition of need in section 6 of title 1, should be looked at by the States as being a little bit more liberal than the test of economic need for cash assistance."

Now it does put in some different plan requirements which are important, but every single objective, Mr. Curtis, of title 16 can be achieved within the present arrangements of title 1.

I have gone through the whole title, and can indicate where various provisions can easily be deleted because some of them are simply repetition of what is now in title 1.

My third point is that section 602 of the bill in title VI which provides for this 5 percent improvement of medical care for old-age assistance recipients in title 1, is really very inequitable, very difficult to administer, and in our opinion ought to be eliminated.

If you will recall Secretary Flemming's testimony, he gave a half-hearted endorsement of it.

He said he thought it was worth trying, but actually, it seems that it is very inequitable. For instance, the State of Illinois wouldn't get anything out of that provision at all, because the State of Illinois already has a very broad-gaged medical-care program. So because it went ahead and on its own out-of-State and local money made the improvement, it would not get anything at all. This provision also puts into the Secretary's hands the authority to determine what is a significant improvement in medical care, which in my opinion would run into a lot of controversy as to what is significant and what is not significant.

I think in the interests of good administration and sound Federal and State relations between the States and Federal Government it would be much better if that were eliminated.

Fourth, the new planning grant money that is contained in section 603 is not necessary in any way whatsoever, because the present title 1 already authorizes 50 percent Federal grants to the States for the administration of medical-care programs for public assistance. So there is a whole new section in here authorizing 50-percent funds to the States up to $50,000 per State, which absolutely is not necessary whatsoever.

The States already have that opportunity to get full Federal matching for planning in medical care, and it would seem to me that that section is unnecessary and just can be eliminated.

It is already in existing law.

Fifth, if title 16 is retained in the wisdom of this committee, if you should decide that you do want to create a whole new medical-care program for the medically indigent, then we do have some specific suggestion for elimination of what we think is much of the surplus language in title 16, which is not designed in any way to assist the States in giving them latitude but rather to curtail them in meeting the needs of people in the medical-care field.

For instance, certain limits are put on laboratory and X-ray expenditures which the States do not have any limitation on now, if you are to meet the laboratory and X-ray costs of individuals on a matching basis, well, you ought to meet them.

So it seems to us that these various limitations and specifications in the bill are not consistent with title I. Title I at the present time now just uses the term "medical care" and leaves it entirely up to each State to determine how much or how little of medical care it wants and matches the Federal funds on that basis.

So we think if you do include title 16 in principle you ought to go over it with a very fine-tooth comb and remove much of what is really unnecessary to effective Federal-State relations.

Sixth, there is a section 705 in the bill which carries out the recommendations of the advisory council on public assistance, of which I was a member establishing medical care guides and reports for public assistance and medical services for the aged.

We think this is highly desirable and we endorse the provisions.

However, in our report of the advisory council on public assistance we did recommend that there should be established an advisory committee on public assistance medical care.

We repeat that recommendation and urge that you include it into the law, and provide that the Secretary in establishing any such guides or standards shall consult with this committee. We believe that on this committee should be representatives of doctors of the medical association, and other persons, including the professions that have an interest, in order to assist the Secretary in establishing those guides and standards so that medical care in this country can be improved. We think that should be incorporated in the section 705 of the bill which creates section 1112 of the act.

Seventh, I would like to make this point, and I think Senator Byrd may be interested in it in connection with the points he made yesterday with the Secretary.

When we made this report, Mr. Chairman, the advisory council on public assistance, which I hope all of the members will study because it was made to the Senate, we asked that the Department do a study of what was the existing deficiencies in the State public assistance programs at the present time for just the present beneficiaries, not broadening the program with respect to new classes. When you are considering the fiscal implications of this program, I would like to draw attention to the table on page 69 of our report, which points out

that at the present time for medical care of just the old-age assistance recipients on the rolls, there is an estimated deficit of $268 million in the present program to meet a reasonable standard of medical care throughout the United States for just the 2.4 million aged persons on the existing assistance rolls. I am not talking about any other group.

(The tables are as follows:)

TABLE 1.—*Old-age assistance and aid to dependent children combined—Estimated annual increase needed[1] in public assistance payments under specified measures*

[Based on numbers of recipients and amounts of assistance expenditures for public assistance at end of calendar year 1958]

Measures used to estimate needed increase	United States	Geographical region[2]			
		Northeast	North Central	South[3]	West
	A. Estimated total increase needed for basic living requirements and special needs including medical care (annual rate in thousands)				
Cost measure of recipient's requirements other than for medical care:					
1. State cost standards, end of calendar year 1958	$576,690	$18,605	$96,055	$423,335	$38,695
2. Twice cost of USDA low-cost standard food plan (for basic items only; special nonmedical needs as in State cost standards):					
(a) Average U.S. cost	1,108,335	78,920	186,500	777,435	65,480
(b) Average cost in specified region	1,090,445	113,300	207,465	688,860	80,820
	B. Estimated increase needed for basic living requirements and special needs excluding medical care (annual rate in thousands)				
Cost measure of recipients' requirements other than for medical care:					
1. State cost standards, end of calendar year 1958	$254,505	$3,335	$51,505	$192,540	$7,065
2. Twice cost of USDA low-cost standard food plan (for basic items only; special nonmedical needs as in State cost standards):					
(a) Average U.S. cost	786,150	63,650	142,010	546,640	33,850
(b) Average cost in specified region	774,260	98,030	162,975	458,065	55,190
	C. Estimated increase needed in medical care expenditures (annual rate in thousands)				
Average amount for medical care per recipient in all States estimated at median amount for 24 States with expenditures above the national median:					
Total, old-age assistance and aid to dependent children combined	$322,185	$15,270	$44,490	$230,705	$31,630
Old-age assistance	268,270	10,230	34,890	194,535	28,615
Aid to dependent children	−53,915	5,040	9,690	36,260	3,015

[1] To meet full need for public assistance for costs of basic living requirements and special needs other than medical care and to provide, through public assistance, medical care in all States similar in scope and cost to care provided in 24 States with average medical care costs per recipient above the national median.

[2] As defined by the U.S. Bureau of the Census; see footnote 3 of text of report, p. 69, for listing of States included in each region.

[3] Estimated increases under the special adaptation of the standard food plan for the South would be about $31,000,000 less annually than under the estimate based on costs of the standard food plan at average cost in the southern region.

NOTE.—See tables 2, 3, and 4 for detailed figures from which above totals are computed.

TABLE 2.—*Old-age assistance and aid to dependent children, separately—State cost standards: Financial need met by public assistance payments for basic requirements and special needs other than for medical care under State cost standards at end of calendar year 1958*

Item	Old-age assistance [1]					Aid to dependent children [2]				
	United States	Geographical region [3]				United States	Geographical region [3]			
		Northeast	North Central	South	West		Northeast	North Central	South	West
	A. Basic data on which estimates were based: Total for 1 month for all recipients combined (in thousands)									
Amounts as determined under State cost standards, end of 1958:										
1. Total amount of recipients' requirements [4]	$215,525	$32,032	$52,746	$81,383	$49,364	$103,575	$23,753	$25,794	$34,954	$19,074
2. Total amount of recipients' income (other than assistance)	50,174	6,529	12,836	18,989	11,820	17,697	3,661	4,483	6,896	2,657
3. Total amount of need (item 1 minus item 2)	165,351	25,503	39,910	62,394	37,544	85,878	20,092	21,311	28,058	16,417
4. Total amount of assistance payments [5]	156,458	25,362	38,496	55,285	37,315	73,562	19,955	18,428	19,122	16,057
5. Unmet need (item 3 minus item 4)	8,893	141	1,414	7,109	229	12,316	137	2,883	8,936	360
	B. Average monthly amounts per recipient									
Amounts as determined under State cost standards, end of 1958:										
1. Amount of recipients' requirements [4]	$89.49	$111.80	$91.71	$73.87	$110.93	$39.44	$42.25	$43.59	$32.96	$46.34
2. Amount of recipients' income (other than assistance)	20.83	22.79	22.32	17.24	26.56	6.74	6.51	7.58	6.50	6.45
3. Amount of need (item 1 minus item 2)	68.66	89.01	69.39	56.63	84.37	32.70	35.74	36.01	26.46	39.89
4. Amount of assistance payments [5]	64.96	88.52	66.94	50.18	83.86	28.01	35.50	31.14	18.03	39.01
5. Unmet need (item 3 minus item 4)	3.70	.49	2.45	6.45	.51	4.69	.24	4.87	8.43	.88
	C. Percent of need for assistance met by assistance payments under State cost standards									
Percent	94.6	99.4	96.5	88.6	99.1	85.7	99.3	86.5	68.2	97.8
	D. Annual amount of increase in assistance payments necessary to meet need under State cost standards (in thousands)									
Total amount	$106,720	$1,690	$16,970	$85,310	$2,750	$147,790	$1,645	$34,595	$107,230	$4,320
Percent of expenditures, end of 1958	5.7	0.6	3.7	12.9	0.6	16.7	0.7	15.6	46.8	2.2

Data for old-age assistance were estimated by staff of the Social Security Administration on the basis of selected data reported by the States as explained in the attachment "Sources Used for the Estimates."

[2] Basic data for aid to dependent children were reported by the individual States, as indicated in table 4.

[3] As defined by the U.S. Bureau of the Census.

[4] For old-age assistance amount of requirements estimated includes (1) cost of basic requirements and of special needs other than medical care as in State cost standards and (2) amounts for medical care as paid; that is amounts included in money payments to recipients and paid to suppliers of goods and services. For aid to dependent children amount of requirements which was reported by the States, includes only costs of requirements to which money payments to recipients were related; these requirements include basic items and special needs including medical care. Amounts directly paid to suppliers of medical care for aid to dependent children recipients were excluded from the amount of requirements because they were excluded from the data reported by the States, their inclusion for purposes of this report would have introduced contradictions in relating other data reported by the States to the total cost of requirements.

[5] For old-age assistance, amounts of assistance include amounts in money payments to recipients and amounts paid directly to suppliers of goods and services. For aid to dependent children, amounts of assistance include only money payments to recipients for reasons explained in footnote 4.

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TABLE 3.—*Old-age assistance and aid to dependent children, separately—Cost standards for basic requirements estimated at twice specified food costs in USDA low-cost food plan: Financial need met by public assistance payments for basic requirements and special needs other than for medical care at end of calendar year 1958, under specified measure of total cost for basic items* [1]

Low-cost USDA food plan from which estimate of total cost of basic requirements is derived [3]	Old-age assistance [2]					Aid to dependent children [2]				
	United States	Geographical region [2]				United States	Geographical region [2]			
		Northeast	North Central	South	West		Northeast	North Central	South	West
	A. Percent of need for assistance, under specified measure, met by assistance payments									
1. Standard USDA food plan:										
(*a*) Average U.S. cost	94.2	99.4	96.4	87.7	99.4	56.8	79.5	64.0	33.6	86.1
(*b*) Average cost in specified region	94.4	99.3	96.1	88.4	99.4	57.1	71.4	60.5	38.2	78.6
2. Adaptation of standard plan for South [4]	94.5			88.6		58.2			40.2	
	B. Average monthly amount of unmet need per recipient									
1. Standard USDA food plan:										
(*a*) Average U.S. cost	$3.98	$0.51	$2.52	$7.05	$0.51	$21.30	$9.17	$17.55	$35.64	$6.30
(*b*) Average cost in specified region	3.84	.63	2.72	6.60	.51	21.05	14.21	20.31	29.14	10.62
2. Adaptation of standard plan for South [4]	3.78			6.47		20.14			26.88	
	C. Total amount of unmet need (all recipients combined)—annual rate (in thousands)									
1. Standard USDA food plan:										
(*a*) Average U.S. cost	$115,050	$1,765	$17,375	$93,160	$2,750	$671,095	$61,880	$124,635	$453,480	$31,100
(*b*) Average cost in specified region	110,940	2,145	18,745	87,300	2,750	663,320	95,880	144,230	370,770	52,440
2. Adaptation of standard plan for South [4]	109,120			85,480		634,560			342,010	
	D. Percentage increase in assistance expenditures necessary to meet need									
1. Standard USDA food plan:										
(*a*) Average U.S. cost	6.1	0.6	3.8	14.0	0.6	76.0	25.8	56.4	197.6	16.1
(*b*) Average cost in specified region	5.9	.7	4.1	13.1	.6	75.1	40.0	65.2	161.6	27.2
2. Adaptation of standard plan for South [4]	5.8			12.9		71.9			149.0	

[1] Amount of needed increase shown is total of amounts under State cost standards (as shown on table 2) plus amounts by which State cost standards for basic items were inadequate under the measures in which the total cost for basic items was estimated at twice the food costs in the specified low-cost USDA food plan.

[2] See table 2 for relevant footnotes.

[3] See text of app. B for discussion of the USDA food plans.

[4] Figure for United States includes figures for the South that were derived from the adaptation of the standard USDA low-cost food plan and figures, for other regions derived from the regional cost of the standard food plan.

In other words, when this committee is considering the fiscal implications of the program, I think you have to be aware of the fact, as I know you have been many times when proposals for changing the Federal-State formula are concerned, that the estimate shows that, if you were to bring all the States up to this minimum level there would need to be $268 million more.

Senator CURTIS. How much is spent now?

Mr. COHEN. On medical care?

Senator CURTIS. Well, on this item where you said there was a deficit of $268 million.

Mr. COHEN. Well, on medical care alone, using your staff's excellent report on this matter, they show that for vendor payments and medical care in old-age assistance in table 2 of your report that $220 million was spent in 1959.

Senator CURTIS. That is Federal funds?

Mr. COHEN. No, that is the total that is Federal-State.

Senator CURTIS. The total?

Mr. COHEN. Yes, sir.

Senator CURTIS. And you say that is $268 million short?

Mr. COHEN. Yes, sir; according to the reported based on 1958 levels.

Senator CURTIS. What is the per capita cost there, if they would supply this deficit?

Mr. COHEN. The per capita cost is for medical care.

Senator CURTIS. Assuming that the Congress would provide the deficit which you say exists?

Mr. COHEN. I can give it to you.

Senator CURTIS. It would be over $200?

Mr. COHEN. About $9 per month or about $100 per year per capita. I want to also give you a much more startling figure. The study estimated what the total deficit would be for all of old-age assistance of the present old-age assistance beneficiaries because——

Senator CURTIS. I don't want to remain on this too long, but maybe you ought to define what a deficit is. Do you mean checks written where there is no money in the bank?

Mr. COHEN. No, sir.

Senator CURTIS. What is it?

Mr. COHEN. Each State determines for itself what is the standard of assistance in a State. That requirement was put in this 1935 at Senator Byrd's insistence. I remember that very distinctly. Each State sets its own standard and has to submit to the Federal Government what that standard is. Now, not all the States have that money to pay that standard. They define the standard and then if the legislature does not put up enough money that biennium they pay a proportion of that amount or a maximum put in the limit.

Senator CURTIS. Is the usual deficit between what the States determine as a standard and what they actually spend?

Mr. COHEN. That is correct, sir. I will give you what the deficit is.

Senator CURTIS. You have already told us.

Mr. COHEN. No, I just did that for medical care. I am now going to give you the standard——

Senator CURTIS. I am just talking about medical care.

Mr. COHEN. Let me start over again. The deficit for all assistance—old age assistance and aid to dependent children—including medical care on the State's own standard for 1958—was $576 million.

Senator CURTIS. Twenty five years after the social security law was passed?

Mr. COHEN. That is correct. Page 69 of the report.

If you then take a different standard, that is using the U.S. Department of Agriculture low-cost food standard plan, and assume that food represents for these low-income people 50 percent of the cost, the deficit comes to $1,108,335,000.

Now, the reason I mention that is, it gives you, irrespective of whether you happen to agree with these particular standards or not, some idea of the gap that exists today with respect to the existing program. This committee and the Congress is already extending to the States an offer to match part of the cost. You already in the Social Security Act hold out to each State, saying within the limits that have been put on, if you put up more money, we will finance more of that cost.

Senator CURTIS. What you are saying is 25 years after the enactment of title 2, it misses taking care of our aged, according to our figures, by half a billion dollars a year.

Mr. COHEN. Yes, sir, and I am only talking about the 2.4 million aged out of the roughly 16 million and the dependent children.

Senator CURTIS. Now, the theory of the Forand bill would go ahead and leave out all of those people again.

Mr. COHEN. Mr. Curtis, as a matter of social priority, in determining what needs to be done, the medical care needs of the people now on old-age assistance ought to be given very careful consideration by this committee and it is for that reason that I am going to suggest that you do something to improve medical care also for people now on old-age assistance, and my specific suggestion, as you know——

Senator CURTIS. Would you treat them just like you treat present beneficiaries of OASI?

Mr. COHEN. What do you mean, Senator Curtis?

Senator CURTIS. Well, the Forand bill, which I do not approve of, takes care of present beneficiaries of OASI, but it excludes all other old people of this generation.

Mr. COHEN. Well, if you are going to adopt, as I hope you would, some kind of an insurance program that would take care of medical costs for these people, then I think you have two alternatives that are open to you: You either must greatly improve title I to take care of the medical care needs of the people who are not covered, or you must, out of Federal funds, in a sense blanket in or purchase the cost of the equivalent medical care for people who otherwise would not be covered by that, and of those two alternatives——

Senator CURTIS. In the Forand bill, I don't want to drag this out too long, but in the Forand bill you blanket in all the present beneficiaries of OASI, do you not?

Mr. COHEN. The OASI?

Senator CURTIS. Yes.

Mr. COHEN. You give them the medical care benefits, yes, that is correct.

Senator CURTIS. That is my quarrel with the architects of social security. Our economy carries an enormous load to support the social security system, and it is still a selective program. It was testified to here this morning that people who went on the beneficiary rolls in

1940 have not paid anything since. They got on the average $22 and now get $50-some, and now you gain propose a payroll tax to add to it medical and hospital benefits. But you exclude all the rest of the aging population.

Senator DOUGLAS. Senator, are you proposing that we make this more universal?

Senator CURTIS. I am against this medical section, but I have always felt that our social security system failed in both respects: One, to set up a prepaid plan for the present generation, which I doubt if it could do, or otherwise meet our problem in this generation.

Senator DOUGLAS. I would like to point out that the McNamara bill includes those under old age insurance, those under old age assistance, but also those in an intermediate zone who are not under either of those two systems and which includes everybody except the aged who are employed fulltime. Your statements in these last few minutes have given me hope, Senator, that you have become a convert to the McNamara plan. [Laughter.]

Senator CURTIS. No, no. I am against both the Forand and the McNamara proposal.

I would like to ask the witness, are you for the Forand bill?

Mr. COHEN. I am.

Senator CURTIS. Are you opposed to the McNamara bill?

Mr. COHEN. No.

Senator CURTIS. Which is your preference?

Mr. COHEN. Let me put it this way, Senator: I think the McNamara bill contains some very desirable provisions. But I am rather conservative myself, you may know from our long contact and experience, you may take a little exception to that [laughter] but if you are going to start on that principle, it is best to take a scope of benefits initially that can be administered efficiently and workably. I would, therefore, take a scope of benefits that would probably cost closer to a half percent of payroll at this time than a percent of payroll, because having been in on the initial administration of social security, I feel the most important thing on any new benefit that we take is to have a sound administrative program that will be effective. I don't believe in taking more than you can handle efficiently.

Senator CURTIS. You mean selecting your beneficiaries?

Mr. COHEN. No, I was not talking——

Senator CURTIS. From that vested group?

Mr. COHEN. No, no, you misunderstand me.

Senator CURTIS. No, I think I have been studying this thing for 20 years and I have heard you testify every time, you and Mr. Cruikshank, for a selected list of beneficiaries.

Mr. COHEN. No.

Senator DOUGLAS. I welcome a new convert to the McNamara-Forand plan.

Senator CURTIS. I told you I was opposed to both, but I want to point out the weakness and the social injustice of the Forand bill.

Mr. COHEN. You didn't give me a chance to finish, Senator Curtis. I was talking about the scope of benefits and not the beneficiaries. I endorse completely the objective either in the McNamara bill or in the principles of title 16 of some method of providing protection to those groups that are not covered. But I do feel that in doing that you

have to keep in mind the criterion that Senator Byrd has said, how much do you want to spend out of general revenues? If you say to me——

Senator CURTIS. You are not proposing to pay the present OASI beneficiaries hospital and medical benefits out of general revenues, are you?

Mr. COHEN. No. But I think that is——

Senator CURTIS. All right. You are, you are selecting beneficiaries.

Mr. COHEN. We are selecting beneficiaries with respect to which the payroll tax income shall apply, yes.

Senator DOUGLAS. Senator, if we include this broader group will you join in your support?

Senator CURTIS. No.

Senator DOUGLAS. If we meet your objection?

Senator CURTIS. I am against Government medicine, I am for the voluntary system. If you are going to force it on me, I want you to be fair in your distribution of the proceeds.

Senator DOUGLAS. Then you won't criticize us if we do make it all inclusive?

Senator CURTIS. Why yes, I am criticizing it because I don't think I can convert you. [Laughter.]

Mr. COHEN. Senator Curtis, you remember several years ago in the Ways and Means Committee when we went over this again and again in talking about how to finance this out of general revenues. We have never been able to get the Ways and Means Committee or the Senate Finance Committee to go along and put the money up out of general revenues.

Senator CURTIS. You are not even suggesting that now?

Mr. COHEN. No, sir, I would. If the Senate Finance Committee would report out paying for that out of general revenues, I would feel it was a very sound idea, and I urge you to get the Senate Finance Committee to do that. But I——

Senator DOUGLAS. I join the witness in that request.

Senator CURTIS. You still insist that a certain vested group should get it whether or not it comes out of general revenues?

Mr. COHEN. I am not a perfectionist, if the Senate Finance Committee were to give me 80 percent of what I asked for I would be very happy and content.

Senator CURTIS. All you have to do is raise your request by 20 percent.

Mr. COHEN. Returning to my eighth point, I do want to urge that the Finance Committee give consideration to the restoration as a minimum of the deletions in public assistance that were made by the Finance Committee and on the floor of the Senate in 1958 under the threat of a Presidential veto when some of the public assistance modifications were dropped out of the bill 2 years ago. These would have been very helpful to the States in developing a broader program of assistance.

As the Senators here will recall, because of the lateness of the hour in 1958, and because the Secretary said that he would recommend that the President veto the 1958 bill if it contained the public assistance provisions of the House-passed bill, the Senate Finance Committee made certain deletions in the public assistance provisions, and Senator Smathers made certain others on the floor.

I would certainly urge if you either provide title 16 or put title 16 in title 1, that you do restore, as a minimum, those 1958 provisions which the House passed which were sound in principle and very meritorious. I am under the impression that the only reason they were taken out either in the Finance Committee or on the floor at that time was in order to attain a bill that the President would sign, at least that is the statement that was made on the floor.

Ninth, in the bill there is an authorization for child welfare services in section 707(a)(3)(a) of $20 million, although the maternal and child health and crippled children authorizations are increased to $25 million. This seems an obvious discrimination to take one of the three childrens' programs and only give it $20 million, and the other two to give them $25 million. Consistent with the report of the advisory council on child welfare services which was also made to this committee we would urge that it be made $25 million.

Tenth, there is one other amendment that I think is desirable. In the House-passed bill, they limited title 3 administrative expenses to the States for the financing of unemployment insurance to $350 million and although they increased the payroll tax one-tenth of 1 percent, bringing in far in excess of that, they then said the States can only get $350 million.

Now, this seems to me an unnecessary limitation on a State when all that money that comes in by a specific payroll tax. It would seem to me if there should happen to be an unfortunate rise in the number of jobless people in the next year or two, to have held down the administrative costs under title 3, even though there is plenty of money coming in. This is an unnecessary restraint on the States. I would urge you to take off that $350 million limitation, and not have any. This is not a cost to the Federal Government, because this is deducted from the payroll tax yield of four-tenths of 1 percent from the employers.

Senator DOUGLAS. The amount formerly allowed for administration was three-tenths of 1 percent, was it not?

Mr. COHEN. Yes, sir, in this bill it is increased to four-tenths of 1 percent.

Senator DOUGLAS. Why is that?

Mr. COHEN. That is because as you recall in connection with the 1958 extension of unemployment insurance, the States borrowed the full $200 million from the loan fund, and then you gentleman authorized, about $600 million to be loaned to the States which they pay back now within the next couple of years.

Now, the House Ways and Means Committee, on the basis of that experience and the recommendations of the Department of Labor, said the loan fund ought to go up to $550 million. So that the States will be better able to borrow if there is another recession. Well, that seems reasonable to me to help the States carry their own load, if joblessness should increase.

But then they said, if it does increase, and you have got to put on more people to pay unemployment claims, we are only going to let the Federal Government give you $350 million worth of administrative expenses. Yet the money is all there. It is money dedicated only to this purpose, not coming out of general revenues. It seems to me that on the face of it that is not only inconsistent but not desirable with

having an unemployment insurance program that will be able to operate quickly and effectively.

Senator DOUGLAS. The extra allowance of one-tenth of 1 percent is really to rebuild the loan fund.

Mr. COHEN. That is correct. It is to rebuild and to increase the loan fund. The previous authorization, first it was you remember the George loan fund of 1944 and then the Reed fund of 1954, has a maximum authorization of $200 million. That has all been disbursed to the States, actually only two States.

Senator DOUGLAS. What were the two States?

Mr. COHEN. The two States were Michigan and Pennsylvania. This bill, incidentally, makes some very desirable changes in making the State repay their loans more promptly so that other States can get it if they need it. All of those provisions in the bill would help the States, which are sound except this one provision which is a definite limitation on the ability of the unemployment insurance system to act quickly.

That is the effective element in unemployment insurance, the automaticity with which the benefits will be paid as soon as the people go into a State unemployment insurance office.

It seems to me, if I may say so, very shortsighted to have put that limitation on. It is my understanding from the House discussions that the Secretary of Labor did urge the committee to take that off, although you may wish to ask if that is still the current policy.

Senator DOUGLAS. May I ask, what proportion of the 3 percent is actually spent for administration? What percentage of benefits, not contributions, would the administrative costs represent?

Mr. COHEN. The administrative costs of the States, not counting the Federal costs, I imagine, are running about $300 million a year, $325 million is authorized for the next year.

Senator DOUGLAS. And how much are the benefits?

Mr. COHEN. Well, the benefits, of course——

Senator DOUGLAS. How much were the benefits last year?

Mr. COHEN. The benefits in 1958 during the recession, I remember that figure very distinctly having just published a study on it, were in the neighborhood of $4 billion.

Senator DOUGLAS. And this last year?

Mr. COHEN. This last year, in 1959, $1.8 billion.

Senator DOUGLAS. So that——

Mr. COHEN. That would be about 15 percent, in sort of a normal period of rather minimal unemployment, and perhaps about, I would say, 8 percent in a period of higher employment.

Mr. Murray points out that includes the employment service as well as unemployment insurance. Yes, the whole system.

Senator DOUGLAS. Yes. Finding jobs as well as paying benefits?

Mr. COHEN. Yes, and the reason I am making a big point of it: from some studies I have underway, I rather suspect unemployment is going to be up next year, Senator, and I would like to have our unemployment insurance system be as ready and as effective to meet this instantly as can be.

Senator DOUGLAS. You want to be careful of what you say or you will be called a prophet of doom and gloom. [Laughter.]

Mr. COHEN. Well, I am only saying insofar as our unemployment insurance system can meet that and thus help our free enterprise economy, and that is within this particular bill to do, I would urge it to be done.

Now, I would like to submit just two things for the record, Mr. Chairman. I have prepared a table here since the chairman expressed an interest yesterday in the material on the cost of this. You will recall that on page 11 of the House committee report is this table that showed for title 16 Federal cost of that would be $165 million if all of the States came in. I don't believe myself that the States have the financial capacity at this time to raise their $159 million to match that. But what I did do was attempt to show those figures in relationship to the proportion of aged in the country. I want to make just a few comments on this table and then if you want I will put it in the record, Mr. Chairman.

The CHAIRMAN. Without objection.

Mr. COHEN. Under that title 16, four States get 60 percent of the Federal money, and that is——

Senator CURTIS. What four States?

Mr. COHEN. New York, Illinois, New Jersey, and Massachusetts.

The CHAIRMAN. You are speaking of the House bill, are you not?

Mr. COHEN. I am speaking of the House bill. This is a further elaboration of my argument that to the extent you are going to keep it, put it directly into title 1 where it can be dovetailed much more sensibly.

Senator CURTIS. You say four States get 60 percent of it.

Mr. COHEN. May I say there, Senator, don't forget that this means that Illinois would only get its $19 million if it put up $19 million of new money, whereas in title 1, there is a lot of money that Illinois is already spending which it doesn't get matched at the present time. I believe I could persuade you with regard to Illinois, that your interests would be better served by putting in the title 1.

Senator CURTIS. Do I understand that four States would get 60 percent of it?

Mr. COHEN. Yes, sir.

Senator CURTIS. Of the Federal money?

Mr. COHEN. Yes, sir.

Senator CURTIS. What percent, say, would the top 10 States get?

Mr. COHEN. The top 10, and I have done this cumulative so you can tak any combination like that. The top 10 get 83.6 percent of the money.

Senator CURTIS. How many States would it take to get 90 percent?

Mr. COHEN. How many States would it take to get 90 percent? Twelve.

Senator CURTIS. Would you read them?

Mr. COHEN. Yes, sir, New York, Illinois, New Jersey, Massachusetts, Connecticut, California, Indiana, Wisconsin, Ohio, Minnesota, Washington, and Pennsylvania, are the 12 States getting 89.3 percent of the Federal funds. I have all of the States here. I believe that this particular proposal which requires the States to put up new money for this would further distort the picture in terms of the question that you yourself raised, Senator Curtis, with respect to one of the other witnesses about Louisiana, and a number of other States.

Senator CURTIS. You think it will further accentuate that problem?

Mr. COHEN. Yes, sir. I think if you study this table very carefully, you will see that the States naturally which can take advantage of title 16 in its present form, would, of course, be very few because they have to put up new money. That is the limiting factor. I think I am doing an exercise in mathematics here merely because I don't see myself, from what I know, that you can expect many of these States to do so. Take my own State, Michigan, which has just gone through a tremendous controversy on raising State funds. Now, under this estimate, we are expected to raise $3,227,000 more for this particular program. Well, we have had our legislature meeting for months arguing how to meet our present obligations, and I don't see how it can be expected that we would be in a position to take advantage of it even though we need to.

Senator DOUGLAS. Mr. Cohen, if you don't expect the Michigan Legislature to appropriate $3 million, how would it appropriate the enormous sums which would be required under the administration medical care bill?

Mr. COHEN. Impossible. It would be impossible for me to conceive of our Michigan Legislature after the whole discussion on new money needed for education and other needed public services, putting up a single penny within the foreseeable future under the administration proposal. I just can't see it——

Senator DOUGLAS. Now, the Secretary yesterday was very optimistic.

Mr. COHEN. Well, I have talked with the State welfare administrators, I talked with 8 or 10 of them myself. They are very close, I think, to State budget directors, State Governors, State people, and uniformly when I discussed this possibility with them, they said, "We see no possibility." They said, "If we had the money now we would use it to expand our present old-age assistance program." So I think it is very unlikely. I think you might like to have the detailed figures in the record.

The CHAIRMAN. Yes.

Mr. COHEN. The other statement that I would like to have put in the record that 22 of those of us who either have been connected with the administration of social security or on any of the advisory councils have signed a statement here urging that the health benefits be met through the contributory social insurance probram.

Senator CURTIS. With what bill?

Mr. COHEN. We do not underwrite a particular bill. We underwrite the principle.

Senator DOUGLAS. That is the principle to which the Secretary said he was unalterably opposed?

Mr. COHEN. Yes, sir, and may I point out that three of the members of the administration, that is, who were in this present administration, two of the Commissioners of Social Security, Mr. Tramburg and Mr. Shottland, and one Deputy Commissioner of Social Security, Mr. Wyman, have signed this statement.

Senator DOUGLAS. Mr. Shottland was the social security administrator.

Mr. COHEN. So was Mr. Tramburg, under this administration.

Senator DOUGLAS. And I believe he was commissioner of social security of California.

Mr. COHEN. He was the Federal Commissioner from 1954 to 1958. Mr. Tramburg was Commissioner in 1953. Mr. Wyman was Deputy Commissioner in 1959. There is in the list the former Commissioner of Social Security, Mr. Altmeyer, and quite a number of other people. I would just like to summarize it this way, in line with what Senator Byrd said, the committee has to make a decision of public policy as to whether there should be any intervention into this field at all. I recognize there are differences of opinion but if you do, Senator Byrd, the contributory social system offers you the best device for assuring fiscal responsibilty that I know of as against general revenue financing which is on a year to year basis, and, therefore, we have signed this statement urging very strongly that the contributory social insurance system be the preferred method of dealing with this question.

The CHAIRMAN. The insertions will be made in the record.

(The documents referred to are as follows:)

DISTRIBUTION OF FEDERAL FUNDS AMONG THE STATES UNDER THE PROPOSED MEDICAL SERVICES FOR THE AGED PLAN

Table 1 shows the estimated distribution of Federal funds under the proposed medical services for the aged plan in the first full year of operation; these estimates are based on the assumption that all States will develop and put plans into effect in that year.

These figures indicate that one-half the States would receive more than 99 percent of the total Federal funds and the other half only 1 percent. New York alone would receive over 30 percent of the total Federal funds. The 4 States receiving the largest amounts would receive almost 60 percent of total funds; 8 States, 77 percent of the total; and 12 States over 91 percent of the funds. The remaining 9 percent of Federal funds would be distributed among 39 States, with 8 percent going to 12 States and 1 percent distributed among the remaining 27 States.

The States receiving the bulk of Federal money tend to be the wealthier industrial States. The States that would receive very small amounts of Federal funds include almost all of the poorer States. For example, almost all the Southern and Western States (not counting the Pacific States) would receive less than one-tenth of 1 percent of the total Federal funds.

All of these poorer States receive a disproportionately small share of Federal funds to their proportion of the total aged population. Thus while New York has 10 percent of the total aged population, it will receive 30 percent of Federal funds; Texas with almost 4½ percent of the aged population will receive only 0.1 percent of Federal funds. The situation in Texas is typical of the other lower per capita income States. Thirty-seven States with 50 percent of the aged population would receive 10 percent of the Federal funds.

TABLE 1.—*Distribution of Federal funds under medical services for the aged plan (proposed title XVI of the Social Security Act), by State*

[States ranked by amount of Federal funds]

Rank	State	Federal funds				Population age 65 and over [1]	
		Amount of Federal funds (in thousands)	Percent of total	Cumulative percent		Number of persons (in thousands)	Percent of total
				Cumulative downward	Cumulative upward		
	Total United States [2]	$165,450	100.0			15,081	100.0
1	New York	50,885	30.8	30.8	100.0	1,529	10.1
2	Illinois	19,068	11.5	42.3	69.2	914	6.06
3	New Jersey	14,624	8.8	51.1	57.8	497	3.30
4	Massachusetts	14,077	8.5	59.6	48.9	523	3.40
5	Connecticut	7,902	4.8	64.4	40.4	220	1.46
6	California	7,956	4.8	69.2	35.6	1,178	7.81
7	Indiana	6,699	4.0	73.3	30.8	418	2.77
8	Wisconsin	6,552	4.0	77.2	26.7	383	2.54
9	Ohio	5,501	3.3	80.6	22.8	834	5.53
10	Minnesota	4,999	3.0	83.6	19.4	335	2.22
11	Washington	4,718	2.8	86.4	16.4	259	1.72
12	Pennsylvania	4,655	2.8	89.3	13.6	1,046	6.94
13	Michigan	3,227	2.0	91.2	10.7	590	3.91
14	Oregon	3,101	1.9	93.1	8.8	173	1.15
15	Kansas	1,684	1.0	94.1	6.9	226	1.50
16	Nebraska	1,455	.9	95.0	5.9	152	1.01
17	Rhode Island	1,355	.8	95.8	5.0	84	.56
18	New Hampshire	1,296	.8	96.6	4.2	65	.43
19	Maryland	1,196	.7	97.3	3.4	198	1.31
20	Virginia	679	.4	97.7	2.7	259	1.72
21	Missouri	567	.3	98.0	2.3	460	3.05
22	Maine	488	.3	98.3	2.0	103	.68
23	Colorado	477	.3	98.6	1.7	139	.92
24	Florida	386	.2	98.8	1.4	453	3.00
25	North Dakota	314	.2	99.0	1.2	52	.34
26	Iowa	241	.1	99.2	1.0	316	2.10
27	Texas	161	.1	99.3	.8	630	4.38
28	District of Columbia	144	.1	99.4	.7	61	.40
29	West Virginia	144	.1	99.5	.6	167	1.11
30	Louisiana	141	.1	99.5	.5	209	1.39
31	Oklahoma	102	.1	99.6	.5	229	1.52
32	North Carolina	95	.1	99.7	.4	285	1.89
33	Wyoming	73	(3)	99.7	.3	25	.17
34	Nevada	62	(3)	99.7	.3	15	.10
35	Hawaii	59	(3)	99.8	.3	28	.19
36	Vermont	55	(3)	99.8	.2	43	.29
37	Alabama	39	(3)	99.8	.2	241	1.60
38	Utah	39	(3)	99.9	.2	55	.36
39	Delaware	38	(3)	99.9	.1	32	.21
40	Idaho	36	(3)	99.9	.1	56	.37
41	Montana	35	(3)	99.9	.1	63	.42
42	Arkansas	29	(3)	99.9	.1	187	1.24
43	Tennessee	23	(3)	99.9	.1	277	1.84
44	Kentucky	16	(3)	(4)	(3)	272	1.80
45	Georgia	15	(3)	(4)	(3)	264	1.75
46	Arizona	13	(3)	(4)	(3)	75	.50
47	New Mexico	10	(3)	(4)	(3)	47	.31
48	South Dakota	8	(3)	(4)	(3)	68	.45
49	Mississippi	6	(3)	(4)	(3)	171	1.15
50	South Carolina	6	(3)	(4)	(3)	145	.96
51	Alaska	1	(3)	100.0	(3)	6	.04

[1] As of July 1, 1958.
[2] Includes the 50 States and the District of Columbia.
[3] Less than 0.05 percent (½ of 1 percent).
[4] More than 99.95 percent.

MEETING THE HEALTH CARE NEEDS OF OLDER PEOPLE THROUGH SOCIAL INSURANCE

WASHINGTON, D.C., *June 30, 1960.*

Hon. RICHARD M. NIXON,
Vice President of the United States,
The Capitol, Washington, D.C.
Hon. LYNDON B. JOHNSON,
Majority Leader, Senate of the United States,
Washington, D.C.
Hon. EVERETT McK. DIRKSEN,
Minority Leader, Senate of the United States,
Washington, D.C.:

The undersigned who have long been identified with the American system of social security, having served the Government in administrative or advisory capacities, urge the incorporation in social security legislation now before the Senate of a program of contributory social insurance through which our citizens can pay for the cost of the hospital and related services they may need in old age. An extension of Federal old age, survivors, and disability insurance to include hospital coverage would provide a systematic way of financing serious illness and prevent the exhaustion of the savings of aged persons and the consequent, often devastating, demands upon the resources of their children.

There is every indication of the willingness of Americans to share the cost of basic health protection for their elderly parents and later for themselves by paying for such a program through their working years. If such health protection were available for older persons, private organizations would be enabled to offer more economical protection to the younger people in our population.

We sincerely hope that the social security bill now pending before the Senate will be amended to provide for hospital and related services to older people through social insurance system.

Sincerely yours,

LIST OF SIGNATORIES

Mr. Arthur Altmeyer, Madison, Wis., former Chairman of Social Security Board and Commissioner for Social Security.

Mr. Joseph P. Anderson, executive director, National Association of Social Workers, member, Advisory Council, 1961 White House Conference on Aging.

Dr. Eveline M. Burns, professor of social work, New York School of Social Work, Columbia University; former Consultant to Committee on Economic Security and Social Security Board, and member of Advisory Committee to Secretary of Health, Education, and Welfare (1954).

Mr. Wilbur J. Cohen, professor, Public Welfare Administration, School of Social Work, University of Michigan, member of the staff of the President's Committee on Economic Security (1934–35).

Mr. Nelson Cruikshank, AFL–CIO, Washington, D.C.; member, Advisory Council on Social Security (1948–49) and Advisory Council on Social Security Financing (1958–59).

Miss Loula Dunn, Chicago, Ill., member, 1959 Advisory Council on Public Assistance.

Mr. Fedele F. Fauri, dean, School of Social Work, University of Michigan; former consultant on social security to House Ways and Means and Senate Finance Committees.

Miss Helen Hall, National Federation of Settlements, member, Advisory Council of the President's Committee on Economic Security (1934–35).

Mr. Seymour Harris, littauer professor of political economy, Harvard University, consultant to President's Council of Economic Advisers.

Miss Jane M. Hoey, New York City, director, Bureau of Public Assistance, Social Security Administration (1936–54).

Mr. Raymond W. Houston, Commissioner, New York State Department of Social Welfare, member, 1959 Advisory Council on Public Assistance.

Mr. John Kidneigh, director, Graduate School of Social Work, University of Minnesota, chairman, 1959 Advisory Council on Child Welfare Services.

Mr. Murray Latimer, Washington, D.C., former chairman, Railroad Retirement Board.

Mr. Richard A. Lester, professor of economics, Princeton University, member, Advisory Committee to Federal Bureau of Employment Security.

Mr. Norman V. Lourie, deputy secretary, Pennsylvania Department of Public Welfare, member of ad hoc advisory committee to Department of Health, Education, and Welfare.

Mr. Charles I. Schottland, dean, Florence Heller Graduate School of Social Welfare, Brandeis University, former Commissioner of Social Security (1954–58).

Mr. Karl de Schweinitz, Washington, D.C., former consultant to Social Security Board, and professor emeritus, University of California.

Mr. Herman M. Somers, chairman, Political Science Department, Haverford College, former consultant to Social Security Administration.

Mr. John W. Tramburg, commissioner, New Jersey State Department of Institutions and Agencies, former Commissioner of Social Security (1953).

Mr. George K. Wyman, executive director, welfare council of Metropolitan Los Angeles, former Deputy Commissioner of Social Security (1959).

Mr. J. Douglas Brown, dean of faculty, Princeton University, chairman of Advisory Council on Social Security (1937–38) and member of Advisory Council (1948–49).

Mr. John J. Corson, McKinsey & Co., Washington, D.C., former Director, Bureau of Old Age and Survivors Insurance.

The CHAIRMAN. Thank you very much, Mr. Cohen, you have made a very interesting statement.

Mr. COHEN. Thank you, Senator.

I may say in conclusion, I would like to be back here 25 years from now, but we will just have to wait and see how that works out.

The CHAIRMAN. I remember how we worked together then.

Mr. COHEN. Yes, sir.

The CHAIRMAN. There will be inserted in the record a statement of the New Jersey Education Association and the New Jersey Civil Service Association at this point.

(The documents referred to are as follows:)

STATEMENT OF THE NEW JERSEY EDUCATION ASSOCIATION AND THE NEW JERSEY CIVIL SERVICE ASSOCIATION, PRESENTED BY JAMES P. CONNERTON, FIELD REPRESENTATIVE, NJEA, JUNE 30, 1960

I wish to express the appreciation of the members of the New Jersey Education Association and the New Jersey Civil Service Association for the privilege of this opportunity to present their problem to this committee.

Our members are well aware that your committee is at this time faced with a number of weighty problems which demand your attention.

We recognize also that our problem is one which affects a limited number of persons. However, the effect on these persons is so severe that we ask this committee to explore every possible avenue of relief.

As you have been informed by both Senators from New Jersey, approximately 2,130 retired New Jersey teachers and approximately 1,300 other retired New Jersey public employees face the grim prospect of suffering the loss of retirement income. For some of these people their already meager resources will be cut as much, as $1,450 per year. The average loss to retired teachers will be approximately $1,300 per year. For other retired public employees the loss will average $960 per year.

These people will lose this badly needed retirement income unless section 204(a) of H.R. 12580 is amended to protect their interests.

The problem results from the fact that the two major public retirement plans in New Jersey (the teachers pension and annuity fund and the public employees retirement system) are integrated with the social security program. Under the terms of this integration these two State retirement funds are permitted to reduce the amount of pension paid by the State to a retired person if this person earned a social security benefit through public employment in New Jersey. The amount of reduction would be equal to the amount of the social security benefit.

In the long run this is a sound and acceptable procedure. In the short run, however, during the period of transition from separate to integrated benefits, some public employees can be adversely affected. Particularly affected are persons who are already entitled to social security benefits in addition to State pension as a result of work in private employment or as dependents of social security beneficiaries.

To cope with these transitional problems, some public pension funds have provided social security benefits for their people on the divisional basis. That is, by permitting those individuals who did not want social security coverage through public employment to elect not to participate in the proposed cooperative program.

In New Jersey, however, both teachers and other public employees were brought in under a plan which provided that all members of each State pension fund were to be participants in the integrated program. If the group voted to accept the plan, there was no provision for an individual to elect not to participate.

When teachers were asked to accept integration of their pension fund with social security, many older teachers were hesitant to go along for fear of financial loss. The argument which convinced many of these people to vote "yes" for integration was that under the terms of the proposal anyone who wanted to avoid integration could do so by retiring from New Jersey public employment before earning "fully insured" social security status.

This understanding was reinforced when the Division of Pensions of the State of New Jersey compiled and distributed to members of the two State pension funds the retirement manuals submitted with this statement.

I quote from one of these manuals, Public Employees Retirement System of New Jersey—Summary of Benefits and Contributions. On page 4 appears the statement, "No reduction is made from the PERS allowance at age 65 if the member does not qualify for social security benefits as a result of public employment alone. Generally, the ability to avoid this reduction depends upon the member's age and date of retirement * * *" Then on page 9 there appears a table which informs each member of the fund as to the date he must retire in order to avoid becoming subject to reduction of his pension.

(The table referred to follows:)

The social security offset schedule

(The following table applies to all active members in the Retirement System who were in public employment on Jan. 1, 1955)

If you were born before these dates—	Men		Women	
	Number of quarters needed for social security coverage after Jan. 1, 1955	Retirement system will reduce your pension allowance if you retire after—	Number of quarters needed for social security coverage after Jan. 1, 1955	Retirement system will reduce your pension allowance if you retire after—
Before Oct. 1, 1892	6	Apr. 1, 1956	6	
Oct. 2, 1892 to Jan. 1, 1893	7	Jul. 1, 1956	6	
Jan. 2 to Apr. 1, 1893	8	Oct. 1, 1956	6	
Apr. 2 to Jul. 1, 1893	9	Jan. 1, 1957	6	
Jul. 2 to Oct. 1, 1893	10	Apr. 1, 1957	6	
Oct. 2, 1893 to Jan. 1, 1894	11	Jul. 1, 1957	6	
Jan. 2 to Apr. 1, 1894	12	Oct. 1, 1957	6	Apr. 1, 1956
Apr. 2 to Jul. 1, 1894	13	Jan. 1, 1958	6	
Jul. 2 to Oct. 1, 1894	14	Apr. 1, 1958	6	
Oct. 2, 1894 to Jan. 1, 1895	15	Jul. 1, 1958	6	
Jan. 2 to Apr. 1, 1895	16	Oct. 1, 1958	6	
Apr. 2 to Jul. 1, 1895	17	Jan. 1, 1959	6	
Jul. 2 to Oct. 1, 1895	18	Apr. 1, 1959	6	
Oct. 2, 1895 to Jan. 1, 1896	19	Jul. 1, 1959	7	Jul. 1, 1956
Jan. 2 to Apr. 1, 1896	20	Oct. 1, 1959	8	Oct. 1, 1956
Apr. 2 to Jul. 1, 1896	20	do	9	Jan. 1, 1957
Jul. 2 to Oct. 1, 1896	21	Jan. 1, 1960	10	Apr. 1, 1957
Oct. 2, 1896 to Jan. 1, 1897	21	do	11	Jul. 1, 1957
Jan. 2 to Apr. 1, 1897	22	Apr. 1, 1960	12	Oct. 1, 1957
Apr. 2 to Jul. 1, 1897	22	do	13	Jan. 1, 1958
Jul. 2 to Oct. 1, 1897	23	Jul. 1, 1960	14	Apr. 1, 1958
Oct. 2, 1897 to Jan. 1, 1898	23	do	15	Jul. 1, 1958
Jan. 2 to Apr. 1, 1898	24	Oct. 1, 1960	16	Oct. 1, 1958
Apr. 2 to Jul. 1, 1898	24	do	17	Jan. 1, 1959
July 2 to Oct. 1, 1898	25	Jan. 1, 1961	18	Apr. 1, 1959
Oct. 2, 1898, to Jan. 1, 1899	25	do	19	July 1, 1959
Jan. 2 to July 1, 1899	26	Apr. 1, 1961	20	Oct. 1, 1959
July 2, 1899, to Jan. 1, 1900	27	July 1, 1961	21	Jan. 1, 1960
Jan. 2 to July 1, 1900	28	Oct. 1, 1961	22	Apr. 1, 1960
July 2, 1900, to Jan. 1, 1901	29	Jan. 1, 1962	23	July 1, 1960
Jan. 2 to July 1, 1901	30	Apr. 1, 1962	24	Oct. 1, 1960
July 1, 1901, to Jan. 1, 1902	31	July 1, 1962	25	Jan. 1, 1961
Jan. 2 to July 1, 1902	32	Oct. 1, 1962	26	Apr. 1, 1961
July 2, 1902, to Jan. 1, 1903	33	Jan. 1, 1963	27	July 1, 1961
Jan. 2 to July 1, 1903	34	Apr. 1, 1963	28	Oct. 1, 1961
July 2, 1903, to Jan. 1, 1904	35	July 1, 1963	29	Jan. 1, 1962
Jan. 2 to July 1, 1904	36	Oct. 1, 1963	30	Apr. 1, 1962
July 2, 1904, to Jan. 1, 1905	37	Jan. 1, 1964	31	July 1, 1962
Jan. 2 to July 1, 1905	38	Apr. 1, 1964	32	Oct. 1, 1962
July 2, 1905, to Jan. 1, 1906	39	July 1, 1964	33	Jan. 1, 1963
Jan. 2 to July 1, 1906	40	Oct. 1, 1964	34	Apr. 1, 1963
July 2, 1906, to Jan. 1, 1907	40	do	35	July 1, 1963
Jan. 2 to July 1, 1907	40	do	36	Oct. 1, 1963
July 2, 1907, to Jan. 1, 1908	40	do	37	Jan. 1, 1964
Jan. 2 to July 1, 1908	40	do	38	Apr. 1, 1964
July 2, 1908, to Jan. 1, 1909	40	do	39	July 1, 1964
Jan. 2, 1909, or thereafter	40	do	40	Oct. 1, 1964

NOTE.—The above table does not consider the problem of those individuals who may earn $4,800 during the final year in which they will achieve the number of quarters needed for social security coverage. Anyone whose earnings reach $4,200 during the final year is automatically credited with 4 quarters for that year under social security.

A number of teachers and other public employees followed these State manuals and advanced their retirement dates so as to avoid becoming subject to a reduction of State pension.

The retirement dates suggested by this table are designed to accomplish retirement before a social security benefit is earned through New Jersey public employment. The dates are based on the number of quarters of coverage required for "fully insured" status under the existing Social Security Act.

If, as proposed by section 204(a) of H.R. 12580, the number of quarters of coverage required for "fully insured" status is reduced, these tables cease to be valid.

Consequently by an action of the Federal Government, these persons would be subjected to a substantial loss of badly needed retirement income, notwithstanding the fact that they have retired in accordance with clear instructions (reinforced in each case by a formal quotation of benefits from the State pension fund) in order to avoid any reduction in pension.

The New Jersey Education Association and the New Jersey Civil Service Association are not asking for any extension of social security benefits for these people. We are asking that the benefits they were promised when they retired will be paid.

We are not asking that regulations be changed specially for these people. We are asking that the requirements for attaining "fully insured" status which existed when these people retired be preserved for them.

To this end, we ask that before section 204(a) of H.R. 12580 is enacted into law it be amended in such a way that some 3,400 deserving retired public employees will not be adversely affected.

(By direction of the chairman, the following is made a part of the record:)

STATEMENT BY SENATORS JACOB K. JAVITS AND KENNETH B. KEATING ON AMENDMENT 6-24-60-E

(For staff analysis and departmental views, see p. 482)

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

DEAR MR. CHAIRMAN: On May 26, 1960, we introduced S. 3594, a bill to modify conditions for a reduced rate of contributions under the Federal Unemployment Tax Act. This bill was prepared in consultation with the United States and New York State Departments of Labor, in order to permit effective coverage of nonprofit religious, charitable, literary, scientific, and educational organizations under the Federal act. The provisions of this bill would permit coverage of such organizations on a reimbursement rather than tax basis without coming into conflict with section 3303(a)(1) of the Federal Unemployment Tax Act, which would make the entire State program ineligible if this treatment were given to nonprofit organizations. The New York State Legislature enacted legislation this year which would permit nonprofit organizations to participate in such coverage, subject to the adoption of Federal enabling legislation. We are also informed that a similar proposal pending in California would also be made possible by the adoption of this proposal.

The introduction of a companion bill in the House of Representatives was discussed with the senior New York member of the Ways and Means Committee, Representative Keogh, but the lateness of its presentation to that committee did not permit consideration of the proposal in that body.

We are, therefore, reintroducing S. 3594 as an amendment[1] to the Social Security Amendments of 1960, H.R. 12580, which will soon be before your committee for consideration. In order that you may fully evaluate the purpose of this amendment, we are enclosing a memorandum prepared in support of this proposal by the division of employment of the New York State Department of Labor, and a letter of transmittal from them, indicating their discussions with Representative Keogh.

We hope that the committee may be able to act favorably on this proposal.

Sincerely,

JACOB K. JAVITS.
KENNETH B. KEATING.

[1] Introduced on June 24, 1960, as amendment 6-24-60-E.

NEW YORK STATE DEPARTMENT OF LABOR,
DIVISION OF EMPLOYMENT,
Albany, N.Y., June 14, 1960.

Re Federal bill to facilitate State coverage of nonprofit organizations.
Hon. JACOB K. JAVITS,
U.S. Senate, Washington, D.C.

(Attention: Mr. Robert Kaufman, legislative assistant).

DEAR SENATOR JAVITS: Mr. Alfred L. Green, the executive director of the division of employment, who is out of the State on official business, has asked me in his absence to handle the Federal bill to facilitate State coverage of nonprofit organizations.

Following the suggestion made by your office, we took up the introduction of a companion bill to S. 3394 with Representative Eugene J. Keogh. Mr. Keogh was receptive to the idea and took it up with the Committee on Ways and Means. Because the committee, on June 9, 1960, reported the social security bill, time did not permit full consideration of the proposal by that committee. It was suggested that the Senate Finance Committee consider the proposal at this stage. Mr. Keogh promised every possible assistance. Please advise what action may be taken in this regard.

For your information, I transmit a copy of the memorandum which was sent to Mr. Keogh on June 6, 1960, in support of the companion bill.

Sincerely yours,

WILLIAM L. O'TOOLE,
Director, Unemployment Insurance Accounts Bureau.

MEMORANDUM IN SUPPORT OF A BILL TO MODIFY CONDITIONS FOR REDUCED RATE OF CONTRIBUTIONS UNDER THE FEDERAL UNEMPLOYMENT TAX ACT

A. OBJECTIVE

Enactment of the bill would afford all States a new method for providing protection against unemployment to employees of nonprofitmaking religious, charitable, literary, scientific, and educational organizations. It would permit the coverage of such organizations on a reimbursement rather than a tax basis. This is not now possible because the States' permitting coverage on a reimbursement basis would be in conflict with section 3303(a)(1) of the Federal Unemployment Tax Act.

Section 3303(a)(1) sets forth standards for the several State laws, adherence to which is required in order that the employers within any such State whose tax rates are less than 2.7 percent be permitted to obtain an additional credit against the Federal unemployment tax for the difference between 2.7 percent and the lower rates accorded employers under the State's experience rating formulas, thus, limiting the payment to the Federal Government in all cases to an excise tax of only three-tenths of 1 percent. The Federal act requires that under State law no reduced rate of contributions may be permitted to a "person" except on the basis of his experience with respect to unemployment. This provides coverage of nonprofitmaking religious, charitable, literary, scientific, and educational organizations on a cost basis because section 7701(a)(1) of the Internal Revenue Code includes such organizations as "persons" within the meaning of section 3303(a). Hence, without the enactment of this bill all employers within any State whose law permitted reimbursement of benefits in lieu of tax would be deprived of the additional credit since the Secretary of Labor would no longer find that under such law no reduced rate of contributions is permitted to a "person" except on the basis of his experience with respect to unemployment.

B. SCOPE OF THE PROBLEM

At the present time in New York State alone approximately 350,000 employees engaged by 7,500 nonprofit organizations devoted exclusively to religious, charitable, literary, scientific, and educational purposes are denied the protection of unemployment insurance extended to persons engaged in private industry. Although the law permits the inclusion of such organizations on a voluntary basis, very few have sought coverage for their employees because the cost is prohibitive. Cognizant of its responsibility to all segments of its labor force, the State of New York sought to provide for such unemployment protection on an optional reimbursement basis. On January 20, 1960, how-

ever, the U.S. Department of Labor ruled that a reimbursement method would not be consistent with the present requirements of the Federal Unemployment Tax Act. This ruling followed presentation of the proposal and reasons for it to the Secretary of Labor by members of the New York Advisory Council on Unemployment Insurance. Efforts by the industrial commissioner of the State of New York to obtain a change of position were fruitless.

C. DESIRABILITY OF PROPOSED LEGISLATION

There is general agreement on the need for the unemployment protection of workers employed by nonprofit organizations which are otherwise exempt from Federal and State taxation. These employees need the protection just as much as other workers. There is no essential difference between officeworkers employed by such organizations and officeworkers of other employers, such as banks, insurance companies, employers in professional occupations, and others or indeed governmental employees. There is no difference between kitchenworkers in hospitals and kitchenworkers in hotels or restaurants. There is no difference between the maintenance staff of buildings owned and operated by such organizations and staff in buildings operated by other real estate owners.

Representative spokesmen of nonprofit organizations share these views. However, after consultation with them, the administration in New York concluded that compulsory taxation on the conventional basis would meet with justified objections. A bill was, therefore, developed which gave such organizations the option to cover their workers either on a reimbursement basis or on the basis of taxation as it applies to private employers. In support of this approach, the Unemployment Insurance Advisory Council of New York said that:

"In planning for the inclusion of the nonprofit institutions it must, however, be realized that they present a special situation involving factors not found in private industry.

"To begin with, these agencies cannot pass on the charge to consumers by increases in price. Furthermore, since they are exempted from income taxes, the unemployment insurance contribution cannot be deducted as a cost of doing business. This takes on special importance for them since they are service organizations and for most the payroll constitutes the largest part of their total operating expenses, running for some as high as 70 or 80 percent and even more.

Then, in very many of these institutions, e.g., colleges, universities, community houses, welfare agencies, literary and scientific societies, the greater part of the staff is professional, holding either tenure or a contract for a fixed term. Turnover among such personnel is relatively slight and generally occurs when a member of the staff resigns voluntarily to go elsewhere. Contributions based on the salaries paid to such persons would impose an added burden on budgets already strained and yet there would be little likelihood that any substantial part of the contributions would ever be used to pay benefits.

"It is these special circumstances in which the nonprofit organizations find themselves that have led the Advisory Council to the conclusion that they should be given a method of financing the cost of the benefits paid out to their employees different from that available to employers in private industry. The council proposes that the nonprofit organizations be dealt with in the same way as the State and its governmental subdivisions.

"Employees of the State of New York and of those municipalities which have elected coverage are given benefits in the event of their unemployment. But neither the State nor the municipalities contribute to the unemployment insurance fund in the same manner as do private employers. They are on a straight-cost basis. They merely reimburse the fund each year for the amount paid out by way of benefits to their employees. The council recommends that the nonprofit institutions be likewise kept free of the obligation to make regular contributions and that they too be permitted to be on a cost basis.

"Such method of financing should not be exclusively mandatory. Each agency should have the option to come into the system either on a cost basis or on a contribution basis, that is, to make contributions in accordance with the same experience rating formula which determines contributions by employers in private industry.

"The purpose frankly is to permit each agency to choose that method of financing which it finds better and cheaper. Those agencies with little or no turnover would consequently be put to little or no cost. Those with high turnover would have no greater cost than that which is borne by private industry.

"For the employees of the nonprofit institutions it would make no difference whatever which method of financing their particular agency chose. They would receive the very same benefits as are made available to the employees in private industry under the very same conditions. The difference would only be in the manner of meeting the costs.

"The special status which the nonprofit institutions hold in our society amply justifies the differentiated treatment which is proposed for them. The nonprofit agencies are engaged in public services, services which Government would in the main be compelled to furnish if these institutions were to go out of existence. Their funds are totally dedicated to these services. No individual derives a personal profit from their operations. If it is right for governments to insure their employees on a cost basis, then it is equally right to enable the nonprofit organizations to do the same."

All of these observations apply with equal force in other States.

D. OBJECTIONS

The following objections have been raised:

1. Allowing State option for coverage on a reimbursement basis would weaken the case for a repeal of the exemption of these organizations under the Federal Unemployment Tax Act.

2. A precedent would be set for coverage on a reimbursement basis and others could demand similar treatment.

3. State unemployment funds would be exposed to losses if an exempt organization ceases operations without funds for reimbursement.

First objection: Weakening the case for repeal of exemption

This point has Federal and State aspects. If a State wishes to make a drive for coverage of nonprofitmaking organizations while the Federal statute does not cover such employers, the proposed amendment will strengthen, not weaken, the State's hand. The State will be free to achieve compulsory coverage on a tax basis or on a reimbursement basis or on a combination, by option or otherwise.

On the Federal level, also, the bill would strengthen the case for the repeal of the exemption, if needed. If all States were to achieve coverage, there would be no need for further Federal action. If this result were not reached, the Federal authorities could point to the unequal treatment and make a strong point for the need for Federal action. The mere fact that some States did provide for coverage would demonstrate the propriety of such coverage and the need therefor. If other States did not fall in line on their own initiative, the argument for Federal initiative would gain weight.

Second objection: Precedent

Allowing for exclusion of nonprofit organizations from experience rating standards will not be a precedent for others.

Nonprofit organizations, not only traditionally but also by the nature of their work, their operations and their financing are in an entirely different category from all others. They are endowed with a public purpose and perform functions necessary to the well-being of the States and the Nation. The idea of general and equal taxation to defray the cost of Government services has no place when nonprofit religious, charitable, literary, scientific, and educational organizations are concerned. Such organizations must of necessity look to others for their financial existence.

On the other hand, the idea of general and equal taxation applies with respect to other employers.

Third objection: Failure to reimburse

It is, of course, possible that some nonprofit organizations may cease operations without funds with the result that benefits are paid without reimbursement.

However, these instances are no different from cases involving insolvent employers whose delinquent contributions are never collected. Benefits are nevertheless paid to their employees on the basis of employment with those employers.

Of major general consideration is the fact that the Federal amendment is only

enabling legislation. Each State which wishes to take advantage of the opportunity to achieve coverage of these organizations on a reimbursement basis will carefully consider all implications of the program. Proposed Federal amendment neither binds nor forces any State, it only paves the way. Whether a State will decide to extend coverage, the manner in which it will do so and the safeguards to be provided are strictly State matters.

STATEMENT OF SENATOR CLIFFORD P. CASE ON AMENDMENT 6-25-60-D

(For staff analysis and departmental views, see p. 464)

JUNE 25, 1960.

Hon. HARRY F. BYRD,
Chairman, Senate Finance Committee,
Washington, D.C.

DEAR SENATOR: I understand that your committee is meeting on June 28 to consider H.R. 12580, the social security bill passed by the House of Representatives last Thursday.

If H.R. 12580 is enacted in its present form it will reduce the retirement allowances of approximately 2,130 New Jersey teachers and 1,300 other New Jersey public employees. The average cut in allowances will be approximately $1,300 per year for retired teachers and approximately $960 per year for other retired public employees.

The people affected by this legislation are members of the New Jersey Teachers Pension and Annuity Fund and the New Jersey Public Employees Retirement System. They have retired under a plan which permits the State of New Jersey to reduce the retirement allowance payable by the State pension fund if the employee earned a social security benefit through New Jersey public employment. Any social security benefit earned in this way is used to relieve the State of all or a portion of its obligation to pay a pension to retired public employees.

Many of the persons affected by this legislation have purposely advanced the dates of their retirement in order to avoid earning a social security benefit through public employment in New Jersey. If H.R. 12580 is enacted in its present form section 204(a) will reduce the number of quarters of coverage required to attain fully insured status to such a degree that all of these people will be considered as having earned their social security benefits through New Jersey public employment.

The effect on these people will be a substantial reduction in income through loss of pension from the State of New Jersey.

The amendment proposed by section 204(a) of H.R. 12580 is designed to provide needed benefits for a number of our senior citizens. This is a desirable purpose. The New Jersey Education Association and the New Jersey Civil Service Employees Association have informed me they are sympathetic with the desire to extend full benefits to these people and agree with this purpose. They agree with me, however, that this can be accomplished by approaches which will not deprive New Jersey public employees of State pensions they have earned during many years of service.

One approach would be the following amendment to section 204(a) of H.R. 12580, already introduced by Senator Williams of New Jersey and me:

"(e) The amendment made by subsection (a) shall not apply in the case of any individual who, on, before, or after the date of enactment of this act, becomes entitled to retirement benefits under the Teachers Pension and Annuity Fund of the State of New Jersey or to retirement benefits under the Public Employees Retirement System of the State of New Jersey."

I ask that your committee give serious consideration to this amendment or to some other approach affording assurance to these deserving public employees who have rendered a number of years of service with the justified expectation that they would be entitled to their benefits upon retirement.

Sincerely,

CLIFFORD P. CASE, *U.S. Senator.*

MADISON, WIS., *June 29, 1960.*

Senator HARRY F. BYRD,
Chairman, Senate Finance Committee,
Washington, D.C.:

To save time of committee I am sending this telegram instead of appearing personally. As you know I was Chairman of Technical Board which prepared original Social Security recommendations and I also directed administration of all phases of Social Security Act from 1935 to 1953. Based on that experience I am sure that contributory social insurance method is far superior to Federal-State noncontributory means test method for proving health benefits to aged workers, widows, and orphans. Official studies by this administration and previous administrations demonstrate need and administrative feasibility. Therefore I urge action at this session.

ARTHUR J. ALTMEYER,
Former Commissioner for Social Security.

STATEMENT OF SENATOR OREN E. LONG, DEMOCRAT, HAWAII, TO THE SENATE FINANCE COMMITTEE IN SUPPORT OF THE BILL, S. 3503, AS A SUBSTITUTE FOR SECTION XVI OF H.R. 12580

Mr. Chairman, I want to record my support for S. 3503 as a substitute for section XVI of H.R. 12580.

I think it has been demonstrated overwhelmingly that this Nation needs a truly effective program of health assistance for our elder citizens. The question before the Congress, as I see it, is how to provide an effective program. Section XVI in the House bill, in my opinion, falls far short of meeting the problem. I do not intend to dwell in detail on the obvious inadequacies of section XVI. But I do want to point out that even under the most ideal conditions, where many or all of the States could find the means of participating in the program, it would mean an additional burden on general revenues.

I agree wholeheartedly with the supplemental views of the eight members of the House Ways and Means Committee who stated on page 326 of House Report 1799 that:

"We are shocked that after 23 years of successful operation of the social security system there are those who would have us rely still on relief and assistance as the sole governmental approach to meeting a major economic hazard of universal occurrence."

There are those who will persist in claiming that it is "socialistic" and somehow un-American to finance a health program for the aged through the social security tax structure. Mr. Walter Lippmann, who is by no means considered a wild-eyed Socialist, has very ably analyzed the situation in a column published in the Washington Post of June 16. In that column Mr. Lippmann states:

"Among the opponents of medical insurance there seems to be a vague and uncomfortable feeling that it is a new-fangled theory, alien to the American way of life and imported, presumably, from Soviet Russia.

"The Founding Fathers were not subject to such theoretical hobgoblins. In 1798 Congress set up the first medical insurance scheme under the U.S. marine hospital service. The scheme was financed by deducting from seamen's wages contributions to pay for their hospital expenses.

"If that was 'socialized medicine,' the generation of the Founding Fathers was blandly unaware of it."

The magazine Business Week, which is certainly not considered a Socialist organ, has concluded that medical care for the aged can be handled best through the social security system:

"The only way to handle their health problem, therefore, is to spread the risks and costs widely. And that can best be done through the social security system to which employers and employees contribute regularly."

Under S. 3503, health assistance would be financed largely through social security tax increases. The program would cost an estimated $1.5 billion a year, of which $1.14 billion would come from a one-quarter of 1 percent increase in the social security tax on employee and employer. This increase would provide benefits for 11.3 million beneficiaries of old-age and survivors' insurance. Benefits to an additional 1.7 million old-age assistance recipients would cost $180 million a year, to come from general revenues. Benefits to 1.8 million other persons (re-

tired men over 65 and retired women over 62) would cost $190 million, also from general revenues. But the Federal Government is already spending an estimated $238 million a year for old-age assistance and other programs which provide medical care for the aged so the net increase in expenditures from general revenues would be about $132 million, or less than a dollar per capita for the Nation.

I therefore urge adoption of S. 3503 as the soundest and most effective approach to the problem of medical care for the aged.

ANDERSON, IND., *June 28, 1960.*

Senator HARRY F. BYRD,
Senate Office Building, Washington, D.C.

DEAR SENATOR BYRD: I want you to know of my opposition to H.R. 12580.

As of 1956 only 17 percent of doctors 75 years of age or over were retired. Many of these men are unable financially to retire completely, and others prefer to remain active. Most of those men who remain active see but very few patients, but their income will be greater than $1,200 a year. Therefore, they would not be eligible for social security benefits.

To me, including doctors in the social security program is a thinly disguised effort to promote additional tax revenues with no intention on the part of Government to ever return any of it to these men who will be paying tax ostensibly for retirement benefits. This is a shameful subterfuge, and Congress should be above stooping to such measures.

I realize that more and more revenue will be necessary to maintain the social security program, because it is an actuarially unsound arrangement. But, if Congress is intent on maintaining it, they should have the fortitude to increase the tax on people who are going to benefit from it. This will not be popular, I know, but it is the only honest thing to do.

I hope you will be one Senator who believes in honesty, and will shun the Marxian philosophy "From each according to his ability, and to each according to his need." We already have too much Russian ideology pervading the of certain Government officials.

You know my opinion, I would appreciate knowing yours.

Yours truly,

H. H. DUIN, M.D.

SAN FRANCISCO, CALIF., *June 30, 1960.*

Senator HARRY FLOOD BYRD,
Chairman, Senate Finance Committee,
New Senate Building, Washington, D.C.:

Request the following statement be read to the Senate Committee on Finance, and inserted into the record of current hearings on social security bill:

The California Labor Federation, representing more than 1,300,000 AFL–CIO members in this State, urges the adoption of a social security measure which contains health care provisions for the aged within the social security system. Our membership is categorically opposed to medical care benefits based on any kind of a means test. It must be recognized that senior citizens of this State and Nation, as a group, have recognized health and medical care needs which are substantially greater than those of younger age groups, and which, in terms of cost, far exceed the financial means of our aged population.

Despite labor's efforts to the contrary, under the widespread development of voluntary prepaid medical care programs in the past decade, the aged have been generally and effectively isolated from the rest of the community to be "experience-rated" by themselves under programs designed less to take care of their extensive needs than to extract the last profit dollar out of their human misery. Thus, the aged, in such isolated high-cost groups, cannot possibly insure themselves adequately as now being proposed by private insurance carriers, the medical associations and other vendors of medical care programs in their advocacy of low-benefit, high-cost plans that would "experience-rate" them apart from the community.

The provision of adequate health care for the aged on a prepaid basis therefore requires the adoption of a social insurance principle of financing such prepaid care as proposed in Forand-type legislation vigorously supported by all AFL–CIO members, based on the concept of providing benefits as a matter of right with dignity and respect for the individual.

The Eisenhower administration's State-Federal program, based on the concept of public assistance and handouts rather than social security with dignity, satisfies virtually no one. It is dependent on State action for implementation and would require the average aged individual with a meager income of less than $1,000 a year to pay out of pocket $250 for medical care, or more than 25 percent of his income, before he could realize benefits equal to 80 percent of his remaining medical care costs in return for a $24 annual contribution. The House-approved social security bill contains medical care provision which compound the evils of the Eisenhower Federal-State program of public assistance with a "pauper's oath" approach in a new program designed to assist States in providing limited medical benefits for the aged who may be determined by the States, as they may choose, to fall into a new category of medical indigents. This is a sham and a disgrace. We urge the Senate Finance Committee to take prompt action to approve a sound health care measure for the aged, based on the social insurance concept which would adequately reward our senior citizens with dignity and legal rights for their years of productive efforts and contribution to the welfare of the Nation. We recognize that time is short in this session of Congress but certainly there is time for men of conviction and courage to act on this matter by passing a health care measure within the social security system that gives recognition to the basic needs of the aged.

THOS. L. PITTS,
Secretary-Treasurer, California Labor Federation AFL–CIO.

AUSTIN, TEX., *June 30, 1960.*

Hon. HARRY BYRD,
Chairman, Committee on Finance, care Mrs. Elizabeth B. Springer, Chief Clerk, Senate Finance Committee, Room 2227, New Senate Office Building, Washington, D.C.:

MY DEAR SENATOR BYRD: The Texas Medical Association wishes to present for the records of the Committee on Finance of the U.S. Senate, the following statement on H.R. 12580.

We urge that physicians not be included under social security coverage. Our membership responded 10 to 1 against inclusion when polled. This past April, our 202 member house of delegates representing 8,200 physicians passed a resolution, without opposition or a dissenting vote, against such coverage for physicians.

Texas physicians neither expect nor want the Federal Government to provide retirement or survivorship benefits for themselves and family. It would seem strange indeed to force the payment of Federal funds upon persons who neither wish nor seek them.

May I thank you for the opportunity to have the views of the Texas Medical Association, Inc., into the records of the Committee on Finance.

Respectfully submitted,

MAY OWEN, M.D.,
President, Texas Medical Association,
Austin, Tex.

BROOKLYN, N.Y., *June 29, 1960.*

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

The Seafarers International Union of North America, representing over 70,000 American merchant seamen and maritime workers, strongly urges your full support of medical care benefits for aged within structure Federal social security system. We oppose means in test requirements in this legislation which would label necessary medical care as Federal handout at expense of all taxpayers.

Aged workers who have contributed so much to progress of this Nation are entitled to this protection as a matter of earned right in keeping with objectives of social security system. Attempts to limit benefits to a means requirement flaunt urgent needs of all the aged for decent medical care.

PAUL HALL,
President, Seafarers International Union of North America, AFL–CIO.

PITTSBURGH, PA., *June 29, 1960.*

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

Inasmuch as appearance before your committee in the closing days is impractical and might tend to delay completion of the committee's work, I would prefer to be recorded as favoring adding health benefits to the OASI system and have this telegram included in the committee record.

T. A. FERRIER, M.D.

NEW YORK, N.Y.

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

Urge strong support for legislation creating medical care benefits for the aged within Federal social security structure. Any means test would destroy objectives of providing decent medical care to meet pressing needs of all the aged. Experience with 50 different unemployment compensation laws and other State programs emphasizes urgent need for uniform Federal program. Medical care for aged should not be treated as charity at the expense of all taxpayers. As director of Social Security Department of Seafarers welfare plan serving 20,000 seamen and maritime workers urge your support to defeat any means test requirement and other burdensome limitations of this legislation.

JOSEPH VOLPIAN,
Director Social Security Department, Seafarers Welfare Plan.

CHICAGO, ILL., *June 29, 1960.*

Senator HARRY F. BYRD,
Chairman, Committee on Finance,
U.S. Senate, Washington, D.C.:

Urge your committee to support legislation to provide health benefits to aged through contributory social security system. Would be willing to testify in behalf of such legislation, but prefer having this telegram on record of your committee.

WILLIAM S. HOFFMAN, Ph. D., M.D.,
Medical Director Sidney Hillman Health Center of Chicago.

NEW KENSINGTON, PA., *June 29, 1960.*

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

One of many physicans who disagree with AMA opposition to health legislation. I and many other physicians strongly urge passage of bill providing health benefits for the aged, financed by OASDI system.

DANIEL FINE, M.D.

BELLAIRE, OHIO, *June 29, 1960.*

Hon. HARRY F. BYRD,
Senate Office Building, Washington, D.C.:

The social security mechanism is reasonably economical. Don't discard a good system just because the AMA opposes. AMA does not represent all physicians, particularly on social matters.

MILTON D. LEVINE, M.D.

STATEMENT OF THE AMERICAN OSTEOPATHIC ASSOCIATION BY CHARLES L. BALLINGER, D.O.

Mr. Chairman and members of the committee, I am Dr. Charles L. Ballinger, of Coral Gables, Fla., representing the American Osteopathic Association. I am also a fellow and secretary of the American College of Osteopathic Surgeons, an affiliate organization.

We very much appreciate the privilege of submitting comment on the pending social security amendments bill, H.R. 12580, section 601, which would establish a new title XVI of the Social Security Act to initiate a new Federal-State grants-in-aid program to help the States assist low-income aged individuals who need assistance in meeting their medical expenses.

We are gratified that in connection with the proposed new title XVI of the Social Security Act, the House-passed bill H.R. 12580 emphasizes osteopathic participation in the medical services for the aged program by express reference to section 1101(a)(7) of the Social Security Act on page 165 of the bill.

It was the Senate Committee on Finance that authored osteopathic inclusion in the Social Security Act definition of "physician" and "medical care" and "hospitalization" (sec. 1101(a)(7)) in 1950.

Several years ago the American Osteopathic Academy of Geriatrics was set up to make special studies, and to organize study groups to interest the members of the osteopathic profession in the subject of geriatrics and to keep them abreast of developments. A number of State laws require refresher courses for osteopathic licensees, and these sessions afford additional opportunity for considerations of current developments. In addition, the profession actively participates in conferences on aging at the National and State and local levels.

The American Osteopathic Association is represented on the 150-member National Advisory Committee for the White House Conference on Aging, January 9 to 12, 1961.

Some 14,000 physicians of the osteopathic school of medicine are in legalized practice in all the States.

More than 400 nongovernment hospitals are staffed by physicians and surgeons (D.O.), 93 of which have been approved by the association for the training of interns and 56 of which are approved by the association for the training of residents. There are 54 government (district, county, or city) hospitals staffed in part or entirely by physicians and surgeons (D.O.). After completion of their internship, osteopathic graduates obtain residency training in one or more of the 12 fields recognized by approved specialty examining boards:

American Osteopathic Board of Anesthesiology.
American Osteopathic Board of Dermatology.
American Osteopathic Board of Internal Medicine.
American Osteopathic Board of Neurology and Psychiatry.
American Osteopathic Board of Obstetrics and Gynecology.
American Osteopathic Board of Ophthalmology.
American Osteopathic Board of Pathology.
American Osteopathic Board of Pediatrics.
American Osteopathic Board of Physical Medicine and Rehabilitation.
American Osteopathic Board of Proctology.
American Osteopathic Board of Radiology.
American Osteopathic Board of Surgery.

An applicant for certification by the American Osteopathic Board of Surgery or for membership in the American College of Osteopathic Surgeons must be a graduate of an approved college of osteopathy and surgery, which requires a minimum of 3 years' preprofessional college work for entrance and 4 years of professional college work for graduation, must have at least 1 year of internship, and a minimum of 3 years of formal training subsequent to internship, must have assisted in not less than 400 major surgical operations, and I call your attention to the fact that is the minimum and most men in their training period do assist in many times that minimum number, and must have performed a minimum of 200 major surgical operations upon his own responsibility subsequent to the completion of the minimum required period of formal training. All the specialties require 3 years special training beyond internship.

These physicians and surgeons and these hospitals are utilized by the Bureau of Employees Compensation for care of Federal civil employees for injuries and illnesses incurred in the course of their employment. They are used in the medicare program of the Defense Department for the care of dependents of members of the armed services. They are available to Federal civil employees under the Federal employees health benefits program, under voluntary health insurance plans.

In connection with any social security medical care program for the aged which is or may be inaugurated, Federal incentives should be provided for encouragement of prepaid health insurance plans on a voluntary basis.

Furthermore, as we suggested to the Senate Subcommittee on Problems of the Aged and Aging during its hearings last August, we believe that more financial support should be made available for basic and applied research in geriatrics. The osteopathic schools of medicine, in common with the other medical schools, are participating in the research and training programs of the National Institutes of Health in such fields as cancer, cardiovascular diseases, arthritis and metabolic diseases, neurological diseases, and mental health, which may be said to bear a primary relation to aging. Lectures and clinical courses are given in the care of the aged, under the subject of gerontology, and kindred subjects throughout the curriculums in our colleges.

The American Osteopathic Association will continue to work with private organizations and Government agencies for the advancement of the health care and welfare of the aged, and desires to be of any possible assistance to this honorable committee in connection with the pending and related legislation.

AMERICAN OSTEOPATHIC ASSOCIATION,
Washington, D.C., July 1, 1960.

Re H.R. 1280.

Hon. HARRY F. BYRD,
Chairman, Senate Committee on Finance,
U.S. Senate, Washington, D.C.

DEAR SENATOR BYRD: Although Dr. Ballinger, of Coral Gables, Fla., has already filed with your committee a statement on the part of the American Osteopathic Association in connection with the social security amendments bill, H.R. 12580, an objectionable and gratuitous suggestion made by the International Chiropractic Association to your committee yesterday to change the form of reference to osteopathy in connection with the definitions of "physicians' services" and "physician" on page 165 of the bill calls for additional comment on our part.

The chiropractic proposal would revise lines 12–16, page 165 of H.R. 12580, to read as follows:

"(e) The term 'physicians' services' means services provided in the exercise of his profession in any State by a physician, osteopath, or chiropractor, licensed in such State; and the term 'physician' includes a physician, osteopath, or chiropractor licensed in such State."

The definition of "physician" on page 165 of the bill as it passed the House emphasizes osteopathic participation by incorporating by reference section 1101(a)(7), adopted in 1950, which includes doctors of osteopathy in the definition of physician applicable to the general provisions of the Social Security Act. We respectfully request that this form of reference be retained for purposes of osteopathic participation.

It was through application of the criterion that in order to qualify for inclusion under the term "physician," as used in the Social Security Act generally, one must be trained in the practice of the healing art in all its branches, that this committee in 1950, based upon the evidence submitted, found that the graduates of the osteopathic schools of medicine so qualified and included them under section 1101(a)(7).

The Congress had similarly defined the terms "physicians" and "medical care" and "hospitalization" as inclusive of osteopathic physicians and hospitals under the provisions of the U.S. Employees Compensation Act in 1938 (52 Stat. 586).

Previous to that, in 1929, the Congress, in regulating the practice of the healing art in the District of Columbia, provided: "The degrees doctor of medicine and doctor of osteopathy shall be accorded the same rights and privileges under governmental regulations" (45 Stat. 1329).

As above stated, we hope that the provision for osteopathic participation under H.R. 12580 will be retained in the form in which it passed the House.

Very truly yours,

C. D. SWOPE, D.O., *Chairman.*

MADISON, WIS., *June 29, 1960.*

Senator HARRY FLOOD BYRD,
Chairman, Senate Finance Committee,
Washington, D.C.:

Local 720 of the Wisconsin Council of County and Municipal Employees by unanimous vote urges your support of the McNamara amendment for medical care for aged to replace title 6 of the House-approved H.R. 12580.

MERCEDES DUFOUR,
Secretary, City-County Building, Madison, Wis.

HUDSON, N.Y., *June 29, 1960.*

Senator HARRY F. BYRD,
Chairman of the Senate Committee on Finance,
Washington, D.C.:

On behalf of the Group Health Association of America I would like to testify in support of legislation to provide health benefits to the aged through contributory social security system. However, I do not want to delay completion of the work of your committee within the remaining days of this congressional session. If my personal appearance would in any way hold up the committee's deliberations I would prefer to be recorded as favoring adding health benefits to the OASDI system and having this telegram included in the committee record.

CALDWELL D. ESSELTYN, M.D.,
President, Group Health Association of America, Hudson, N.Y.

NEW YORK, N.Y., *June 29, 1960.*

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

Would like to appear before your committee to testify in support of legislation to provide health benefits to the aged through contributory social security system. However, I do not want to delay completion of committee's work in closing days of congressional session. If my personal appearance would in any way hold up the committee's deliberations, I would prefer to be recorded in favor of adding health benefits to the OASDI system and having my telegram included in the committee's records. My own record and experience may be identified by reference to Who's Who in America.

GEORGE BAEHR, M.D.

YELLOW SPRINGS, OHIO, *June 29, 1960.*

Senator HARRY F. BYRD,
Committee on Finance,
Senate Office Building, Washington, D.C.:

Have just learned of public hearing on health care for aged today and tomorrow. I urge support of legislation to provide health benefits through OASI, if we are as a nation truly concerned to meet health problems of older people and maintain humane standards of quality and quantity of health services. This would permit contributions of individuals through employed lifetime and give widest flexibility in administration with least likelihood of regional and sectional variations in coverage and service.

Please include this telegram in committee's record.

JAMES P. DIXON, M.D.,
President, Antioch College.

WASHINGTON, D.C., *June 29, 1960.*

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

Re Finance Committee hearings June 29 and 30 on health care for the aged. I wish to record with your committee my full support of legislation to provide health care to the aged through the contributory social security system. I would request the opportunity to testify re above but do not want to delay the

work of the committee in the closing days of the congressional session. I ask that this telegram expressing my stand in favor of adding health benefits to the OASDI system be placed in the committee's record in lieu of my appearance before the committee.

WARREN F. DRAPER, M.D.,
Executive Medical Officer, UMWA Welfare.

ST. LOUIS, MO., *June 29, 1960.*

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

The Missouri State Labor Council AFL–CIO respectfully urges your committee to approve medical care benefits for the aged within the social security system. We think this should be done without a means test.

JOHN I. ROLLINS, *President.*

WASHINGTON, D.C. *June 29, 1960.*

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

May I on behalf of more than 400,000 workers represented by the International Union of Electrical, Radio, and Machine Workers AFL–CIO urgently request that you and your colleagues on the Senate Finance Committee give favorable consideration to legislation providing medical care for the aged within the Federal social security system. At the same time our international union is strongly opposed to the imposition of any means test.

I can assure you that this represents the militant sentiment of the overwhelming majority of members of our union as concretely evidenced in innumerable local, regional, and national meetings and by thousands of letters and telegrams which I and other leaders of this union have received. I firmly believe that you will be serving not only splendid humanitarian purposes but also purposes of our Nation's welfare and internal strength if you vote approval of this legislation.

JAMES B. CAREY,
President, IUE–AFL–CIO.

WASHINGTON, D.C. *June 29, 1960.*

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

This statement is in support of legislation to provide health benefits to aged through an expansion of the existing social security system. Kindly request that this opinion be included in the committee's record. Because of the element of time for adjournment it is impossible for me to appear personally before the committee such a request is made.

DR. E. C. MAZIQUE,
President, National Medical Association.

PHILADELPHIA, PA., *June 29, 1960.*

HON. HARRY F. BYRD,
Committee on Finance,
U.S. Senate, Washington, D.C.:

On behalf of the city of Philadelphia and its 2 million inhabitants I desire to testify in support of legislation to provide health benefits to aged through social security system. Contributory social insurance is far superior to State-Federal means test approach. Blue Cross hearings in Pennsylvania have demonstrated serious health problems of the aged. Social security approach is akin to insurance while the means test approach tends to pauperize recipients. Since I do not wish to delay committee's work, I will gladly forgo presenting my view personally but wish to be on record regarding the urgent need for adding health benefits to the OASDI system at this session of Congress.

DAVID BERGER,
City Solicitor of Philadelphia.

WASHINGTON, D.C., *June 29, 1960.*

HON. HARRY F. BYRD,
Chairman, Committee on Finance,
U.S. Senate, Washington, D.C.:

The National Consumers League has long supported the establishment of a system of health benefits for the aged under the social security law. We have studied many alternative proposals over the years and have concluded that there is no more effective, economical, and dignified way of providing our elder citizens with the health care they so desperately need. The approach taken in the bill passed recently by the House of Representatives utilizing a means test under a Federal-State public assistance program is inadequate and does not solve the problem. Because we feel so strongly that it is urgent for the Senate to act during the current session we would like very much to testify in detail on our views before your committee. But recognizing the need for brief hearing to enable the Senate to act before adjournment, we are taking this means of presenting in capsule form for the committee's consideration our strong views in support of a contributory health insurance program for the aged under the Social Security System. We urge your committee to act in support of the simple and democratic solution of the health needs of our elder citizens. Please include this telegram in the record of the hearing.

VERA MAYER,
General Secretary, National Consumers League.

WASHINGTON, D.C., *June 29, 1960.*

HON. HARRY FLOOD BYRD,
Room 2227, New Senate Office Building,
Washington, D.C.:

On behalf of the members of the American Bakery & Confectionery Workers' International Union, AFL–CIO, we urge most strongly that the Senate Finance Committee approve legislation calling for medical care benefits for the aged within the Social Security System as being the most reasonable, effective, and practical way of dealing with an extremely pressing problem facing the senior citizens of our Nation. By the same token we are most emphatically opposed to any proposal which demands a means test.

DANIEL E. CONWAY,
International President,
American Bakery & Confectionery Workers International Union.

NEW YORK, N.Y., *June 29, 1960.*

HON. HARRY FLOOD BYRD,
Chairman, Senate Finance Committee,
Room 2227, New Senate Office Building, Washington, D.C.:

On behalf of more than a quarter of million members of the American Federation of Musicians, may I urge favorable consideration by you and your committee colleagues of legislation now before you that would provide medical care benefits for the aged within the social security system. We are opposed to means test provisions as proposed.

HERMAN KENIN,
President, American Federation of Musicians, AFL–CIO.

WASHINGTON, D.C., *June 29, 1960.*

HON. HARRY FLOOD BYRD,
Chairman, Senate Finance Committee, Room 2227, New Senate Office Building,
Washington, D.C.:

Urge support of medical care benefits for aged through social security system. Use of a means test must be avoided and principle of health benefits through social insurance maintained. Recommend that bill (S. 3503) introduced by Senator McNamara be reported out of committee.

ARNOLD S. ZANDER,
International President, American Federation of State, County & Municipal Employees.

NEW YORK, N.Y., *June 29, 1960.*

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

We should like to testify in support of legislation to provide health benefits to aged through social security system contributory social insurance superior to State-Federal means test approach period but we do not want to delay committee's work so we will forgo presenting our views personally and wish to be on record regarding urgent need for adding health benefits to OASI system at this session of Congress.

COUNCIL OF THE GOLDEN RING CLUBS
OF SENIOR CITIZENS,
ADOLPH HELD, *Chairman.*

DETROIT, MICH., *June 29, 1960.*

Senator HARRY BYRD,
Chairman, Senate Finance Committee,
Room 2227, New Senate Office Building,
Washington, D.C.:

In view of the fact that hearings on H.R. 12580 are scheduled for only June 29 and 30 and because of the short time remaining to the Congress, I do not believe it is necessary for me to appear in person to testify. I would however like to have the views of the International Union, United Automobile, Aircraft & Agricultural Implement Workers of America, on health insurance for the aged recorded as follows: We believe that the subject has been thoroughly studied and the issues thoroughly debated. Out of all this public discussion one conclusion remains clear—financing of hospital and medical is the most pressing problem for millions of America's older citizens. Our own experience with over 100,000 living retired UAW workers confirms this. We believe the problem is an urgent one and that congressional action is needed in this legislative session. We urge you to reject any Federal-State or means test approach as the basic solution to providing health care to the aged. Such programs will not meet the problem, are fiscally impractical, and would undermine the dignity of the hard-pressed aged. We strongly urge that you adopt a measure based on use of the social insurance system to provide benefits as a matter of right on an actuarially sound and feasible basis.

WALTER P. REUTHER,
President, International Union, United Automobile, Aircraft & Agricultural Implement Workers of America.

TRENTON, N.J., *June 28, 1960.*

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

DEAR SENATOR BYRD: We respectfully urge you to support the Mills bill title XVI, H.R. 12580 as adopted by the House of Representatives on June 23 and to disapprove any amendments that might be offered which will place old-age medical care within the realm of social security.

Very truly yours,

JOHN J. DEBUS, R.P.,
MPA Secretary.

RALEIGH, N.C., *June 29, 1960.*

The SENATE FINANCE COMMITTEE,
New Senate Office Building, Washington, D.C:

The officers and members of the North Carolina State AFL-CIO respectfully request and urge you to adopt a medical care program with benefits for the aged within the social security system. The program proposed by the administration is unrealistic, unworkable, and absolutely not in the best interest of anyone but the large insurance companies. The helpless aged people of America are looking to you for help. Please do not desert them by favoring the rich insurance carriers.

W. M. BARBEE,
President North Carolina State AFL-CIO.

CHICAGO, ILL., *June 29, 1960.*

SENATE FINANCE COMMITTEE,
New Senate Office Building, Washington, D.C.:

The thousands of members of my organization urge your committee adopt medical care benefits for aged within the social security system. we oppose the means-test legislation.

JESSE CLARK,
President, Brotherhood of Railroad Signalmen.

WASHINGTON, D.C., *June 29, 1960.*

SENATE FINANCE COMMITTEE,
New Senate Office Building, Washington, D.C.:

The Tobacco Workers International Union and its membership urge your committee to adopt medical care benefits for aged within social security system. We oppose means-test legislation.

JOHN O'HARE,
President.
R. J. PETREE,
Secretary-Treasurer, Tobacco Workers International Union AFL–CIO.

BOSTON, MASS., *June 29, 1960.*

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

The Massachusetts State labor council is genuinely concerned about the need for a medical care program for the aged integrated with the social security system. In our opinion, the legislation enacted by the House is most inadequate and impractical it would turn the needy over to the greedy. Strongly urge that your committee speedily approve a medical benefit for the aged program as part of the social security system.

KENNETH J. KELLEY,
Secretary-Treasurer, Massachusetts State Labor Council.

WASHINGTON, D.C., *June 29, 1960.*

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

In behalf of the International Association of Machinists I respectfully urge your committee to adopt a medical care program for the aged within the structure of the present social security system. We are unalterably opposed to the means-test legislation adopted by the House of Representatives.

A. J. HAYES,
International President.

WASHINGTON, D.C., *June 29, 1960.*

SENATE FINANCE COMMITTEE,
New Senate Office Building, Washington, D.C.:

We earnestly request your consideration of pending social security legislation before your committee on behalf of the aged. We feel means-test legislation is most inadequate and will be detrimental in providing care needed by our elderly citizens. We urge your committee's approval to provide medical care benefits within social security system.

THOMAS F. MURPHY,
Secretary, Bricklayers, Masons & Plasterers International Union of America.

MARINETTE, WIS., *June 29, 1960.*

SENATE FINANCE COMMITTEE,
New Senate Office Building, Washington, D.C.

HONORABLE GENTLEMEN: The International Glove Workers Union of America is asking your support in adopting a medical care benefits for the aged within the social security system.

JOSEPH GOODFELLOW,
President, International Glove Workers Union, America.

INDIANAPOLIS, IND., *June 29, 1960.*

SENATE FINANCE COMMITTEE,
New Senate Office Building, Washington, D.C.:

On behalf of the 325,000 members of the Indiana State AFL–CIO, we urge committee adopt medical care benefits for aged within social security system and we oppose means-test legislation.

DALLAS SELLS,
President Indiana State AFL–CIO.
MAX F. WRIGH,
Secretary-Treasurer, Indiana State AFL–CIO.

NASHUA, N.H., *June 29, 1960.*

SENATE FINANCE COMMITTEE,
New Senate Office Building, Washington, D.C.:

Urge committee adopt medical care benefits for aged within social security system and oppose means-test legislation.

THOMAS J. PITARYS,
President, New Hampshire State AFL–CIO.

WASHINGTON, D.C., *June 29, 1960.*

SENATE FINANCE COMMITTEE,
New Senate Office Building, Washington, D.C.:

The Pattern Makers League of North America urges you to work and vote for medical care benefits for the aged within the framework and principles of the social security system. We urge you to oppose patently unfair and unrealistic means-test legislation.

Respectfully.

G. HALLSTROM, *General President.*

OMAHA, NEBR., *June 29, 1960.*

SENATE FINANCE COMMITTEE,
New Senate Office Building, Washington, D.C.:

We urgently request adoption medical care benefits for aged within social security system and oppose means-test legislation.

R. W. NISLEY,
President, Nebraska State AFL–CIO.

CLEVELAND, OHIO, *June 29, 1960.*

SENATE FINANCE COMMITTEE,
New Senate Office Building, Washington, D.C.:

On behalf of Brotherhood of Locomotive Firemen & Enginemen which I represent as its president I cannot urge your honorable committee too strongly to adopt medical care benefits for aged within social security system. I am opposed to the means-test legislation.

H. E. GILBERT.

MILWAUKEE, WIS, *June 29, 1960.*

SENATE FINANCE COMMITTEE,
New Senate Office Building, Washington, D.C.:

We urge the Finance Committee to act favorably on legislation to provide medical care for our aged. These people are the victims of time and are left stranded in a sea of high economy. We further urge that the committee place the responsibility of administering the welfare of our aged under the social security system and not to subject them to pauperism by submitting to a means test.

GEORGE A. HABERMAN,
President, Wisconsin State AFL-CIO.
GEORGE W. HALL,
Secretary-Treasurer, Wisconsin State AFL-CIO.

OKLAHOMA CITY, OKLA., *June 29, 1960.*

SENATE FINANCE COMMITTEE,
New Senate Office Building,
Washington, D.C.:

Respectfully urge committee adopt medical care benefits for aged within social security system and oppose means test legislation.

J. J. CALDWELL,
Secretary-Treasurer, Oklahoma AFL-CIO.

CINCINNATI, OHIO, *June 29, 1960.*

SENATE FINANCE COMMITTEE,
New Senate Office Building,
Washington, D.C.:

On behalf of the 65,000 members of the International Union of United Brewery, Flour, Cereal, Soft Drink, and Distillery Workers of America, we urge the members of your committee to support and adopt the medical care benefits for the aged within the social security system.

JOSEPH E. BRADY,
Director of Legislation.

HIGHLAND PARK, MICH., *June 29, 1960.*

SENATE FINANCE COMMITTEE,
New Senate Office Building,
Washington, D.C.:

Respectfully request your committee adopt program providing medical care benefits for aged within social security system. Two hundred thousand maintenance-of-way employees and their families favor this method of caring for our older people. The means test proposal is wholly inadequate.

HAROLD C. CROTTY,
President, Brotherhood of Maintenance-of-Way Employees.

KANSAS CITY, MO., *June 29, 1960.*

SENATE FINANCE COMMITTEE,
New Senate Office Building,
Washington, D.C.:

In behalf of my organization, the Brotherhood of Railway Car Men of America, request your committee adopt medical care benefits for the aged with social security system and oppose means test legislation. Your consideration will be greatly appreciated.

A. J. BERNHARDT, *General President.*

ALBANY, N.Y., *June 29, 1960.*

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

GENTLEMEN: We vigorously support the concept of medical care for the aged under the social security system and urge your committee to include provisions of this sort in a bill reported out to the Senate.

No single piece of legislation is viewed with greater urgency by the 140,000 members of this union. This has been demonstrated in thousands of signatures to Forand bill petitions sent through this office to the Congress.

This concept is fully in keeping with the American tradition of Government accepting responsibility where private sectors of our economy have been unable to cope with a pressing human need. We have had firsthand experience attempting to negotiate aged health care insurance into our union group plans. The cost is so prohibitive that our raising this issue has only served to arouse bitter employer opposition. Obviously this need can only be met on an economical basis through a national program tied into the already tried and proven social security system.

Under no circumstances would we favor legislation of this type which made availability of medical care contingent upon a means test. This would be a cruel indignity to the senior citizens of America who should at least have the medical care provisions outlined in the Forand bill.

The contents of this message have been read to, and unanimously approved by, the international executive board of our union now in session at Albany.

PAUL L. PHILLIPS,
President, United Papermakers & Paperworkers, AFL–CIO.

TOLEDO, OHIO, *June 29, 1960.*

SENATE FINANCE COMMITTEE,
New Senate Office Building,
Washington, D.C.:

The 30,000 members and officers of the American Flint Glass Workers Union of North America urgently request the members of the Senate Finance Committee to adopt medical care benefits for aged within social security system. Strictly opposed to any legislation containing a State Public Assistance program to retirees who are impoverished.

CHARLES M. SCHEEF, *International President.*

WINSTON-SALEM, N.C., *June 29, 1960.*

SENATE FINANCE COMMITTEE,
New Senate Office Building,
Washington, D.C.:

Medical care for aged urgently needed. Urge adoption of social security system plan without applying means test.

JOHN W. FOSTER, M.D.

UNION CITY, N.J., *June 29, 1960.*

SENATE FINANCE COMMITTEE,
New Senate Office Building,
Washington, D.C.:

Our international union at its recently concluded convention called upon Congress to adopt legislation providing for medical care benefits for aged within the framework of the social security system. Any departure from this procedure would result in watered down legislation that would fall far short of meeting the needs of the aged. This would be particularly true of the introduction of a means test provision that is administratively unsound and humiliating in its application. We urge you to pass legislation incorporating the sound and equitable principle of the Forand Bill.

MORT BRANDENBURG,
General President, Distillery Rectifying Wine and Allied Workers, International Union of America, Affiliated with the AFL–CIO.

BANGOR, MAINE., *June 29, 1960.*

SENATE FINANCE COMMITTEE,
New Senate Office Building,
Washington, D.C.:

We strongly urge adoption of medical care for the aged with the social security program. We strongly oppose the means test as not necessary.

ALBERT B. CAMIRE,
President, the Bangor Builders Construction Trade Council.

BANGOR, MAINE, *June 29, 1960.*

SENATE FINANCE COMMITTEE,
New Senate Office Building,
Washington, D.C.:

Third biennial convention just concluded adopted a resolution unanimously urging the Congress to enact legislation to give medical care for the aged without a means test and under the social security system.

B. J. DORSKY,
Maine State Federated Labor Council.

BANGOR, MAINE, *June 29, 1960.*

SENATE FINANCE COMMITTEE,
New Senate Office Building,
Washington, D.C.:

Urge you adopt medical care benefits for aged under social security program also urge you oppose means test.

CARPENTERS LOCAL UNION 621.

NEWARK, N.J., *June 29, 1960.*

SENATE FINANCE COMMITTEE,
Senate Office Building, Washington, D.C.:

Urge your committee to adopt legislation providing medical care benefits for aged within social security system and to oppose means test legislation.

JOEL R. JACOBSON,
President, New Jersey State CIO Council 772.

BANGOR MAINE, *June 29, 1960.*

SENATE FINANCE COMMITTEE CHAIRMAN,
New Senate Office Building, Washington, D.C.:

Our local union urges that the committee adopt a medical care benefit program for the aged within the social security system. Opposed to the means test.

EDWARD L. BRALEY,
Business Agent, Local 321, Plumbers and Fitters.

PHILADELPHIA, PA., *June 30, 1960.*

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

Respectfully urge committee adopt medical care benefits for aged within social security system. Pauper test legislation on this subject a disgrace.

ANDREW JANASKIE,
General President, American Federation of Hosiery Workers.

BALTIMORE, MD., *June 30, 1960.*

SENATE FINANCE COMMITTEE,
New Senate Office Building, Washington, D.C.:

Urge your committee adopt medical care benefits for our senior citizens within our social security system and oppose means test legislation.

W. F. STRONG,
President, Maryland State and District of Columbia AFL–CIO.

INDIANAPOLIS, IND., *June 30, 1960.*

SENATE FINANCE COMMITTEE,
New Senate Office Building, Washington, D.C.:

On behalf of our more than 110,000 members and their families we urge your committee act favorably on adoption of medical care benefits for aged within the social security system and oppose the means test.

INTERNATIONAL TYPOGRAPHICAL UNION,
ELMER BROWN, *President,*
JOHN PILCH, *First Vice President,*
A. BEVIS, *Second Vice President,*
JOE BAILEY, *Third Vice President,*
WILLIAM R. CLOUD, *Secretary-Treasurer.*

WASHINGTON, D.C., *June 30, 1960.*

U.S. SENATE FINANCE COMMITTEE,
New Senate Office Building,
Washington, D.C.:

On behalf of the 220,000 members of our brotherhood, it is strongly urged your committee adopt medical care benefits for aged within social security system. Also I respectfully urge committee to oppose means test legislation.

L. M. RAFTERY,
General President, Brotherhood of Painters, Decorators, and Paperhangers of America.

PRESSMEN'S HOME, TENN., *June 29, 1960.*

CHAIRMAN, SENATE FINANCE COMMITTEE,
New Senate Office Building,
Washington, D.C.:

The membership of the International Printing Pressmen and Assistants Union of North America wishes to be recorded in favor of adoption of medical care benefits for aged within social security system. We strongly oppose the means test legislation.

A. J. DE ANDRADE, *President,*
GEORGE L. GOOGE, *Secretary-Treasury.*

INDIANAPOLIS, IND., *June 30, 1960.*

SENATE FINANCE COMMITTEE,
Room 2227, New Senate Office Building,
Washington, D.C.:

On behalf of this entire organization of more than 100,000, we urge you to use your influence to adopt medical care benefits for aged within social security system and oppose means test legislation.

W. C. BIRTHRIGHT,
General President, Secretary-Treasurer, Journeymen Barbers, Hairdressers, Etc, International Union.

SPRINGFIELD, ILL., *June 29, 1960.*

SENATE FINANCE COMMITTEE,
Room 2227, New Senate Office Building,
Washington, D.C.:

Aged citizens of Illinois are urgently and desperately in need of generous medical care benefits. In behalf of 1,250,000 members of our State AFL–CIO, I am urging the Senate Finance Committee to oppose the hodgepodge means test proposal and give our senior citizens effective medical care within the social security system.

R. G. SODERSTROM,
President, Illinois State Federation of Labor & Congress of Industrial Organizations.

SALT LAKE CITY, UTAH., *June 29, 1960.*

SENATE FINANCE COMMITTEE,
Room 2227, New Senate Office Building,
Washington, D.C.:

In behalf of the retired senior citizens in Utah we respectfully urge your committee adopt medical care program for the aged within the framework of the social security system. We strenuously oppose the means test as a basis for medical care benefits.

JOHN R. SCHONE,
President, Utah State AFL–CIO.

NEW YORK, N.Y., *June 29, 1960.*

SENATE FINANCE COMMITTEE,
Room 2227, New Senate Office Building,
Washington, D.C.:

Strongly urge, on behalf of our union, adoption of medical care benefit within social security system. No means test should be provided for.

ALEX ROSE,
President United Hatters Cap & Millinery Workers International Union.

NEW YORK, N.Y., *June 29, 1960.*

SENATE FINANCE COMMITTEE,
Room 2227, New Senate Office Building,
Washington, D.C.:

Strongly urge enactment of medical care benefit legislation within social security program to meet desperate need of 16 million American senior citizens. Proposed means test would work great hardship on those needing help.

MILTON GORDON,
Secretary-Treasurer, International Union of
Doll & Toy Workers of the United States & Canada, AFL–CIO.

ST. ALBANS, VT., *June 29, 1960.*

SENATE FINANCE COMMITTEE,
Room 2227, New Senate Office Building,
Washington, D.C.:

The Vermont Labor Council and its affiliated members urge you to adopt medical care benefits for aged within social security system. Oppose means test legislation.

VERMONT LABOR COUNCIL, AFL–CIO,
JAMES R. CROSS,
Secretary-Treasurer.

BIRMINGHAM, ALA., *June 29, 1960.*

SENATE FINANCE COMMITTEE,
Room 2227, New Senate Office Building,
Washington, D.C.:

Urge you adopt medical care benefits for aged within social security system to provide adequate health insurance, and oppose means test legislation which would only be inadequate public relief for fewer people.

BARNEY WEEKS,
President, Alabama Labor Council.

KANSAS CITY, MO., *June 29, 1960.*

SENATE FINANCE COMMITTEE,
Room 2227, New Senate Office Building,
Washington, D.C.:

On behalf of 150,000 members of the International Brotherhood of Boilermakers, Iron Shipbuilders, Blacksmiths, Forgers & Helpers, who have by every means of communication available to this office expressed their personal desires with reference to any social security legislation, I earnestly urge that your com-

mittee adopt plan for medical care benefits for the aged within the social security system. Our organization and our members are especially opposed to any type of means test legislation. Your favorable consideration will be sincerely appreciated.

WILLIAM A. CALVIN,
President, International Brotherhood of Boilermakers, Iron Shipbuilders, Blacksmiths, Forgers & Helpers.

JACKSON, MISS., *June 29, 1960.*

SENATE FINANCE COMMITTEE,
Room 2227, Senate Office Building,
Washington, D.C.:

Sincerely request that you adopt care legislation within social security system. The bill as adopted by House of Representatives does not fill the need for our aged people in this State.

CLAUDE RAMSEY,
President, Mississippi Labor Council, AFL–CIO.

HARRISBURG, PA., *June 29, 1960.*

SENATE FINANCE COMMITTEE,
Room 2227, New Senate Office Building,
Washington, D.C.:

By reason of the recent Pennsylvania AFL–CIO convention action, please be advised that over 2,400 delegates unanimously endorsed by resolution action medical care benefits for aged within the present social security system and opposed any means test qualifications for participation. Therefore, on behalf of over 1 million union members, I urge the Senate Finance Committee to adopt medical care benefits for aged within the present social security system.

HARRY BOYER,
Copresident, Pennsylvania AFL–CIO.

NEW YORK, N.Y., *June 29, 1960.*

SENATE FINANCE COMMITTEE,
Room 2227, New Senate Office Building,
Washington, D.C.:

On behalf of the National Maritime Union, AFL–CIO, I herewith urge the Finance Committee to adopt medical care benefits for aged within social security system and strongly oppose means test legislation.

JOSEPH CURRAN,
President, National Maritime Union.

CHICAGO, ILL., *June 29, 1960.*

SENATE FINANCE COMMITTEE,
New Senate Office Building,
Washington, D.C.:

On behalf of the Illinois State Federation of Labor and Congress of Industrial Organizations urge your committee to adopt medical care benefits for aged within social security system. Oppose means test legislation.

MAURICE F. MCELLIGOTT,
Secretary-Treasurer, Illinois State Federation of Labor and Congress of Industrial Organizations.

WASHINGTON, D.C., *June 29, 1960.*

SENATE FINANCE COMMITTEE,
New Senate Office Building,
Washington, D.C.:

On behalf of the Communications Workers of America, I respectfully urge the committee to adopt medical care benefits for the aged within the social security system and that you oppose any means test to qualify for benefits.

J. A. BEIRNE,
President, Communications Workers of America.

PHILADELPHIA, PA., *June 29, 1960.*

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

Respectfully urge upon your committee the soundness and necessity of approving legislation medical care benefits for the aged placing it firmly within social security system and paid for by the beneficiaries and avoiding any means test. As one of the organizations that has pioneered in the field of provision for the fast increasing of aged proportion of our population we are sure that these principles as well as the need are imperative.

SAL B. HOFFMAN,
President.
ARTHUR G. MCDOWELL,
Director, Civic and Government Affairs, Upholsterers' International.

WASHINGTON, D.C., *June 29, 1960.*

SENATE FINANCE COMMITTEE,
New Senate Office Building,
Washington, D.C.:

The Operative Plasterers' and Cement Masons' International Association urges your committee to adopt legislation providing for medical care benefits for the aged within the social security plan. We strongly oppose means test legislation.

EDWARD J. LEONARD,
General President, Operative Plasterers' and Cement Masons' International Association.

PHOENIX, ARIZ., *June 29, 1960.*

SENATE FINANCE COMMITTEE,
New Senate Office Building, Washington, D.C.:

The Arizona State AFL-CIO urges the Senate Finance Committee to adopt medical care benefits for aged within social security system. We must meet the needs of our senior citizens.

K. S. BROWN,
Arizona State AFL-CIO.

DENVER, COLO., *June 29, 1960.*

SENATE FINANCE COMMITTEE,
New Senate Office Building, Washington, D.C.:

Respectfully urge your support for medical care proposal to assure adequate health care for our senior citizens within the framework of the social security system. Our Nation cannot afford to force our oldsters to subject themselves to a means test in order to qualify for medical aid. Your support will be appreciated.

GEORGE A. CAVENDER,
President.
A. TOFFOLI,
Secretary-Treasurer, Colorado Labor Council AFL-CIO.

PORTLAND, OREG., *June 29, 1960.*

SENATE FINANCE COMMITTEE,
New Senate Office Building, Washington, D.C.:

Urge your committee recommend medical care benefits for aged within social security system and not apply the means test. Many States unable or unwilling to share medical expenses.

J. T. MARR,
Executive Secretray, Oregon AFL-CIO.

BOISE, IDAHO, *June 29, 1960.*

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

Urge you adopt legislation providing for medical care benefits for aged within social security system.

IDAHO STATE AFL–CIO,
DARRELL H. DORMAN,
President.
ALBERT BEATTY,
Secretary-Treasurer.

CINCINNATI, OHIO, *June 29, 1960.*

SENATE FINANCE COMMITTEE,
New Senate Office Building, Washington, D.C.:

The members of the International Molders and Foundry Workers Union believe it would be wonderful for the older people of this Nation if the committee were to adopt medical care benefits for aged within social security system and we urge the members of the Senate Finance Committee to support this legislation.

CHESTER A. SAMPLE,
President.

MILWAUKEE, WIS., *June 29, 1960.*

SENATE FINANCE COMMITTEE,
New Senate Office Building, Washington, D.C.:

On behalf of the Allied Industrial Workers of America, AFL–CIO, I wish to urge your committee to adopt medical care benefits for the aged which are tied in with the social security system. Now is not the time to turn back the clock by enactment of means test legislation. We do ourselves a disservice when we propose to degrade our senior citizens in this fashion. While our organization does not expect Congress to enact a measure which will resolve all the aspects of this problem in one fell swoop, we do look to Congress for a sound start toward a solution. This can only be done, in our opinion, by providing benefit right. In other words, benefits must be earned and received on much the same basis as old-age, survivors, and disability benefits. We respectfully urge your support for such a measure.

CARL W. GRIEPENTROG,
President, International Union Allied Industrial Workers of America, AFL–CIO.

WASHINGTON, D.C., *June 29, 1960.*

SENATE FINANCE COMMITTEE,
New Senate Office Building, Washington, D.C.:

We most earnestly endorse and urge the adoption of medical care benefits for the aged within the social security system. However, we oppose the means test legislation and trust the committee will see fit to support our plea.

GEORGE L. WARFEL,
President, the National Association of Special Delivery Messengers.

WASHINGTON, D.C., *June 29, 1960.*

SENATE FINANCE COMMITTEE,
New Senate Office Building, Washington, D.C.:

The membership of the Amalgamated Association of Street, Electric Railway, and Motor Coach Employees of America urge the Senate Finance Committee to adopt medical care benefits for aged within the social security system and oppose means test legislation.

O. J. MISCHO, *International Secretary-Treasurer.*

HELENA, MONT., *June 29, 1960.*

SENATE FINANCE COMMITTEE,
New Senate Office Building, Washington, D.C.:

Montana labor respectfully requests your committee adopt medical care benefits for aged within social security system and we oppose means test legislation.

JAMES S. UMBER,
President, Montana State AFL–CIO.

COLUMBUS, OHIO, *June 29, 1960.*

SENATE FINANCE COMMITTEE,
New Senate Office Building, Washington, D.C.:

The recent Ohio AFL–CIO convention passed unanimously a resolution calling for passage of Forand-type legislation in the field of health care. Our 1 million members are thoroughly convinced that the only sound approach to health care for retired persons 65 and over is through the social security system with universal coverage as opposed to the ways and means approach of matching Federal grants to participating States and coverage based on need.

ELMER F. COPE,
Secretary-Treasury, Ohio AFL–CIO.

ALBUQUERQUE, N. MEX., *June 29, 1960.*

SENATE FINANCE COMMITTEE,
New Senate Office Building, Washington, D.C.:

The New Mexico State AFL–CIO and all of its affiliated organizations and members join the national AFL–CIO and other interested groups in urging your committee to adopt the most universal economical and dignified approach in medical care benefits for the aged by use of the social security system as opposed to the inequitable means test which would lead to manifold inequities and whose enforcement inevitably involves an affront to the dignity of millions of older people.

JAMES A. PRICE,
President,
TOM E. ROBLES,
Executive Secretary-Treasury, New Mexico State AFL–CIO.

CHICAGO, ILL., *June 29, 1960.*

SENATE FINANCE COMMITTEE,
New Senate Office Building, Washington, D.C.:

On behalf of 275,000 members of the Building Service Employees International Union we respectfully ask your support of the principles incorporated in the Forand bill. We strongly support the contributory insurance principle for medical care benefits for the aged, and oppose the means test principle. We believe the present opportunity to amend the social security system should be used to add a practical and significant program for health care for the aged as opposed to stopgap legislation.

DAVID SULLIVAN,
General President, Building Service Employees International Union.

CHICAGO, ILL., *July 1, 1960.*

SENATE FINANCE COMMITTEE,
New Senate Office Building, Washington, D.C.:

On behalf of 700 members represented I urge your committee adopt medical care benefit legislation for the aged under social security. We are opposed to the means test legislation. We believe it imperative when people over 65 years of age have illness they should not be deprived of hospitalization or medical aid due to financial reasons. Therefore financial aid through social security would to a degree relieve the aged peoples medical fears after retirement.

FRED RIEHL,
The American Railway Supervisor Association, President and General Chairman SP and PFE Lodge No. 351 and Affiliates, 2545 Carmel Street, Oakland, Calif.

CHICAGO, ILL., *June 30, 1960.*

SENATE FINANCE COMMITTEE,
New Senate Office Building,
Washington, D.C.:

In behalf of American Federation of Teachers respectfully urge Senate Finance Committee adapt medical care benefits for the aged within social security system. We advise that we vigorously oppose any means test as part of this legislation.

CARL J. MEGEL,
President, American Federation of Teachers.

NEW YORK, N.Y., *June 29, 1960.*

SENATE FINANCE COMMITTEE,
New Senate Office Building,
Washington, D.C.:

On behalf of Office Employees International Union AFL–CIO, I urge you to adopt Forand type medical care benefits for aged within the social security system. We are in definite opposition to means test legislation.

HOWARD COUGHLIN,
President, Office Employes International Union.

COLUMBUS, OHIO, *June 29, 1960.*

SENATE FINANCE COMMITTEE,
New Senate Office Building,
Washington, D.C.

GENTLEMEN: We strongly urge your support for legislation that would provide honorable release from the hazard of medical costs in old age within the framework of the social security system and to oppose the medical aid plans proposed by the House Ways and Means Committee that only provides medical aid through State public assistance programs.

Sincerely yours,

PHIL HANNAH,
President, Ohio AFL–CIO.

CHICAGO, ILL., *June 29, 1960.*

SENATE FINANCE COMMITTEE,
New Senate Office Building,
Washington, D.C.:

In behalf of membership United Cement, Lime & Gypsum Workers and international union located in 42 States permit me to respectfully urge your committee adopt medical care benefits for aged within social security system and oppose means test legislation.

FELIX C. JONES, *General President.*

CHARLESTON, W. VA., *June 29, 1960.*

SENATE FINANCE COMMITTEE,
New Senate Office Building, Washington, D.C.:

Respectfully urge the committee to adopt a medical care program for the aged which will be theirs as a matter of right within the established social security system. Means test legislation is not, in our opinion, a sound effective approach to an increasingly serious social problem.

MILES C. STANLEY,
President, West Virginia Labor Federation, AFL–CIO.

NEW YORK, N.Y., *June 29, 1960.*

SENATE FINANCE COMMITTEE,
New Senate Office Building, Washington, D.C.:

On behalf of the 60,000 members of the International Alliance of Theatrical Stage Employees I respectfully request that your committee act favorably on medical care benefits for the aged within social security system and eliminate the means test requirement.

RICHARD F. WALSH,
International President IATSE & MPMO of United States and Canada.

INDIANAPOLIS, IND., *June 29, 1960.*

SENATE FINANCE COMMITTEE,
New Senate Office Building, Washington, D.C.:

On behalf of United Brotherhood of Carpenters and Joiners of America, we urge your committee adopt medical care benefits for aged within social security system and oppose "means test" legislation.

M. A. HUTCHESON,
General President.

WASHINGTON, D.C., *June 29, 1960.*

SENATE FINANCE COMMITTEE,
New Senate Office Building, Washington, D.C.:

Respectfully urge committee report favorable medical care for aged under social security and reject means test.

JAMES A. CAMPBELL,
National President American Federation of Government Employees.

WASHINGTON, D.C., *June 29, 1960.*

SENATE FINANCE COMMITTEE,
New Senate Office Building,
Washington, D.C.:

International Brotherhood of Bookbinders Union, in behalf of its 65,000 members, urges committee to adopt a medical care benefits for aged bill within framework of social security system without any ability-to-pay test.

JOSEPH DENNY,
President.
WESLEY A. TAYLOR,
Secretary-Treasurer.

ST. PAUL, MINN., *June 29, 1960.*

SENATE FINANCE COMMITTEE,
New Senate Office Building,
Washington, D.C.:

The Minnesota AFL–CIO Federation of Labor, representing 175,000 affiliates, respectfully urge you to adopt medical care benefits for the aged within the social security system and we are definitely opposed to pauper's oath method of establishing eligibility.

R. A. OLSEN,
President.
R. E. HESS,
Executive Vice President.
NEIL C. SHERBURNE,
Secretary-Treasurer.

CHICAGO, ILL., *June 29, 1960.*

SENATE FINANCE COMMITTEE,
New Senate Office Building,
Washington, D.C.:

In behalf of our membership (8,000), I urge that your committee adopt medical care benefits for the aged within the social security system, as all of our people are opposed to the means test legislation. Our people feel that it is

imperative when a person beyond the age of 65 is confronted with an illness there should not be any financial worry attached as to medical and hospitalization security. Handling this question through social security will at least relieve one of the many financial worries that the majority of our people will have when retirement age arrives.

J. P. TAHNEY,
Grand President, American Railway Supervisors Association.

STATEMENT OF THE AMERICAN PUBLIC WELFARE ASSOCIATION

This statement presents the views of the American Public Welfare Association on H.R. 12580, the Social Security Amendments of 1960, as passed by the House of Representatives.

The American Public Welfare Association is the only national organization of local and State public welfare departments and of individuals engaged in public welfare at all levels of government. Its membership includes Federal, State, and local welfare administrators, board members and welfare workers from every jurisdiction. As the result of the discussions in our councils, committees and conferences, our board of directors of 27 persons, representing all parts of the country, adopts official policy positions on issues of current significance. These policy positions govern the association's testimony on proposed legislation relevant to the field of public welfare.

Over the years the association has supported strongly all sound recommendations which have advocated broadening and strengthening the social insurance programs of our country. We have talked many times with the Senate Committee on Finance about our observations of the social insurance and public welfare programs and believe that we have unique background for evaluating the interrelationship of social insurance and public assistance.

COMMENTS ON TITLE XVI

For more than 20 years the association's medical care committee, made up of persons knowledgeable in health and welfare programs throughout the country, has studied the medical care problems of needy and low-income individuals and families and methods of administering and financing medical services required by them. The medical care committee is fully familiar with the present extent of medical care programs in public welfare and with the gaps which still remain. Despite the fact that the association, since its inception almost 30 years ago, has considered as a major responsibility the stimulation and promotion of programs of medical care of adequate quality and quantity in the public assistance programs, and although there have been very large expenditures for medical care in these programs, we find that there are gaps and deficiencies still existing in many States with respect to the provision of medical care for the needy aged and other needy persons. We do not believe there are more than 15 to 20 States in which needy persons, including the aged, can receive all the medical care they require with the assistance of public funds. We are in full agreement with the decision of the House Ways and Means Committee, therefore, that there must be action taken to improve the provision of medical care for aged persons, although we are not in complete agreement with the method suggested, nor do we believe that the proposal fully meets the need.

H.R. 12580 proposes that a new title XVI, medical services for the aged, be added to the Social Security Act. We have studied this title with care and have certain comments which we would like to submit for consideration.

We approve:

1. The prohibition in title XVI against the imposition of residence requirements as an eligibility factor in determining eligibility of low-income aged persons for medical care;
2. The fact that the bill recognizes the broad scope of services needed by the aged (although we do disagree with the limitations in amount placed on certain essential services and supplies);
3. The requirement that both institutional and noninstitutional services be provided to the aged. This, we believe, will serve to reduce unnecessary institutionalization of older persons;
4. The prohibition against an enrollment fee premium or similar charge to be imposed as a condition of any individual's eligibility for medical benefits

under the plan. (We believe that there should also be a prohibition against any deductible or coinsurance feature since this is a needs program and not an insurance program.)

DOVETAILING TITLE XVI INTO TITLE I

We question whether there is actual need for this new title, even though we agree with the intent and the provisions we have commented on. Essentially the program described in title XVI is part of the old-age assistance program and a number of States are already assisting medically needy aged persons under title I. We believe that the same ends could be achieved by amending title I to make clear the intent of Congress that old-age assistance should include aged persons of low income who are unable to finance their full medical care requirements. It appears to us, from the viewpoint of economical and sound administration that this revision of title I would be more satisfactory than the establishment of a wholly new title. We believe, too, from our observation of State legislative activities, that most States would find it more possible to obtain authorization, if needed, to expand services and assistance under title I than to obtain legislation establishing a new program. As one example we would point out that Texas would undoubtedly need a constitutional amendment in order to participate in title XVI.

COMMENTS ON SECTION 602 OF THE BILL

In this connection we would like to comment on section 602 of H.R. 12580 which proposes somewhat more favorable Federal matching for States (an increase in the matching ratio of 5 percent) contingent upon a showing of an improvement in their old-age assistance medical care program. There are both inequities and problems in this provision since it would provide no additional funds in OAA medical care to those States that have, at great State expense and with very limited Federal matching, financed broad programs of medical services and supplies for aged persons. These States, of course, could show no improvement in their medical care programs since they already include all essential medical requirements. We are in full agreement that the poorer States need additional help but we think that this can be accomplished through further modifications of the matching formula based upon per capita income in the States. The improvement grants suggested in section 602 would, in fact, reward a number of average or high income States that have been backward in meeting the medical care requirements of their aged persons. Our suggestion that title XVI be included in title I would do away with this provision and would make it possible, through an appropriate modification of the matching formula, to establish a more equitable method of Federal participation for both the higher and lower income States.

COMMENTS ON SECTION 705 OF THE BILL

The association is pleased to note section 705 of H.R. 12580, which would amend the general provisions of the Social Security Act to require the Secretary to develop and revise from time to time guides or recommended standards as to the level, content, and quality of medical care and medical services to be used in evaluating and improving the public assistance medical care programs, including programs of medical services for the aged. We have long felt that the Department, through its Bureau of Public Assistance, should provide more leadership to the States in this connection. We are pleased to see a recommendation of this kind in the recent report of the Advisory Council on Public Assistance. We would suggest that in addition to this provision there be a requirement that the Secretary establish a broadly constituted medical advisory committee, as was also recommended in the report of the Advisory Council on Public Assistance.

HEALTH INSURANCE FOR OASDI BENEFICIARIES

We believe, however, that even with the changes we have suggested in title XVI and related portions of H.R. 12580, our country would be far from meeting the health needs of all aged persons. In our opinion this can only be done through an extension of the old-age, survivors, and disability insurance program to include health service benefits. We will still need provisions under public

assistance for those persons who do not qualify under OASDI, but we are fully convinced that the social insurance mechanism is the soundest approach to meeting medical need for the great bulk of aged persons.

The association, as a result of its studies, has included in its Federal legislative objectives, which are reviewed each year by the association's board of directors, the following statement:

"Health costs of old-age, survivors, and disability insurance beneficiaries should be financed through the OASDI program. Arrangements for achieving this objective should take into account the priority needs of the groups to be served; availability of facilities, personnel, and services; and protection and encouragement of high quality of care, including the organization of health and related services to effect appropriate utilization of services and facilities."

As this policy statement indicates, we are in full accord with the principle of amending the OASDI program to include the financing of certain health benefits for social security beneficiaries. We believe that it is not the wish of the American people that substantial numbers of our aged citizens be required to turn to public assistance for help with their medical needs. Whereas cash benefits under the OASDI program in many instances may be sufficient for the individual's average maintenance requirements, it is rare that medical costs of an unpredictable or large character can be met unless the aged or disabled person has considerable other income and resources. It has been established that only a small proportion of aged and disabled people fall into this fortunate group.

We strongly urge, therefore, the establishment of a program of health benefits for social security beneficiaries as part of OASDI. This program, together with the expansion of OAA to provide better for the medical needs of persons not eligible under social insurance or whose needs cannot be fully met in that way, would give to all aged persons the assurance that they will not have to go without essential medical care when their working years are over. We subscribe to the principle of financing the costs of any health insurance benefits to OASDI beneficiaries through the contributory social insurance program so widely accepted by the American people. We believe that it is both proper and desirable for all employers, employees, and the self-employed to finance the costs so that individuals during their working years will build for themselves health insurance coverage which will meet their needs after retirement. It appears that voluntary insurance cannot accomplish this for any large number of persons within the reasonably near future.

SUPPORT FOR OTHER PROVISIONS IN THE BILL

We should like to comment briefly on some of the social insurance provisions in H.R. 12580. It appears to us that the recommendations for change, both major and minor, are in the right direction. We are particularly pleased with the removal of the age 50 limitation for disability insurance benefits. We support strongly, too, the measure which would strengthen the rehabilitation aspects of the disability program by providing a 12-month period of trial work during which benefits would be continued for all disabled workers who attempt any planned rehabilitation rather than limiting this trial work period to those receiving services under the official Federal-State vocational rehabilitation program, as at present.

We support the change in the insured status requirement for retired workers, the new benefit protection provisions for widows and children, and the extension of coverage to self-employed physicians and to a number of other groups.

We are pleased to note that the authorization for appropriation for the maternal and child health services program would be increased to $25 million and the services for crippled children authorization to $25 million. We are disappointed that the bill proposes that the authorization for appropriation for the child welfare program be increased only to $20 million. Our studies of needs in this program indicate that this authorization, too, should be increased to $25 million and we have previously recommended this to the Congress. The new authorization for research and demonstration projects in the child welfare services program, which would permit grants to public and other nonprofit institutions and agencies for this purpose, would meet an existing need for further study in the child welfare field.

FEDERAL LEGISLATIVE OBJECTIVES, 1960

(Prepared by Committee on Welfare Policy, American Public Welfare Association)

The American Public Welfare Association believes that the States and their political subdivisions have the primary responsibility for developing and administering effective public welfare services in the United States. The Federal Government has the obligation to develop nationwide goals and to use its constitutional taxing power to equalize the financing of public welfare so that public welfare services may be available on a reasonably equitable basis throughout the country. The States, their political subdivisions, and the Federal Government, in cooperation, must provide the leadership and the professional and technical personnel to carry out these obligations. The association's legislative objectives are based on these premises and on the recognition of the importance of preserving and strengthening family life, encouraging self-responsibility, and assuring humanitarian concern for individuals and families.

To accomplish these purposes the association believes that:

Contributory social insurance is a preferable governmental method of protecting individuals and their families against loss of income due to unemployment, sickness, disability, death of the family breadwinner, and retirement in old age;

Public welfare programs should provide effective services to all who require them including financial assistance and preventive, protective, and rehabilitative services, and these services should be available to all persons without regard to residence, settlement, or citizenship requirements;

The benefits of modern medical science should be available to all; and to the extent that individuals cannot secure them for themselves governmental or other social measures should assure their availability;

Democracy has a special obligation to assure to all the Nation's children full and equitable opportunity for family life, healthy growth, and maximum utilization of their potentialities.

These general principles are amplified in other policy statements approved by the board of directors of the association. The welfare policy committee of the association has reviewed all of these statements in the light of current needs and has developed specific legislative objectives for 1960. While the following list does not include all of the association's policy positions, it presents in condensed form those immediate and longer range legislative objectives which are most likely to be of current significance in improving public welfare services.

PUBLIC WELFARE PROGRAMS

Scope of program

1. The comprehensive nature of public welfare responsibility should be recognized through Federal grants-in-aid which will enable the States to provide not only financial assistance (including medical care) and other services for the aged, the blind, the disabled, and dependent children, but also general assistance and services for all other needy persons.

2. Federal financial aid should be available to assist States in carrying out public welfare responsibility for preventive, protective, and rehabilitative services to all who require them, irrespective of financial need.

The Federal Government should participate financially in State and local projects which would encourage, extend, or establish programs for self-support, self-care, or the rehabilitation of persons receiving or likely to need public assistance.

3. The Federal Government should participate financially only in those assistance and other welfare programs which are available to all persons within the State who are otherwise eligible without regard to residence, settlement, or citizenship requirements.

4. In order to strengthen family life, the aid to dependent children program should provide Federal aid to the States for any needy child living in the home of any relative.

5. Specific provisions should be made for Federal financial participation in the maintenance of children in foster care.

6. Child welfare services in the Social Security Act should be broadened in scope, should specifically include child welfare srevices for the delinquent child, and the funds authorized and appropriated should be increased in all States sufficiently to extend and improve their programs compatible with the

growing child population and the continuing advances in knowledge which make more effective services attainable.

Specific provision should be made for Federal financial assistance to States to stimulate and support programs for the prevention and control of juvenile delinquency. This should include research and the training of personnel.

7. The category of aid to the permanently and totally disabled should be modified by eliminating the Federal restriction requiring a disability to be permanent and total and by eliminating the age requirement so that all needy disabled persons may be aided under the program.

8. The Federal Government should participate financially in the development of specialized services for the aged, irrespective of financial need.

9. The Federal Government, in cooperation with the States, should study the restriction on Federal financial participation in assistance payments to adults living in public nonmedical institutions.

Methods of financing programs

10. The continuation of the Federal open-end appropriation is essential to a sound State-Federal fiscal partnership in all aspects of public assistance. Since it is not possible to predict accurately the incidence and areas of need, flexibility, and comprehensiveness are necessary in financing public assistance programs.

11. Federal financial participation should be on an equalization grant basis provided by law and applicable to financial assistance (including medical care) for all needy persons, welfare services (including child welfare), and administration.

12. Any maximums on Federal participation in public assistance (including medical care) should continue to be related to the average payment per recipient and should be increased sufficiently to assure reasonable standards of maintenance, comprehensive medical care of high quality and appropriate quantity, and the preservation and strengthening of family life.

Federal participation in aid to dependent children should be increased to a level which will assure treatment of children equitable with that accorded other public assistance recipients.

13. There should be no reduction in the overall Federal proportion of assistance and service expenditures unless and until changes in the scope and adequacy of Federal legislation affecting public assistance and social insurance enable the States to meet needs more effectively.

14. No change should be made in the Federal matching formulas which would result in a reduction in the Federal share of State and local administrative costs.

15. Federal aid for public assistance should be on the same basis for Puerto Rico, the Virgin Islands, and Guam as for other jurisdictions. In particular, the annual dollar limitations on Federal participation should be removed.

16. The Federal Government should participate financially in the costs of any State and local civil defense welfare services.

17. Federal legislation should provide funds for American nationals in need of assistance and other services who are repatriated from abroad.

Administration

18. States should have the option to administer Federal funds for assistance and services by categories or by a single comprehensive program covering all needy persons.

19. Adequate and qualified personnel is essential in the administration of public welfare programs. Federal financial participation in administrative costs of State welfare programs should be sufficient to enable States to provide for the adequate administration of all welfare programs.

20. Adequate Federal funds should be authorized on a permanent basis to assist States in training staff for State and local public welfare programs and moneys should be appropriated for this purpose.

21. All public welfare programs in which the Federal Government participates financially should be administered by a single agency at the local, State, and Federal level.

22. Federal, State, and local public welfare agencies should participate in and assist in the administrative coordination of all related programs in which there is Federal financial participation.

23. The administration of the Children's Bureau should be maintained within the Social Security Administration.

SOCIAL INSURANCE PROGRAMS

OASDI

24. The contributory old-age, survivors, and disability insurance program, as a preferable means of meeting the income-maintenance needs of people and as a means of keeping the need for public assistance to a minimum, should be strengthened. Among the needed improvements are: making benefit payments more adequate, increasing the amount of earnings creditable for contribution and benefit purposes in line with current conditions, providing benefits for disabled insured persons of any age and for their dependents, extending coverage to earners still excluded.

25. Health costs of old-age, survivors, and disability insurance beneficiaries should be financed through the OASDI program. Arrangements for achieving this objective should take into account the priority needs of the groups to be served; availability of facilities, personnel, and services; and protection and encouragement of high quality of care, including the organization of health and related services to effect appropriate utilization of services and facilities.

26. The funds of the insurance program should be available to help restore persons on the OASDI disability rolls to gainful employment since such expenditures would result in a net saving to the fund and increase the number of persons rehabilitated.

27. To the extent that changes to improve the OASDI program increase the cost of the program, contributions should be increased to insure the financial stability of the program.

28. The membership of the Advisory Council on Social Security Financing, established by the 1956 amendments, should include representation from public welfare and its functions should be broadened to include responsibility for recommending improvements in all aspects of old-age, survivors, and disability insurance, with particular emphasis on methods of keeping the program in line with current economic conditions and with changes in levels of living, and as a means of keeping the need for public assistance to a minimum.

29. Adequate and qualified personnel are essential in the administration of the old-age, survivors, and disability insurance program. Federal funds should be utilized for the professional training of staff in institutions of higher learning.

Unemployment insurance

30. The unemployment insurance program, as a preferable means of meeting the income-maintenance needs of unemployed people and as a means of keeping the need for public assistance to a minimum, should be strengthened. Among the needed improvements are establishing Federal standards which would assure more adequate benefit payments including benefits for dependents; extension of coverage to earners still excluded; provision for a minimum duration of benefits and appropriate extension of the duration during any period of extended unemployment; provision for more equitable eligibility conditions; provisions for less restrictive disqualification requirements; and an increase in the amount of earnings creditable for contribution and benefit purposes in line with current conditions.

Other social insurance

31. Study should be given to ways of improving and extending, on a sound social insurance basis, temporary disability insurance benefits and workmen's compensation programs, with emphasis on planning for effective medical care and vocational rehabilitation.

RESEARCH AND DEMONSTRATION PROJECTS

32. Federal funds should be authorized and appropriated for research and demonstration projects in all aspects of social security and public welfare.

RELATED PROGRAMS

33. The Federal Government should provide leadership, funds, and research for the promotion of health and the prevention of sickness and disability contributing to dependency. Federal health programs should encourage and enable State and local health departments to make a more effective contribution to broad programs of physical restoration. In view of the increasing number of children and the increasing cost of medical service, the amounts authorized and appropriated for maternal and child health and crippled children's services in the Social Security Act should be increased.

34. Public welfare has a responsibility to assure that comprehensive rehabilitative services are made available to persons who require them. In carrying out this objective, public welfare programs have the responsibility to restore individuals to self-care and independent living and to strengthen family life. As part of this responsibility, public welfare agencies are concerned with the availability of adequate vocational rehabilitation services for individuals who can benefit from them.

Since many eligible individuals in the United States still are deprived of vocational rehabilitation services, such services should be strengthened so that all vocationally handicapped persons who present reasonable possibilities of attaining a vocational objective would be served. The vocational rehabilitation program also should be strengthened by permitting States to designate the State agency which can most effectively administer this program.

35. Federal programs should provide more effective aid to help meet the needs of mentally retarded and other handicapped children.

36. The nonquota entry of foreign-born orphans should be limited to children who are placed for adoption in the United States with the approval of authorized social agencies, and to children who are adopted abroad by U.S. citizens residing in the country where the adoption takes place.

37. The Federal Fair Labor Standards Act should be amended to extend coverage and to increase the minimum wage in line with current conditions.

38. Federal programs should provide more effective aid to help meet the needs of migratory workers and their families.

JUNE 27, 1960.

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

DEAR MR. CHAIRMAN: I am informed that on Tuesday, June 28, your committee will meet in executive session to consider H.R. 12580 and related proposals amending the Social Security Act.

In this connection I would appreciate your consideration of a bill which I filed on Wednesday, June 23, which would amend title II of the Social Security Act and the Internal Revenue Code so as to increase the minimum insurance benefits payable under such title, to increase the amount of earnings upon which such benefits are based, to increase the amount of such benefits payable to widows, widowers, and parents, to increase the amount of earnings permitted without loss of benefits, and for other purposes. I believe this is a modest, constructive and self-sufficient package making needed changes in our social security system. Enclosed is a copy of the bill, S. 3725, and my remarks in its regard as they appeared in the Congressional Record.

Thank you for your consideration.

Sincerely,

LEVERETT SALTONSTALL,
U.S. Senator.

[S. 3725, 86th Cong., 2d sess.]

A BILL To amend title II of the Social and Security Act and the Internal Revenue Code so as to increase the minimum insurance benefits payable under such title, to increase the amount of earnings upon which such benefits are based, to increase the amount of such benefits payable to widows, widowers, and parents, to increase the amount of earnings permitted without loss of benefits, and for other purposes

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled, That this Act may be cited as the "Social Security Amendments of 1960".

TITLE I—AMENDMENTS TO TITLE II OF THE SOCIAL SECURITY ACT

INCREASE IN MINIMUM BENEFTS

SEC. 101. (a) The table in section 215(a) of the Social Security Act is amended by striking out all the figures in columns I, II, III, IV, and V down to, and including, the line which reads

"13.01 13.48 36.10 37.00 66 67 40 60.00"

and inserting in lieu thereof the following:

"____ 13.48 ____ 37.00 ____ 67 40 $60.00".

(b) The amendments made by subsection (a) shall be applicable only in the case of monthly benefits under title II of the Social Security Act for months after the month following the month in which this Act is enacted, and in the case of lump-sum death payments under such title with respect to deaths occurring after the month following the month in which this Act is enacted.

INCREASE IN EARNINGS BASE

SEC. 102. (a)(1) Section 209(a)(3) of the Social Security Act is amended by inserting "and prior to 1961" after "1958".

(2) Section 209(a) of such Act is further amended by adding at the end thereof the following new paragraph:

"(4) That part of remuneration which, after remuneration (other than remuneration referred to in the succeeding subsections of this section) equal to $6,000 with respect to employment has been paid to an individual during any calendar year after 1960, is paid to such individual during such calendar year;".

(b)(1) Section 211(b)(1)(C) of such Act is amended by inserting "and prior to 1961" after "1958", and by striking out "; or" and inserting in lieu thereof "; and".

(2) Section 211(b)(1) of such Act is further amended by adding at the end thereof the following new subparagraph:

(D) For any taxable year ending after 1960, (i) $6,000 minus (ii) the amount of the wages paid to such individual during the taxable year; or".

(c)(1) Section 213(a)(2)(B)(ii) of such Act is amended by striking out "after 1958" and inserting in lieu therof "after 1958 and before 1961, or $6,000 in the case of a calendar year ending after 1960".

(2) Section 213(a)(2)(B)(iii) of such Act is amended by striking out "after 1958" and inserting in lieu thereof "after 1958 and before 1961, or $6,000 in the case of a taxable year ending after 1960".

(d) The table in section 215(a) of such Act is amended by striking out all the figures in columns II, III, IV, and V beginning with, and following, the line which reads

"$101. 50	102. 30	315	319	109	254. 00"

and inserting in lieu thereof the following:

"101. 50	102. 30	315	319	109	255. 20
102. 40	103. 20	320	323	110	258. 40
103. 30	104. 20	324	328	111	262. 40
104. 30	105. 10	329	333	112	266. 40
105. 20	106. 00	334	337	113	269. 60
106. 10	107. 00	338	342	114	273. 60
107. 10	107. 90	343	347	115	277. 60
108. 00	108. 50	348	351	116	280. 80
		352	356	117	284. 80
		357	361	118	288. 80
		362	365	119	292. 00
		366	370	120	296. 00
		371	375	121	296. 00
		376	379	122	296. 00
		380	384	123	296. 00
		385	389	124	296. 00
		390	393	125	296. 00
		394	398	126	296. 00
		399	403	127	296. 00
		404	407	128	296. 00
		408	412	129	296. 00
		413	417	130	296. 00
		418	421	131	296. 00
		422	426	132	296. 00
		427	431	133	296. 00
		432	436	134	296. 00
		437	440	135	296. 00
		441	445	136	296. 00
		446	450	137	296. 00
		451	454	138	296. 00
		455	459	139	296. 00
		460	464	140	296. 00
		465	468	141	296. 00
		469	473	142	296. 00
		474	478	143	296. 00
		479	482	144	296. 00
		483	487	145	296. 00
		488	492	146	296. 00
		493	496	147	296. 00
		497	500	148	296. 00"

(e) Section 215(e)(1) of such Act is amended by striking out "after 1958" and inserting in lieu thereof "after 1958 and before 1961, and the excess over $6,000 in the case of any calendar year after 1960".

(f) The amendments made by subsections (a) and (c)(1) shall apply only with respect to remuneration paid after 1960. The amendments made by subsections (b) and (c)(2) shall apply only with respect to taxable years beginning after 1960. The amendment made by subsection (d) shall apply only with respect to monthly insurance benefits under title II of the Social Security Act for months after the month following the month in which this Act is enacted, and lump-sum death payments under such title in the case of deaths occurring after the month following the month in which this Act is enacted.

INCREASE IN WIDOW'S, WIDOWER'S, AND PARENT'S INSURANCE BENEFITS

SEC. 103. (a) Paragraph (2) of subsection (e) of section 202 of such Act is amended to read as follows:

"(2) Such widow's insurance benefit for each month shall be equal to 85 per centum of the primary insurance amount of her deceased husband."

(b) Paragraph (3) of subsection (f) of such section is amended to read as follows:

"(3) Such widower's insurance benefit for each month shall be equal to 85 per centum of the primary insurance amount of his deceased wife."

(c) Paragraph (2) of subsection (h) of such section is amended to read as follows:

"(2)(A) Except as provided in subparagraph (B), such parent's insurance benefit for each month shall be equal to 85 per centum of the primary insurance amount of such deceased individual.

"(B) For any month for which more than one parent is entitled to parent's insurance benefits on the basis of such deceased individual's wages and self-employment income, such benefit for each such parent for such month shall be equal to 75 per centum of the primary insurance amount of such deceased individual.

"(C) In any case in which (i) any parent is entitled to a parent's insurance benefit for a month on the basis of a deceased individual's wages and self-employment income and (ii) another parent of such deceased individual becomes entitled to a parent's insurance benefit for such month on the basis of such wages and self-employment income and on the basis of an application filed after such month and after the month in which the application of the parent referred to in clause (i) was filed, the amount of the parent's insurance benefit of the parent referred to in clause (i) for the month referred to in such clause shall be 85 per centum of the primary insurance amount of such deceased individual and the amount of the parent's insurance benefit of the parent referred to in clause (ii) for such month shall be 65 per centum of such primary insurance amount."

(d) The amendment made by this section shall apply with respect to monthly benefits payable under section 202 of the Social Security Act for months after the month following the month in which this Act is enacted.

SAVINGS PROVISIONS

SEC. 104. Where—

(1) one or more persons were entitled (without the application of section 202(j)(1) of the Social Security Act) to monthly benefits under section 202 of such Act for the month after the month in which this Act is enacted on the basis of the wages and self-employment income of a deceased individual; and

(2) one or more persons are entitled to benefits under section 202 (e), (f), or (h) of the Social Security Act for any subsequent month on the basis of such individual's wages and self-employment income; and

(3) no person, other than those persons referred to in paragraph (1) of this section, is entitled to benefits under such section 202 on the basis of such individual's wages and self-employment income for such subsequent month or for any month after the month following the month in which this Act is enacted and prior to such subsequent month; and

(4) the total of the benefits to which all persons are entitled under section 202 of the Social Security Act on the basis of such individual's wages and self-employment income for such subsequent month would, but for this section, be reduced by reason of the application of section 203(a) of such Act, as amended by this Act;

then the amount of the benefit to which each such person referred to in paragraph (1) of this section is entitled for such subsequent month shall be determined—

(5) in case such person is entitled to benefits under subsection (d) or (g) of such section 202, as though this Act had not been enacted; or

(6) in case such person is entitled to benefits under subsection (e), (f), or (h) of such section 202, without regard to any provision of this Act other than section 103;

except that the provisions of this section shall not apply with respect to any such person if the amount of the benefit to which he is entitled is larger, after the application of section 203(a), as amended by this Act, without the application of this section.

MAXIMUM FAMILY BENEFITS IN CERTAIN CASES

SEC. 105. (a) Section 203(a)(3) of the Social Security Act is amended—

(1) by striking out "and is not less than $68, then such total of benefits shall not be reduced to less than the smaller of" and inserting in lieu thereof ", then such total of benefits shall not be reduced to less than $99.10 if such primary insurance amount is $66, to less than $102.40 if such primary insurance amount is $67, to less than $106.50 if such primary insurance amount is $68, or, if such primary insurance amount is higher than $68, to less than the smaller of"; and

(2) by striking out "the last figure in column V of the table appearing in section 215(a)" and inserting in lieu thereof "the amount determined under this subsection without regard to this paragraph, or $200.60, whichever is larger".

(b) The amendments made by subsection (a) shall apply in the case of monthly benefits under section 202 or section 223 of the Social Security Act for months after the month following the month in which this Act is enacted, but only (1) if the insured individual on the basis of whose wages and self-employment income such monthly benefits are payable became entitled (without the application of section 202(j)(1) or section 223(b) of such Act) to benefits under section 202(a) or section 223 of such Act after the month following the month in which this Act is enacted, or (2) if such insured individual died before becoming so entitled and no person was entitled (without the application of section 202(j)(1) or section 223(b) of such Act) on the basis of such wages and self-employment income to monthly benefits under title II of the Social Security Act for the month following the month in which this Act is enacted or any prior month, or (3) if such insured individual was entitled, for the month following the month in which this Act is enacted, to benefits under section 202(a) or 223 of the Social Security Act based on a primary insurance amount of more than $108.

RETIREMENT TEST

SEC. 106. (a) So much of section 203 of such Act as follows subsection (a) thereof is amended to read as follows:

"DEDUCTIONS ON ACCOUNT OF EXCESSIVE EARNINGS

"(b) Deductions, in such amounts and at such time or times as the Secretary shall determine, shall be made from any payment or payments under this title to which an individual is entitled and from any payment or payments to which any other persons are entitled on the basis of such individual's wages and self-employment income until the total of such deductions equals—

"(1) such individual's benefit or benefits under section 202 for any month, and

"(2) if such individual was entitled to old-age insurance benefits under section 202(a) for such month, the benefit or benefits for such month under section 202 of all other persons based on such individual's wages and self-employment income,

if in such month such individual (except a child entitled to child's insurance benefits who has attained the age of 18) is under age 72 and if for such month he is charged with excess earnings, under the provisions of subsection (f) of this section, equal to the total of such benefits referred to in clauses (1) and (2); except that if the excess earnings so charged are less than such total of benefits, such deductions with respect to such month shall be equal only to the amount of such excess. If a child who has attained the age of 18 and is entitled to child's insurance benefits, or a person who is entitled to mother's insurance benefits, is married to an individual entitled to old-age insurance benefits under section 202(a), such child or such person, as the case may be, shall, for the purposes of this subsection and subsection (f), be deemed to be entitled to such benefits on the basis of the wages and self-employment income of such individual entitled to old-age insurance benefits. If a deduction has already been made under this subsection with respect to a person's benefit or benefits under section 202 for a month, he shall be deemed entitled to payments under such section for such month for purposes of further deductions under this subsection and charging of other excess earnings under subsection (f) only to the extent of the total of his benefits remaining after such earlier deductions have been made. For purposes of this subsection and subsection (f)—

"(A) if an individual's benefit or benefits under subsection (a) would, but for the penultimate sentence thereof, be reduced, he shall be deemed to be entitled to payments under section 202 equal to the amount of such benefit or benefits for such month which would remain (but for such penultimate sentence) after application of subsection (a); and

"(B) if a deduction is made with respect to an individual's benefit or benefits under section 202 because of the occurrence in any month of an event specified in subsection (c) or (d) of this section or in section 222 (b), such individual shall not be considered to be entitled to any benefits under such section 202 for such month.

"DEDUCTIONS ON ACCOUNT OF NONCOVERED REMUNERATIVE ACTIVITY OR FAILURE TO HAVE CHILD IN CARE

"(c) Deductions, in such amounts and at such time or times as the Secretary shall determine, shall be made from any payment or payments under this title to which an individual is entitled, until the total of such deductions equals such individual's benefit or benefits under section 202 for any month—

"(1) in which such individual is under the age of seventy-two and on seven or more different calendar days of which he engaged in noncovered remunerative activity outside the United States; or

"(2) in which such individual, if a wife under age 65 entitled to a wife's insurance benefit, did not have in her care (individually or jointly with her husband) a child of her husband entitled to a child's insurance benefit and such wife's insurance benefit for such month was not reduced under the provisions of section 202(q); or

"(3) in which such individual, if a widow entitled to a mother's insurance benefit, did not have in her care a child of her deceased husband entitled to a child's insurance benefit; or

"(4) in which such individual, if a former wife divorced entitled to a mother's insurance benefit, did not have in her care a child of her deceased former husband, who (A) is her son, daughter, or legally adopted child and (B) is entitled to a child's insurance benefit on the basis of the wages and self-employment income of her deceased husband.

For purposes of paragraphs (2), (3), and (4) of this subsection, a child shall not be considered to be entitled to a child's insurance benefit for any month in which an event specified in section 222(b) occurs with respect to such child. No deduction shall be made under this subsection from any child's insurance benefit for the month in which the child entitled to such benefit attained the age of 18 or any subsequent month.

"DEDUCTIONS FROM DEPENDENTS' BENEFITS BECAUSE OF NONCOVERED REMUNERATIVE ACTIVITY OF OLD-AGE INSURANCE BENEFICIARY

"(d)(1) Deductions shall be made from any wife's husband's, or child's insurance benefit, based on the wages and self-employment income of an individual entitled to old-age insurance benefits to which a wife, husband, or child is entitled, until the total of such deductions equals such wife's, husband's, or child's insurance benefit or benefits under section 202 for any month in which the individual, on the basis of whose wages and self-employment income such benefit was payable, is under the age of seventy-two and on seven or more different calendar days of which he engaged in noncovered remunerative activity outside the United States.

"(2) Deductions shall be made from any child's insurance benefit to which a child who has attained the age of eighteen is entitled or from any mother's insurance benefit to which a person is entitled, until the total of such deductions equals such child's insurance benefit or benefits or mother's insurance benefit or benefits under section 202 for any month in which such child or person entitled to mother's insurance benefits is married to an individual entitled to old-age insurance benefits under section 202(a) who is under the age of seventy-two and on seven or more different calendar days of which he engaged in noncovered remunerative activity outside the United States.

"OCCURRENCE OF MORE THAN ONE EVENT

"(e) If more than one of the events specified in subsections (c) or (d) and section 222(b) occurs in any one month which would occasion deductions equal to a benefit for such month, only an amount equal to such benefit shall be deducted.

"MONTHS TO WHICH EXCESSIVE EARNINGS ARE CHARGED

"(f) For the purposes of subsection (b)—

"(1) If an individual's earnings for a taxable year are not more than the product of $100 times the number of months in such year, no month in such year shall be charged with any excess earnings.

"(2) If an individual's earnings for a taxable year are in excess of $100 times the number of months in such year, the amount of his excess earnings (as defined in paragraph (4)) shall be charged to months as follows: There shall be charged to the first month of such taxable year an amount of his excess earnings equal to the sum of the payments to which he and all other persons are entitled for such month under section 202 on the basis of his wages and self-employment income (or the total of his excess earnings if such excess earnings are less than such sum) and the balance, if any, of such excess earnings shall be charged to each succeeding month in such year to the extent, in the case of each such month, of the sum of the payments to which such individual and all other persons are entitled for such month under section 202 on the basis of his wages and self-employment income, until the total of such excess has been so applied. Notwithstanding the preceding provisions of this paragraph, no part of the excess earnings of an individual shall be charged to any month (A) for which such individual was not entitled to a benefit under this title, (B) in which such individual was age 72 or over, or (C) in which such individual did not engage in self-employment and did not render services for wages (determined as provided in paragraph (6) of this subsection) of more than $100.

"(3) As used in paragraph (2), the term 'first month of such taxable year' means the earliest month in such year to which the charging of excess earnings described in such paragraph is not prohibited by the application of clause (A), (B), or (C) thereof.

"(4) For purposes of paragraph (2), an individual's excess earnings for a taxable year shall be the excess of his earnings for such year over $100 multiplied by the number of months in such year, except that of the first $1,200 of such excess (or all of such excess if it is less than $1,200), an amount equal to one-half thereof shall not be included.

"(5) For purposes of clause (C) of paragraph (2)—

"(i) An individual will be presumed, with respect to any month, to have been engaged in self-employment in such month until it is shown to the satisfaction of the Secretary that such individual rendered no substantial services in such month with respect to any trade or business the net income or loss of which is includible in computing (as provided in paragraph (6) of this subsection) his net earnings or net loss from self-employment for any taxable year. The Secretary shall by regulations prescribe the methods and criteria for determining whether or not an individual has rendered substantial services with respect to any trade or business.

"(ii) An individual will be presumed, with respect to any month, to have rendered services for wages (determined as provided in paragraph (6) of this subsection) of more than $100 until it is shown to the satisfaction of the Secretary that such individual did not render such services in such month for more than such amount.

"(6)(A) An individual's earnings for a taxable year shall be (i) the sum of his wages for services rendered in such year and his net earnings from self-employment for such year, minus (ii) any net loss from self-employment for such year.

"(B) In determining an individual's net earnings from self-employment and his net loss from self-employment for purposes of subparagraph (A) of this paragraph and paragraph (5), the provisions of section 211, other than paragraphs (1), (4), and (5) of subsection (c), shall be applicable; and any excess of income over deductions resulting from such a computation

shall be his net earnings from self-employment and any excess of deductions over income so resulting shall be his net loss from self-employment.

"(C) For purposes of this subsection, an individual's wages shall be computed without regard to the limitations as to amounts of remuneration specified in subsections (a), (g)(2), (g)(3), (h)(2), and (j) of section 209; and in making such computation services which do not constitute employment as defined in section 210, performed within the United States by the individual as an employee or performed outside the United States in the active military or naval service of the United States, shall be deemed to be employment as so defined if the remuneration for such services is not includible in computing his net earnings or net loss from self-employment.

"(7) For purposes of this subsection, wages (determined as provided in paragraph (6)(C)) which, according to reports received by the Secretary, are paid to an individual during a taxable year shall be presumed to have been paid to him for services performed in such year until it is shown to the satisfaction of the Secretary that they were paid for services performed in another taxable year. If such reports with respect to an individual show his wages for a calendar year, such individual's taxable year shall be presumed to be a calendar year for purposes of this subsection until it is shown to the satisfaction of the Secretary that his taxable year is not a calendar year.

"(8) Where a month is charged with an individual's excess earnings and the excess earnings so charged are less than the total of the payments (without regard to such charging) to which all persons are entitled under section 202 for such month on the basis of his wages and self-employment income, the difference between such total and the excess so charged to such month shall be paid (if it is otherwise payable under this title) to such individual and other persons in the proportion that the benefit to which each of them is entitled (without regard to such charging and prior to the application of section 203(a)) bears to the total of the benefits to which all of them are entitled (without regard to such charging and prior to the application of section 203(a)).

"PENALTY FOR FAILURE TO REPORT CERTAIN EVENTS

"(g) Any individual in receipt of benefits subject to deduction under subsection (c) (or who is in receipt of such benefits on behalf of another individual), because of the occurrence of an event specified therein, who fails to report such occurrence to the Secretary prior to the receipt and acceptance of an insurance benefit for the second month following the month in which such event occurred, shall suffer an additional deduction equal to that imposed under subsection (b), except that the first additional deduction imposed by this subsection in the case of any individual shall not exceed an amount equal to one month's benefit even though the failure to report is with respect to more than one month.

"REPORT OF EARNINGS TO SECRETARY

"(h)(1)(A) If an individual is entitled to any monthly insurance benefit under section 202 during any taxable year in which he has earnings or wages, as computed pursuant to paragraph (6) of subsection (f), in excess of the product of $100 times the number of months in such year, such individual (or the individual who is in receipt of such benefit on his behalf) shall make a report to the Secretary of his earnings (or wages) for such taxable year. Such report shall be made on or before the fifteenth day of the fourth month following the close of such year, and shall contain such information and be made in such manner as the Secretary may by regulations prescribe. Such report need not be made for any taxable year (i) beginning with or after the month in which such individual attained the age of 72, or (ii) if benefit payments for all months (in such taxable year) in which such individual is under age 72 have been suspended under the provisions of the first sentence of paragraph (3) of this subsection.

"(B) If the benefit payments of an individual have been suspended for all months in any taxable year under the provisions of the first sentence of paragraph (3) of this subsection, no benefit payment shall be made to such individual for any such month in such taxable year after the expiration of the period of three years, three months, and fifteen days following the close of such taxable year within such period the individual, or some other person entitled to benefits under this title on the basis of the same wages and self-employment

income, files with the Secretary information showing that a benefit for such month is payable to such individual.

"(2) If an individual fails to make a report required under paragraph (1), within the time prescribed therein for any taxable year and any deduction is imposed under subsection (b) by reason of his excess earnings (as defined in subsection (f)) for such year, he shall suffer additional deductions as follows:

"(A) if such failure is the first one with respect to which an additonal deduction is imposed under this paragraph, such additional deduction shall be equal to his benefit or benefits for the last month of such year for which he was entitled to a benefit under section 202;

"(B) if such failure is the second one for which an additional deduction is imposed under this paragraph, such additional deduction shall be equal to two times his benefit or benefits for the last month of such year for which he was entitled to a benefit under section 202;

"(C) if such failure is the third or a subsequent one for which an additional deduction is imposed under this paragraph, such additional deduction shall be equal to three times his benefit or benefits for the last month of such year for which he was entitled to a benefit under section 202;

except that the number of additional deductions required by this paragraph with respect to a failure to report earnings for a taxable year shall not exceed the number of months in such year for which such individual received and accepted insurance benefits under section 202 and for which deductions are imposed under subsection (b) by reason of his excess earnings (as defined in subsection (f)). In determining whether a failure to report earnings is the first or a subsequent failure for any individual, all taxable years ending prior to the imposition of the first additional deduction under this paragraph, other than the latest one of such years, shall be disregarded.

"(3) If the Secretary determines, on the basis of information obtained by or submitted to him, that it may reasonably be expected that an individual entitled to benefits under section 202 for any taxable year will suffer deductions imposed under subsection (b) by reason of his excess earnings (as defined in subsection (f)) for such year, the Secretary may, before the close of such taxable year, suspend the total or less than the total payment for each month in such year (or for only such months as the Secretary may specify) of the benefits payable on the basis of such individual's wages and self-employment income; and such suspension shall remain in effect with respect to the benefits for any month until the Secretary has determined whether or not any deduction is imposed for such month under subsection (b). The Secretary is authorized, before the close of the taxable year of an individual entitled to benefits during such year, to request of such individual that he make at such time or times as the Secretary may specify, a declaration of his estimated earnings for the taxable year and that he furnish to the Secretary such other information with respect to such earnings as the Secretary may specify. A failure by such individual to comply with any such request shall in itself constitute justification for a determination under this paragraph that it may reasonably be expected that the individual will suffer deductions imposed under subsection (b) by reason of his excess earnings (as defined in subsection (f)) for such year. If, after the close of a taxable year of an individual entitled to benefits under section 202 for such year, the Secretary requests such individual to furnish a report of his earnings (as computed pursuant to paragraph (6) of subsection (f)- for such taxable year or any other information with respect to such earnings which the Secretary may specify, and the individual fails to comply with such request, such failure shall in itself constitute justification for a determination that such individual's benefits are subject to deductions under subsection (b) for each month in such taxable year (or only for such months thereof as the Secretary may specify) by reason of his excess earnings (as defined in subsection (f)) for such year.

"CIRCUMSTANCES UNDER WHICH DEDUCTIONS AND REDUCTIONS NOT REQUIRED

"(i) In the case of any individual, deductions by reason of the provisions of subsection (b), (c), or (h) of this section, or the provisions of section 222(b), shall, notwithstanding such provisions, be made from the benefits to which such individual is entitled only to the extent that such deductions reduce the total amount which would otherwise be paid, on the basis of the same wages and self-employment income, to such individual and the other individuals living in the same household.

"ATTAINMENT OF AGE SEVENTY-TWO

"(j) For the purposes of this section, an individual shall be considered as seventy-two years of age during the entire month in which he attains such age.

"NONCOVERED REMUNERATIVE ACTIVITY OUTSIDE THE UNITED STATES

"(k) An individual shall be considered to be engaged in noncovered remunerative activity outside the United States if he performs services outside the United States as an employee and such services do not constitute employment as defined in section 210 and are not performed in the active military or naval service of the United States, or if he carries on a trade or business outside the United States (other than the performance of service as an employee) the net income or loss of which (1) is not includible in computing his net earnings from self-employment for a taxable year and (2) would not be excluded from net earnings from self-employment, if carried on in the United States, by any of the numbered paragraphs of section 211(a). When used in the preceding sentence with respect to a trade or business (other than the performance of service as an employee', the term 'Untied States' does not include Puerto Rico or the Virgin Islands in the case of an alien who is not a resident of the United States (including Puerto Rico and the Virgin Islands); and the term 'trade or business' shall have the same meaning as when used in section 162 of the Internal Revenue Code of 1954.

"GOOD CAUSE FOR FAILURE TO MAKE REPORTS REQUIRED

"(l) The failure of an individual to make any report required by subsection (g) or (h)(1)(A) within the time prescribed therein shall not be regarded as such a failure if it is shown to the satisfaction of the Secretary that he had good cause for failing to make such report within such time. The determination of what constitutes good cause for purposes of this subsection shall be made in accordance with regulations of the Secretary."

(b) The amendments made by subsection (a) shall be applicable with respect to deductions on account of excessive earnings, under section 203 of the Social Security Act (as amended by such subsection (a)), for months of taxable years which begin after the month following the month in which this Act is enacted and with respect to other deductions, made under such section as so amended, for months after the month following the month in which this Act is enacted.

(c)(1) Paragraph (5) of section 202(q) of such Act is amended (A) by striking out "paragraph (1) or (2) of section 203(b)" each place it appears therein, and inserting in lieu thereof "paragraph (1) or (2) of section 203 (c)", and (B) by striking out "section 203(c)" and inserting in lieu thereof "section 203(b) or (d)".

(2) Paragraph (6) of such section 202(q) is amended (A) by striking out "section 203(b) (1) or (2)" and inserting in lieu thereof "section 203(c) (1) or (2)", (B) by striking out "section 203(c)" and inserting in lieu thereof "section 203 (b) or (d)", and (C) by striking out "paragraph (1) or (2) of section 203(b)" and inserting in lieu thereof "paragraph (1) or (2) of section 203(c)".

(3) The amendments made by this subsection shall be applicable only with respect to the computation, under section 202(q) of the Social Security Act, of deductions made under section 203 of such Act, as amended by subsection (a) of this Act.

(d)(1) Section 215(g) of such Act is amended by striking out "section 203(a))" and inserting in lieu thereof "section 203(a) and deduction under section 203(b))".

(2) The amendment made by paragraph (1) shall be applicable only with respect to deductions made under section 203 of the Social Security Act, as amended by subsection (a) of this Act.

TITLE II—AMENDMENTS TO INTERNAL REVENUE CODE OF 1954

AMENDMENTS TO DEFINITION OF SELF-EMPLOYMENT INCOME

SEC. 201. (a) Section 1402(b)(1)(C) of the Internal Revenue Code of 1954 (relating to definition of self-employment income) is amended by inserting "and before 1961" after "1958", and by striking out "; or" and inserting in lieu thereof "; and".

(b) Section 1402(b)(1) of such Code is further amended by adding at the end thereof the following new paragraph:

"(D) for any taxable year ending after 1960, (i) $6,000, minus (ii) the amount of the wages paid to such individual during the taxable year; or".

AMENDMENTS TO DEFINITION OF WAGES

SEC. 202. Section 3121(a)(1) of such Code (relating to definition of wages) is amended by striking out "$4,800" each place it appears and inserting in lieu thereof "6,000".

MISCELLANEOUS TECHNICAL AMENDMENTS

SEC. 203. (a) The second sentence of section 3122 of such Code (relating to Federal service) is amended by striking out $4,800" and inserting in lieu thereof "$6,000".

(b) Section 6414(c)(1) of such Code (relating to special refunds of employment taxes) is amended—

(1) by inserting "and prior to the calendar year 1961" after "the calendar year 1958";

(2) by inserting after "exceed $4,800," the following: "or (C) during any calendar year after the calendar year 1960, the wages received by him during such year exceed $6,000,"; and

(3) by inserting before the period at the end thereof the following: "and before 1961, or which exceeds the tax with respect to the first $6,000 of such wages received in such calendar year after 1960".

(c) Section 6413(c)(2)(A) of such Code (relating to refunds of employment taxes in the case of Federal employees) is amended by striking out "or $4,800 for any calendar year after 1958" and inserting in lieu thereof "$4,800 for the calendar year 1959 or 1960, or $6,000 for any calendar year after 1960".

EFFECTIVE DATES

SEC. 204. The amendments made by section 201 shall apply only with respect to taxable years beginning after 1960. The amendments made by sections 202 and 203 shall apply only with respect to remuneration paid after 1960.

AMENDMENT OF SOCIAL SECURITY ACT AND INTERNAL REVENUE CODE, RELATING TO MINIMUM INSURANCE BENEFITS

Mr. SALTONSTALL. Mr. President, I introduce, for appropriate reference, a bill which would amend title II of the Social Security Act and the Internal Revenue Code so as to increase the amount of earnings permitted without loss of benefits, to increase the minimum insurance benefits payable, to increase the amount of such benefits payable to widows, and to increase the amount of earnings upon which such benefits are based.

The House Ways and Means Committee has reported out a bill which will probably be passed by the other body today. This proposal includes some important and desirable improvements in the social security program, somewhat overlooked because of the attention given the problem of medical aid for the aged.

But there are some needed improvements in the social security system omitted from the House bill which have been discussed and proposed before, and which are not so complicated or ambitious that they could not be considered for amending legislation this year. My bill embodies four helpful changes in a compact, practical and responsible "package." I file it now for the timely attention of the Senate, to be considered along with the proposal from the House of Representatives.

I believe that our elderly citizens should be encouraged to be productive, contributing members of their community. This is perhaps the most important aspect of old age—the emptiness and feeling of unwantedness which comes to a person who feels that his or her talent or effort is not needed by others. If our aged people are treated as helpless and worthless in terms of a community's vigor and productivity they can never live out their lives in warmth and happiness.

I have frequently advocated a change in the retirement test under the old-age, survivors, and disability insurance program which would encourage our older

citizens who are so inclined to participate more actively in the occupation of their choice. The present retirement test acts to curtail severely such activity by drastically cutting benefits when the yearly earnings limit of only $1,200 is exceeded. My proposal would allow substantial continuing benefits up until the level of $2,400 outside earnings a year, and would gradually rather than suddenly scale down the benefits for persons exceeding $2,400 in their yearly earnings. This would provide the needed incentive for the full life. In itself it constitutes a needed psychological boost for older people, who under the present law are pressed to close up shop and go home as soon as $1,200 is taken in. My measure would create an incentive among social security beneficiaries to work at all ranges of benefits and for all earnings levels up to $2,400.

In addition, I believe that the lowest beneficiary amount per month should be upped from $33 to $40 and that aged widows' benefits should be increased from 75 to 85 percent of the husband's benefit amount. Many feel that this category of beneficiary is treated the most inequitably under the present law. Both changes would save money on public assistance.

My bill would finance these improvements by increasing from $4,800 to $6,000 the maximum on earnings taxable and creditable toward benefits. Thus, social security tax rates are not increased, yet the suggested improvements are paid for in a sound and responsible manner. The whole package would help bring about a better balanced system with a financial base that more closely relates benefits to earnings, accommodating increased wages, which is the whole concept of the OASI program.

I ask unanimous consent that a brief outline of my four-point measure may be included in the Record at this point in my remarks, followed by a factual analysis of each provision and a table of costs and savings.

The PRESIDING OFFICER (Mr. Randolph in the chair). The bill will be received and appropriately referred; and, without objection, the outline, factual analysis and table will be printed in the Record.

The bill (S. 3725) to amend title II of the Social Security Act and the Internal Revenue Code so as to increase the minimum insurance benefits payable under such title, to increase the amount of earnings upon which such benefits are based, to increase the amount of such benefits payable to widows, widowers, and parents, to increase the amount of earnings permitted without loss of benefits, and for other purposes, introduced by Mr. Saltonstall, was received, read twice by its title, and referred to the Committee on Finance.

The outline, factual analysis, and table, presented by Mr. Saltonstall, are as follows:

"BRIEF OUTLINE

"1. Change the retirement test on limitation of outside earnings so that for persons with yearly earnings over $1,200, $1 in benefits are withheld for every $2 of earnings over $1,200 up to $2,400. For annual earnings over $2,400, $1 in benefits would be withheld for each $1 in earnings in excess of $2,400.

"2. Raise the benefit for persons receiving the smallest minimum monthly amounts from $33 to $40.

"3. Increase aged widows' benefit from 75 to 85 percent of the husband's benefit amount.

"4. Increase from $4,800 to $6,000 the maximum on earnings taxable and creditable toward benefits.

"FACTUAL ANALYSIS

"I

"A combination proposal: withhold $1 in benefits for each $2 of earnings in excess of $1,200 and up to $2,400, and withhold $1 in benefits for each $1 in earnings in excess of $2,400: The chief disadvantages of the 1-for-2 proposal are the increases in cost and the fact that some benefits would be paid to people at relatively high earnings levels. A way to reduce these disadvantages would be to modify the proposal by a provision that earnings above $2,400 a year would reduce benefits dollar for dollar. With this modification the man and wife getting the present maximum of $180 would get no benefits for the year at the point when the man's earnings reached $3,960 and the cost would be 0.08 percent of payroll rather than 0.11 percent. The proposal would furnish an incentive to work at all ranges of benefits, and for all earnings levels up to $2,400 and would guarantee against loss as a result of earning above that amount. And while it does not have the simplicity that is so attractive about the straight 1-for-2 proposal, it

nevertheless, like the straight 1-for-2 proposal, would remove the incentive for the beneficiary to seek out jobs paying less than $1,200 and to restrict his work activity so as not to go above that amount.

"Increase to $40 the minimum monthly amount payable to an old-age insurance beneficiary, a disability insurance beneficiary, and a sole survivor beneficiary.

"An estimated 1.8 million beneficiaries would benefit from this increase in the minimum, effective January 1, 1961: 1.2 million old-age insurance beneficiaries. 200,000 wives, 250,000 widows and parents, and over 100,000 mothers and children. A very high proportion of those who receive assistance supplementation would be affected by this proposal. In some of these cases there would be some saving in public assistance funds; in others, funds would be made available to provide a more adequate total income for the family or otherwise meet needs that are not now met.

"Generally it is undesirable to reduce the spread of benefits in a wage related system; however, the relatively small increase to $40 does not reduce the spread significantly. Moreover, if the increase in the minimum benefit were combined with an increase in the earnings base, so that the maximum as well as the minimum primary insurance amount were raised, the spread of benefits would not be reduced.

"The cost is estimated at 0.04 percent of payroll.

"III

"Increase the aged widow's benefit from 75 percent to 85 percent of the primary insurance amount of the insured worker. (The proposal would apply also to the aged widower's benefit and to the single parent's benefit.)

"Under present law a widow gets a benefit amounting to three-fourths of the primary insurance amount—that is. the amount her husband would have been paid if he had lived and qualified for benefits. There is no reason to suppose that an aged widow needs less to live on than her husband would have needed if she had died and he had lived. All beneficiary studies have shown that aged widows are generally the neediest group among the beneficiaries.

"An increase in the widow's insurance benefit to 100 percent of the primary insurance amount could be justified. An increase of that magnitude would, however, be quite costly. An adjustment to 85 percent would be considerably less costly and would seem a reasonable step to be taken at this time.

"If the widow's insurance benefit were increased to 85 percent of the primary insurance amount it could be expected that the need for supplementary old-age assistance payments to a substantial proportion of the widows who now get old-age assistance to supplement insurance benefits would be reduced.

"The cost of the proposal is estimated to be 0.23 percent of payroll.

"IV

"Increase from $4,800 to $6,000 the maximum on earnings taxable and creditable under the old-age, survivors, and disability insurance program.

"In the opinion of the Department (and this opinion is shared, at least in its general application, by the Advisory Council on Social Security Financing and by other study groups and experts who have considered the question) it is essential that the maximum on earnings taxable and creditable under the program be raised as earnings go up.

"One of the essential characteristics of the old-age and survivors insurance program is that benefits are related to earnings. If the maximum on creditable earnings is not increased as wages rise, fewer and fewer workers will have their benefits in fact related to their earnings. Originally all of the wages of all but the very most highly paid workers were covered by the program so that the very great majority of the Nation's workers had their full earnings capacity insured. At present the program covers all of the earnings of only the lower paid half of the regularly employed men in the country. In the opinion of the Department, the principle of covering all the wages of the large majority of covered workers is a sound one. While it is not at all necessary to restore the original situation, under which all but 6 percent of regularly employed men had full coverage of their earnings, it does seem desirable that three-fourths or so of regularly employed male workers should have all their earnings taxed and credited toward their benefits. An increase to $6,000 would accomplish this objective.

"Another important consideration about the earnings base is that failure to increase it as earnings go up means that a smaller and smaller proportion of

payroll is available to serve as the financial base of the program. At present it is estimated that about 22 percent of total earnings in covered work is not taxable to finance the program. With an earnings base of $6,000 the percentage of earnings in covered work that would be nontaxable would be reduced to about 14 percent.

"If the earnings base were increased it would, of course, be necessary to increase the maximum benefit payable in order that creditable wages above the present wage base will result in higher benefits. This increase in benefit amount, however, would be quite gradual.

"In addition to being desirable in itself, the recommended increase in the earnings base would make it possible to adopt the other recommended changes (which would result in paying additional benefits) without increasing the tax rate that is required to finance the program. Because all of a worker's earnings (up to the earnings base) are subject to the same tax rate, but a higher percentage of his earnings is paid in benefits at lower earnings levels than at higher earnings levels, raising the earnings base increases the income to the system more than it increases the benefits payable. An increase in the earnings base to $6,000 would reduce the level-premium cost of the program by 0.4 percent of taxable payroll (0.38 percent for old-age and survivors insurance, and 0.02 percent for disability insurance.)

"In summary, the recommended increase in the wage base to $6,000 would provide a sounder financial base for the program, would reinforce the relationship of benefits to wages, and would improve the protection afforded by the program for a great many people at moderate wage levels who will be retiring in the future; and it also would make possible, without an increase in the contribution rate, the other improvements that are recommended.

"[Attachment No. 2]

"Table of costs and savings

"Proposal	1st year public assistance savings [1]	OASI cost [2] (percent of payroll)
	Millions	
Increase minimum benefit to $40	$25	0.04
Increase aged widows benefit from 75 percent to 85 percent of husband's benefit amount	9	.23
Retirement test proposal	None	.08
Increase from $4,800 to $6,000 the maximum on earnings taxable and creditable toward benefits	None	[3]—.38
Total	[4] 34	[3]—.03

"[1] The savings have been calculated only for the 1st year. It is very important to keep in mind that there will be much greater savings effects from the proposals in later years. It also should be noted that the general fund would save substantially over the years through a reduction in the cost of veterans' pensions.

"[2] The costs shown in this column for each of the individual proposals have been computed in such a way as to eliminate overlapping cost effects. For example, increasing the aged widow's benefit to 85 percent of her husband's benefit amount would cost less if the minimum benefit had already been increased to $40 than if it had not, since in the former case many widows would get 85 percent of the husband's benefit because of the $40 minimum, and would not get an increase when the widow's benefit went to 85 percent. This sort of offsetting or overlapping effect of the proposals has been taken into account and the costs computed in such a way as to make it possible to add them and get the true cost of the total package. Accordingly, it is not possible simply to pull out of the package any given proposal and say that by itself the proposal would increase the level-premium cost of the program by the amount shown, or that the level-premium cost of the package without the proposal would be decreased by the amount shown.

"[3] It will be noted that this figure is the savings in cost from the increase in the tax and benefit base.

"[4] This figure is the total saving to Federal, State, and local governments. (The Federal share would be about $20,000,000. This is calculated as approximately 60 percent of the total saving shown, since 60 percent is the approximate Federal share of all public assistance costs.)

"ADDENDUM

"It is worth noting, by way of overall fiscal perspective, that the OASI system is now underfinanced, actuarially speaking, by 0.20 percent of payroll. If the package described herein were adopted, it would result in reducing this imbalance to 0.17 percent of payroll."

STATEMENT OF RAILWAY LABOR EXECUTIVES' ASSOCIATION IN SUPPORT OF HEALTH BENEFITS PROPOSAL TO AMEND H.R. 12580 TO INCLUDE MEDICAL INSURANCE BENEFITS IN TITLE II OF THE SOCIAL SECURITY ACT

My name is G. E. Leighty and I submit this statement as chairman of Railway Labor Executives' Association. I am also president of the Order of Railroad Telegraphers, one of the organizations affiliated with Railway Labor Executives' Association.

Railway Labor Executives' Association is an association composed of the chief executives of all the standard railway labor organizations. Together these organizations represent virtually all the railway employees in the country. The organizations affiliated with Railway Labor Executives' Association are the following:

American Railway Supervisors' Association.
American Train Dispatchers' Association.
Brotherhood of Locomotive Engineers.
Brotherhood of Locomotive Firemen & Enginemen.
Brotherhood of Maintenance of Way Employees.
Brotherhood of Railroad Signalmen.
Brotherhood of Railroad Trainmen.
Brotherhood Railway Carmen of America.
Brotherhood of Railway and Steamship Clerks, Freight Handlers, Express and Station Employees.
Brotherhood of Sleeping Car Porters.
Hotel & Restaurant Employees and Bartenders International Union.
International Association of Machinists.
International Brotherhood of Boilermakers, Iron Ship Builders, Blacksmiths, Forgers & Helpers.
International Brotherhood of Electrical Workers.
International Brotherhood of Firemen & Oilers.
International Organization Masters, Mates and Pilots of America.
National Marine Engineers' Beneficial Association.
Order of Railway Conductors & Brakemen.
Railroad Yardmasters of America.
Railway Employees' Department, AFL-CIO.
Sheet Metal Workers' International Association.
Switchmen's Union of North America.
The Order of Railroad Telegraphers.

As the committee well knows, railroad employees are covered with respect to their age and disability retirement and survivor benefits under the Railroad Retirement Act and are not covered by the old age, survivors, and disability insurance system set up under the Social Security Act. Consequently, railroad employees are not directly affected by the health benefits proposal to amend H.R. 12580 to include medical insurance benefits in title II of the Social Security Act.

Under these circumstances the question may well be asked as to what interest railroad employees have in the proposal and this question should be answered at the outset. Our interest stems from a variety of sources:

1. Although we are primarily concerned with conditions directly affecting the employees we represent, as participants in the American labor movement we have an interest in the welfare of all Amreican workers. Standards of living and of well being do not isolate themselves by industries, and such standards when accepted or established for a substantial segment of the working population tend to become measures of the standards to be applied in other segments.

2. All but two of the organizations affiliated with Railway Labor Executives' Association are also affiliated with the AFL-CIO. The AFL-CIO is vigorously supporting the health benefits proposal and we feel that the committee should know that our association joins in that support.

3. Many of the organizations affiliated with Railway Labor Executives' Association represent to varying degrees employees in other industries who are covered by the OASDI system and who are directly affected by the proposal. In some of our organizations this is true of the great preponderance of the membership.

4. The organizations affiliated with Railway Labor Executives' Association and who represent nonoperating employees (nearly three-fourths of all railroad employees) have for some years been wrestling with the problem of making

hospital, surgical, and medical insurance available to retired employees. We believe that our experience in this respect will be helpful to the committee in evaluating the various possible approaches to the problem.

5. As the ensuing discussion will show, the experience referred to in the preceding paragraph shows that we have not yet succeeded in finding an adequate solution to our problem. Consequently we had concluded that if the Forand bill, H.R. 4700, were given favorable consideration in the House we would seek to have the bill amended to include amendments to the Railroad Retirement Act so as to extend corresponding insurance benefits to beneficiaries under that act. Likewise, although we understand that we cannot ask this committee to consider amendments to the Railroad Retirement Act, it is our hope that if favorable consideration is given to the inclusion of medical insurance benefits in title II of the Social Security Act, as we urge, the same bill may be amended by the Senate to extend corresponding insurance benefits to Railroad Retirement Act beneficiaries.

We have examined the testimony presented to the House Ways and Means Committee on behalf of the AFL–CIO by Mr. Nelson H. Cruikshank and we feel that that testimony thoroughly, conscientiously, and objectively explores the issues involved and points most convincingly to the proper resolution of those issues. No purpose would be served in repeating or paraphrasing that discussion. We concur in it and believe that it demonstrates beyond question that medical insurance benefits should be included in title II of the Social Security Act.

In 1954 the organizations representing nonoperating railroad employees negotiated through collective bargaining a nationwide plan for providing hospital, surgical, and medical protection for active employees. Under this plan, on roads where hospital associations were in existence the existing arrangements were adapted to provide the negotiated protection. With respect to the nonhospital association railroads a single national insurance policy was negotiated to provide specified benefits at specified premiums. Under this policy the Travelers Insurance Co. was the primary insurer and reinsured varying percentages of the risk with other qualifying companies desiring to participate.

Initially this plan was applicable only to the protection of employees on a 50–50 contributory basis and separate arrangements had to be made to make insurance for dependents available on a voluntary basis at the expense of the employee. Subsequently, however, renegotiations have provided for the employee and dependents benefits to be on a noncontributory basis and the dependents benefits for hospital association roads and nonhospital association roads are now all included in the one insurance policy.

The arrangements above summarized deal exclusively with active employees and their dependents. We have at least so far not been able, through collective bargaining, to negotiate for the continuation of any degree of employee or dependent protection after the retirement of the employee. This presented a most serious problem. Prior to the negotiation of the collective bargaining plan many railroad employees participated in individual or group insurance or benefit plans with varying arrangements for continuation or conversion after retirement. In many instances such protection ceased to be available after the plan covering active employees went into effect. Even if the protection continued to be available an employee who wanted to protect his continuation or conversion privileges upon retirement would generally find it necessary to continue to carry the protection as an active employee, thus incurring the expense of unnecessary duplicate coverage while in active service.

To meet this situation as best we could, the organizations negotiated a separate group policy providing benefits available on a voluntary individual premium payment basis for retired and furloughed employees and their dependents (and initially also for dependents of active employees prior to their coverage in the collectively bargained plan). The opportunity was thus made available to all employees covered by the collectively bargained plan while in active service to continue protection upon retirement, on a reduced benefit basis and at their own expense. Where hospital associations are in operation retired employees are generally permitted under varying arrangements to continue protection for themselves, though their dependents are generally not covered. In instances where retired employees on hospital association roads do not have continued hospital association protection available they are eligible upon retirement to be covered by the Travelers policy for both employee and dependents benefits and all employees on such roads are eligible to be covered by dependents benefits.

In working out and administering this plan we have had excellent cooperation from the insurer; administration costs and retentions have been kept to a minimum, thus making the greatest possible proportion of premiums available for benefit payments; and every effort has been made to strike a reasonable balance between benefits and costs so as to provide as nearly adequate benefits as could be obtained at premium rates that retired employees might be expected to be able to afford. The plan is, so far as I know, the largest group plan for retired employees in the country. With all of these favorable circumstances, this plan may well be regarded as representing the best arrangements now attainable for retired employees who are severed for insurance purposes upon retirement from the group comprising active employees.

Nevertheless, our experience indicates that the best attainable under these circumstances is not enough. There is much to be said for the proposition that retired employees should continue for insurance purposes to be a part of the group in which they participated during active service and that employers should continue to carry responsibility for the protection of the entire group. Perhaps such a solution if sufficiently generally adopted and if group insurance based on employment becomes sufficiently universal might be considered preferable to the assumption of responsibility by the Government. But our experience indicates that such a solution is not foreseeable.

It is clear from our experience that the adverse circumstances inherent in the type of arrangement we now have make it impossible to achieve really satisfactory results by this approach. The administrative costs involved in handling individual applications, checking eligibility for participation and receiving and properly crediting monthly premium payments necessarily absorbs a disproportionate share of the premium. Individual choice as to participation results in coverage of a disproportionately small segment of the group eligible to participate and must involve a considerable degree of adverse selection.

The present premium rates under our policy for retired employees are $4.48 per month for employee benefits only, $4.60 per month for dependents only, and $9.08 per month for employee and dependents benefits. The benefits include hospital room and board charges up to $8 per day but not to exceed $480 for each period of disability. Hospital extras are covered to a maximum of $80 for each period of disability and an ambulance charge up to $25 is allowed. Surgical expenses are covered under a schedule with $150 maximum. We believe that it is readily apparent from an examination of these premium rates and benefit limitations that some better method of providing hospital, surgical, and medical benefits for retired employees must be found.

It was estimated in 1959 that during the approximately 4½ years that our plans had been in effect probably about 130,000 nonoperating employees had retired and that about 119,000 of these were still living. About 40 percent of our employment is on hospital association roads and employees retiring from service on those roads would, as above indicated, generally continue hospital association protection with respect to employee benefits and would be eligible to participate in the Travelers plan only for dependents' benefit insurance. It may thus be calculated 60 percent of the 119,000 surviving retired employees or 70,400 have been eligible for insurance for employee benefits. As of June last year 17,753 were actually participating for employee benefits; 15,520 had dependents benefit insurance but this latter figure would include employees from hospital association roads eligible for dependents benefit insurance only and must therefore be related to the 119,000 figure rather than to the 70,400.

It cannot be assumed, of course, that the difference between the 70,400 who have been eligible and the 17,753 participating for employee benefits are without any hospital, surgical, or medical insurance. Some, we have no way of knowing how many, undoubtedly carry other forms of protection by reason of continuation or conversion of other insurance carried while in active service or policies that have been taken out upon or during retirement or various other possible types of protection. The figures do indicate, however, that the degree of participation in relation to the size of the total group is too low to achieve results that can be regarded as a real solution to the problem. Perhaps there is a very high degree of adverse selection. Perhaps the nonparticipating eligibles do not feel that their income is sufficient to afford any insurance payments and that they must, therefore, run the risk of incurring uninsured expenses and hope that this does not happen. Or perhaps they consider the benefits available relative to the premium rates inadequate to give them their money's worth. Whatever the reason, it is apparent that intensive efforts under favorable circum-

stances have not succeeded in developing adequate hospital, surgical, and medical insurance for retired employees by this method.

We bring this experience to your attention with the sincere hope that most thoughtful consideration will be given to what it portends not only with respect to railroad employees but also with respect to employees covered by the Social Security Act. We think it compels the conclusion that there is a genuine need to include medical insurance benefits in our social insurance structure.

MEETING THE HEALTH CARE NEEDS OF OLDER PEOPLE
THROUGH SOCIAL INSURANCE,
Washington, D.C., June 30, 1960.

Hon. HARRY FLOOD BYRD,
Senate Office Building, Washington, D.C.

DEAR SENATOR BYRD: Enclosed is a copy of the letter to the Vice President and Senate majority and minority leaders from a distinguished group of persons long identified with our social insurance system. This letter urges that H.R. 12580, the social security bill, be amended to provide contributory social insurance which would pay the cost of hospital and related services for our older citizens.

It is our earnest hope that you will support such an amendment.

Sincerely yours,

FEDELE F. FAURI.
CHARLES I. SCHOTTLAND.

MEETING THE HEALTH CARE NEEDS OF OLDER PEOPLE
THROUGH SOCIAL INSURANCE,
Washington, D.C., June 30, 1960.

Hon. RICHARD M. NIXON,
Vice President of the United States,
The Capitol,
Washington, D.C.

Hon. LYNDON B. JOHNSON,
Majority Leader,
Senate of the United States,
Washington, D.C.

Hon. EVERETT MCK. DIRKSEN,
Majority Leader,
Senate of the United States,
Washington, D.C.

The undersigned who have long been identified with the American system of social security, having served the Government in administrative or advisory capacities, urge the incorporation in social security legislation now before the Senate of a program of contributory social insurance through which our citizens can pay for the cost of the hospital and related services they may need in old age. An extension of Federal old-age, survivors, and disability insurance to include hospital coverage would provide a systematic way of financing serious illness and prevent the exhaustion of the savings of aged persons and the consequent, often devastating, demands upon the resources of their children.

There is every indication of the willingness of Americans to share the cost of basic health protection for their elderly parents and later for themselves by paying for such a program through their working years. If such health protection were available for older persons, private organizations would be enabled to offer more economical protection to the younger people in our population.

We sincerely hope that the social security bill now pending before the Senate will be amended to provide for hospital and related services to older people through the social insurance system.

Sincerely yours,

(List of signators attached.)

LIST OF SIGNATORS

Mr. Arthur Altmeyer, Madison, Wis., former Chairman of Social Security Board and Commissioner for Social Security.

Mr. Joseph P. Anderson, executive director, National Association of Social Workers, member, Advisory Council, 1961 White House Conference on Aging.

Dr. Eveline M. Burns, professor of social work, New York School of Social Work, Columbia University, former consultant to Committee on Economic Security and Social Security Board, and member of advisory committee to Secretary of Health, Education, and Welfare (1954).

Mr. Wilbur J. Cohen, professor, public welfare administration, School of Social Work, University of Michigan, member of the staff of the President's Committee on Economic Security (1934–35).

Mr. Nelson Cruikshank, AFL–CIO, Washington, D.C., member, Advisory Council on Social Security (1948–49) and Advisory Council on Social Security Financing (1958–59).

Miss Loula Dunn, Chicago, Ill., member, 1959 Advisory Council on Public Assistance.

Mr. Fedele F. Fauri, dean, School of Social Work, University of Michigan, former consultant on social security to House Ways and Means and Senate Finance Committees.

Miss Helen Hall, National Federation of Settlements, member, Advisory Council of the President's Committee on Economic Security (1934–35).

Mr. Seymour Harris, Littauer professor of political economy, Harvard University, consultant to President's Council on Economic Advisers.

Miss Jane M. Hoey, New York City, Director, Bureau of Public Assistance, Social Security Administration (1936–54).

Mr. Raymond W. Houston, commissioner, New York State Department of Social Welfare, member, 1959 Advisory Council on Public Assistance.

Mr. John Kidneigh, director, Graduate School of Social Work, University of Minnesota, chairman, 1959 Advisory Council on Child Welfare Services.

Mr. Murray Latimer, Washington, D.C., former Chairman, Railroad Retirement Board.

Mr. Richard A. Lester, professor of economics, Princeton University, member, Advisory Committee to Federal Bureau of Employment Security.

Mr. Norman V. Lourie, deputy secretary, Pennsylvania Department of Public Welfare, member of ad hoc advisory committee to Department of Health, Education, and Welfare.

Mr. Charles I. Schottland, dean, Florence Heller Graduate School of Social Welfare, Brandeis University, former Commissioner of Social Security (1954–58).

Mr. Karl de Schweinitz, Washington, D.C., former consultant to Social Security Board, and professor emeritus, University of California.

Mr. Herman M. Somers, chairman, Political Science Department, Haverford College, former consultant to Social Security Administration.

Mr. John W. Tramburg, commissioner, New Jersey State Department of Institutions and Agencies, former Commissioner of Social Security (1953).

Mr. George K. Wyman, executive director, Welfare Council of Metropolitan Los Angeles, former Deputy Commissioner of Social Security (1959).

Mr. J. Douglas Brown, dean of faculty, Princeton University, Chairman of Advisory Council on Social Security (1937–38) and member of Advisory Council (1948–49).

Mr. John J. Corson, McKinsey & Co., Washington, D.C., former Director, Bureau of Old-Age and Survivors Insurance.

CONGRESS OF THE UNITED STATES,
HOUSE OF REPRESENTATIVES,
Washington, D.C., June 29, 1960.

Hon. HARRY F. BYRD,
Chairman, Senate Finance Committee,
U.S. Senate.

DEAR MR. CHAIRMAN: I am writing on behalf of the city of El Centro in the hopes that your esteemed committee may be able to assist that community to solve a problem which has been called to my attention.

My colleagues on the House Ways and Means Committee have suggested that I contact you directly because the House has already enacted H.R. 12580, the Social Security Amendments of 1960.

In 1957 the city of El Centro acted in good faith in response to the desires of the employees of the municipally owned hospital to be covered by Federal social security. Action was taken upon the advice of the State employees' retirement system to divorce hospital employees from that system. An account

was established with the Internal Revenue Service and the city and employees have made payments which have been deposited to the proper social security accounts since that time.

Recently, the city was advised by the State employees' retirement system that due to a technicality, the account was not properly established. The hospital employees thus have been ruled to be without either State or Federal retirement coverage since 1957.

I am enclosing a report from the Social Security Administration on the case which has just been furnished to me for your committee's consideration. Also enclosed is the draft of a proposed amendment to H.R. 12580 which has been prepared by Mr. Robert Hoyer of the Baltimore office of the Social Security Administration.

Any relief which your committee could provide to correct this unfortunate situation would win the unending gratitude of the officials of the city of El Centro and the employees of the municipal hospital, all of whom have indicated that they wish to have the Federal coverage which they had erroneously been led to believe that they enjoyed.

Also enclosed is a complete compilation of correspondence and exhibits which have been prepared for your consideration by Mr. T. Ernest Johnson, administrator of the El Centro Municipal Hospital.

Mr. Johnson has indicated his willingness to come to Washington immediately if he can be of assistance to the committee in any way.

Please call on me if I can be of any assistance in any way.

Sincerely yours,

D. S. SAUND,
Member of Congress.

PROPOSED AMENDMENT TO H.R. 12580, PREPARED BY MR. ROBERT HOYER, BALTIMORE OFFICE, SOCIAL SECURITY ADMINISTRATION

Notwithstanding any provision of section 218 of the Social Security Act, the agreement with the State of California heretofore entered into pursuant to such section 218 may, at any time prior to 1962, be modified pursuant to subsection (c)(4) of such section 218 so as to apply to services performed on and after July 1, 1957, for the El Centro Municipal Hospital by employees and former employees of the city of El Centro in positions which were covered by the California State employees' retirement system on June 30, 1957, and which are not covered by such system on the date of the enactment of this subsection. The preceding sentence shall not apply to services performed by any individual who on December 31, 1959, was an employee of such city and was on such date either a member of such retirement system or eligible to become a member thereof.

DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE,
SOCIAL SECURITY ADMINISTRATION,
Washington, D.C., June 29, 1960.

Hon. D. S. SAUND,
House of Representatives,
Washington, D.C.

DEAR MR. SAUND: This refers to your letter of May 27 concerning old-age and survivors insurance coverage for certain employees of the city of El Centro, i.e., some employees working at the El Centro Community hospital.

The information which we have indicates that the employees for whom coverage is desired were in positions under the State employees' retirement system from October 1, 1953, to July 1, 1957. Effective July 1, 1957, the positions were removed from coverage under the State system. Those employees who were members of the system prior to July 1, 1957, or who were employed prior to July 1, 1957, and who thereafter became members of the system upon completion of 6 months' service, were permitted to retain their membership in the retirement system.

In 1959 the city took action to provide coverage for employees of the city, including hospital employees, who were then members of the State employees' retirement system and who chose to be covered. This coverage was accomplished under a special provision in the Federal law which permits certain States to cover members of retirement systems on a "desire for coverage" basis. Such coverage is limited to the members who have chosen coverage and to all new members of the system. The employees of the hospital for whom coverage

is now desired were not members and, therefore, they were not covered by this action.

Under the Federal law, the fact that they were in positions under the retirement system on September 1, 1954, precludes their obtaining coverage under the provisions which authorize the coverage of positions which are not under a retirement system. Prior to the 1954 amendments, the law specifically precluded the coverage of positions under a retirement system. When such coverage was made possible by the 1954 amendments, it was conditioned upon certain requirements. Having thus opened the door to the coverage of positions under a retirement system, the Congress stipulated that (with minor exceptions not applicable here) the required conditions must be met with respect to all positions which were under a retirement system as of the enactment date of the 1954 amendments, i.e., September 1, 1954.

Initially the Federal law conditioned the coverage of positions under a retirement system upon a favorable referendum among the eligible members of the system. The coverage based on such a referendum included the coverage of all positions which are or had been under the retirement system including the positions of those who were not members and also those who may have voted against coverage.

In the 1956 amendments, an alternative procedure for the coverage of retirement system people was made available to certain States. Under this provision (California was given this option in the 1957 amendments), coverage can be provided only for those members of a retirement system who desire coverage. It was under this procedure that coverage was provided for those employees of the city of El Centro who were members of the State employees' retirement system.

One of the results of the use of this special procedure is that it establishes two deemed "retirement systems" for coverage purposes. One system is composed of the members who have chosen coverage. The other system is composed of the members who did not choose coverage as well as all other positions under the system including the positions of those who are not eligible for membership. It is possible under Federal law to provide coverage for this group which would include the El Centro Hospital employees. Such coverage is possible, however, only if a referendum is held and a majority of the eligible employees vote in favor of coverage. Coverage on the basis of the members' desires is not available under these circumstances. We recognize that as a practical matter it would be unlikely that there could be a favorable referendum in respect to a group which consists (as to those eligible to vote) only of those who have not voted in favor of coverage.

You are, of course, aware of the fact that there is a proposed legislative change in H.R. 12580 under which a retirement system covering the positions of employees of a city-owned hospital which also covers positions of other city employees could be deemed to constitute a separate retirement system for hospital employees only for coverage purposes. It does not appear that this provision would furnish a basis for providing coverage for the employees involved for the reason that the employees of the El Centro Community Hospital for whom coverage under the State agreement is sought, are not presently members of any retirement system. We believe that this would preclude the use of this proposed legislative change in respect to employees working at the El Centro Community Hospital.

If we can be of any further assistance in this matter, please let us know.

Sincerely yours,

W. L. MITCHELL, *Commissioner.*

STATEMENT OF THE INTERNATIONAL ASSOCIATION OF HEALTH UNDERWRITERS, BY BRUCE GIFFORD, MANAGING DIRECTOR, IAHU

We wish to limit our comment to the matter contained in title VI of H.R. 12580. This would add to the Social Security Act a new "title XVI—medical services of the aged."

Our organization, the International Association of Health Underwriters, is an association which represents persons active in the merchandising of health insurance.

We cannot stress often or pointedly enough the importance of the matter contained in the above-mentioned legislation. It is indeed a broad subject. Ramifications extend into a number of areas of our social and economic life.

In consideration of the scope of this matter and because of the number of alternative proposals, we feel there is need for all facts to be assembled before conclusions are drawn.

On the above-mentioned title VI there were no hearings conducted by the House of Representatives. Only limited hearings have been conducted by the Senate. Title VI is a departure from the traditional concepts of social security in that it would provide to the eventual recipient service benefits. The philosophy of social security is based on cash benefits.

Further, because of the divergent nature of the several programs recommended to provide health care for the aging; because of the lack of statistics on persons over 65 who are medically indigent, and because of the forthcoming White House Conference on the Problems of the Aging in early January 1961 we urge avoidance of hasty action. We believe that further study of the entire subject is fully warranted.

From statistics available, it would appear that about 2½ million persons over 65 are now indigent and receiving assistance. In addition it is roughly estimated there are approximately 1 million medically indigent which title VI would take care of on a needs basis. Subtracting these numbers from the estimated 15½ million persons over 65 in this country there remain approximately 12 million. Latest indications point to the fact that voluntary insurance will have by the end of 1960 more than 8 million of this total covered. Voluntary insurance with programs now operative and those being designed can and will solve this problem. Group insurance is being employed in three significant ways to provide benefits for older persons and their dependents: 1. Continuation of insurance acquired during active employment in period of retirement. 2. Continuation of insurance coverage to those who remain in active employment past normal retirement age. 3. Conversion of group coverage to individual insurance at retirement.

Additionally, a significant number of persons have been covered and thousands more will be protected through mass enrollment techniques being employed by a number of companies. Two companies alone now have more than 2 million persons over 65 protected by health insurance fulfilling the particular needs of the individual. Furthermore, employers and insurance companies are working together on programs of funding welfare and benefit programs during the active life of employees, so there will be money available to pay for health care needs after retirement.

We question the wisdom of enacting permanent legislation to solve a temporary problem. G. Warfield Hobbs, vice president of the First National City Bank of New York and chairman of the National Committee on Aging warns that if sentiment of politics carries us overboard on a permanent basis to solve the temporary financial problems of a segment of the aged population, "we may find in the future that we are providing perhaps more than necessary for a very large and self-supporting aged group at the expense of other age groups."

As proof that the new generation of older citizens is attaining better financial independence, Hobbs cites current old-age assistance figures.

"In 1950 the number of over age 65 receiving public assistance reached a high of 2,789,000," he said. "By December 1959 there was a decrease to 2,394,000 despite the fact that there were 3 million more in the aged group. The reduction continues at a rate of about 3,000 a month in spite of a net gain in the number of aged of about 30,000 a month."

Dr. Willard C. Rappleye in his report as president of the Josiah Macy, Jr., Foundation said, "planning for the long-term future under conditions which exist then should be given more consideration rather than creating permanent legislation for a temporary phase of our economy."

Representing the interest of many small businessmen who are insurance agents and producers comprising an army of salesmen who have helped to bring health insurance coverage to more than 130 million Americans, we are unalterably dedicated to the goal of providing health care insurance in adequate amounts at reasonable prices to the overaged American public. As businessmen working toward the continued development of our great economy, we willingly pay taxes for the operation of the services and facilities of Government which all acknowledge cannot be provided in a private and voluntary way, but where there is an alternative, we are irrevocably committed to the course of individual and personal responsibility over and against the intrusion of Government.

Again we urge extensive study of this problem. This is too serious a subject for hasty action. The 1961 White House Conference on the Problems of the Aging will bring to light much information on the subject hitherto unrevealed.

STATEMENT OF IRVIN P. SCHLOSS, LEGISLATIVE ANALYST, AMERICAN FOUNDATION FOR THE BLIND

I appreciate this opportunity to state the views of the American Foundation for the Blind, the national voluntary research and consultant agency in work for the blind, on H.R. 12580, the Social Security Amendments of 1960.

The American Foundation for the Blind believes that H.R. 12580, except for one serious shortcoming, generally advances the programs provided for under the Social Security Act. We are particularly pleased with the proposed change in the disability insurance provisions which would make it possible for an individual with the requisite quarters of coverage to be eligible for monthly cash benefits at the age at which he becomes disabled. This is a logical and desirable extension of the program, and we respectfully urge this committee's approval.

Although there are certainly many desirable improvements in the various provisions of the Social Security Act which are not included in H.R. 12580 and which should be considered by the committee—such as prohibition of residence requirements in the public assistance titles; addition of a general assistance category to the public assistance titles; alteration in the formula for Federal payments to the States to provide for equal treatment of Puerto Rico, Guam, and the Virgin Islands; increased Federal payments to the States; extension of partial exemption of earnings in some of the public assistance titles; and alteration of the definition of disability in sections 216 and 223 of title II for certain types of severe disabilities—we would urge the committee to give priority consideration at this time to devising a sound and effective program of medical care for persons 65 years of age and over within the old-age, survivors, and disability insurance system.

The provisions for medical care of the aged presently incorporated in title VI of H.R. 12580 are wholly inadequate from the standpoint of the need which must be met and unsound and impractical from a fiscal standpoint. The program now provided for in the bill would not begin to meet the real need for adequate medical care of the millions of persons living on social security retirement pensions. Many States are not able to take full advantage of existing Federal-State matching fund programs in public assistance and vocational rehabilitation, and it is completely unrealistic to expect them to be able to provide even a minimal medical care program for their aged residents with the system of financing required in the bill.

On the other hand, there are a number of bills pending before the committee which do provide for adequate, comprehensive medical services for persons 65 and over and which also provide for sound financing through the OASDI mechanism.

The concept of these OASDI bills is sound, practical, and in the best interest of the American people. By making it possible for persons to provide during their optimum years of employment through a contributory insurance plan for their medical care needs after retirement age, when their income is substantially curtailed, such legislation would enable our senior citizens to receive adequate medical care for which they themselves have paid. At present, many older persons must do without the medical care they need because they cannot afford it; or else they must seek it on a charity basis—a demoralizing prospect for an individual who has spent his productive years as a typical independent American, contributing to the growth and development of our national economy.

The typical retired worker finds himself in a difficult position today. Steadily increasing living costs force him to make every penny of his social security retirement pension stretch as far as possible. He and his wife begin to do without many small pleasures they enjoyed a few short years before the retirement he had so keenly looked forward to. He views with alarm the steadily increasing payments for doctor bills and medicines as the chronic ailments which attend the aging process become more persistent and frequent. An acute health situation requiring surgery or hospitalization for a period of 2 or 3 weeks arises and virtually wipes out his savings; and as a result, he and his wife live in dread of another similar occurrence because they do not have the financial resources required for today's medical care.

I know that the situation I have just described is duplicated many times over in our country today. With an adequate medical care insurance program under the social security system, it need not happen.

According to the Social Security Administration, more than half a million old-age pension recipients are also receiving public assistance under title I of the Social Security Act, providing for grants to States for old-age assistance. Similarly, approximately 25,000 recipients of retirement pensions and disability insurance payments have found it necessary to go on the public assistance rolls in the aid to the blind and in the aid to the permanently and totally disabled categories, titles X and XIV of the act. There can be no question that the high cost of medical care is a highly significant contributing factor. How much better it would be for the country economically and for the individual psychologically if he received adequate medical care because he had insured himself for it and no longer needed public assistance to make ends meet.

Approximately 175,000 blind people—nearly half of our blind population—are over 65. Many are blind from cataracts and other conditions which frequently accompany aging. An adequate medical care program under the social security system would make many operations for sight restoration possible—operations which just are not being performed because the people concerned cannot afford them.

The American Foundation for the Blind respectfully urges the Committee on Finance to replace title VI of H.R. 12580 with a comprehensive medical care plan for the aged which uses the social security mechanism for financing and administration. By so doing, the committee will assure our senior citizens of adequate medical care in a psychologically wholesome and economically sound manner.

TESTIMONY OF THE PHYSICIANS FORUM ON H.R. 12580, SUBMITTED BY DR. ALLAN M. BUTLER, PROFESSOR OF PEDIATRICS, HARVARD MEDICAL SCHOOL, AND CHAIRMAN, THE PHYSICIANS FORUM

The Physicians Forum is a national organization of physicians in existence for more than 20 years. Our members, who number over 1,000 and are mainly private practitioners, also belong to their county medical societies or other recognized professional associations.

The Physicians Forum appreciates this opportunity to present its views on the medical care section of H.R. 12580. As we have not had an opportunity to read H.R. 12580, our recommendations at this time will be limited to basic principles derived from our experience as physicians and our deliberations on the several proposals submitted earlier to the Congress. We will shortly forward to you a supplementary statement which will compare and evaluate H.R. 12580 and the other current major proposals for medical care of the aged.

The years of medical practice of our members and professional associates give us extensive personal knowledge of the great medical needs of the aged and the frequently insurmountable obstacles they encounter in attempting to get good medical care. More often than we wish to recall, we have seen our patients, on reaching retirement, fail to receive necessary hospitalization, diagnostic procedures, and other medical services, and forced to give up their personal physicians.

From our experience we also know that currently available health insurance has not eliminated the financial obstacle to good medical care for the aged. Many do not have health insurance, particularly those needing it the most, while those covered still suffer considerable financial hardship because benefit payments are usually so inadequate.

Our elderly patients with Blue Cross policies are also the hardest hit by the current wave of increases in Blue Cross rates; as a result, many find it difficult to pay the premiums and some have had to give up their policies. We are deeply worried about the unfortunate predicament these patients will face when they require hospitalization.

It is clear to us that currently available health insurance must be bolstered by the Federal social security system to assure universal coverage of the aged regardless of their limited and usually shrinking economic resources.

In the 25 years of the Federal social security system, we physicians have witnessed with gratitude the financial help it has provided to our patients. For many, this was sufficient to maintain their personal dignity without which mental and physical health rapidly deteriorates. For some, it made possible the con-

tinuation of important doctor-patient relationships or the purchase of necessary medical services. To the best of our knowledge, the benefits of the Federal social security system have been provided with a minimum of redtape and without political interference.

More recently, the Federal social security system has worked directly with the medical profession in administering the disability freeze and the disability benefits programs. Practicing physicians who have participated in this work have found the same rational approach that has characterized the entire system. In particular, there has been no interference with professional judgments, no loss of professional integrity, no lowering of the quality of care.

As physicians, we are distressed and ashamed that our principal professional organization should continue its anachronistic and unscientific opposition to the addition of medical care benefits to the Federal social security system. This is the only financially sound way to give everyone basic insurance against the costs of medical care in old age. We are deeply disturbed that some of our fellow physicians are so callous as to advocate instead extension of charity medicine to further large segments of the population.

Charity medicine is not conducive to high quality medical care, is not compatible with good doctor-patient relationships, and is often not adequate to the medical needs. Moreover, the prerequisite means test is distasteful to the American people. We are confident that most physicians have a higher regard for their elderly patients and a sounder understanding of what is good for the health of the aged.

The medical profession would legitimately benefit in an economic way from the addition of medical care benefits to the Federal social security system. Judging from the effects of voluntary health insurance, extension of coverage to a large new group of people with modest or low incomes, means full payment to physicians for many services previously provided on a charity or semicharity basis.

It is important for physicians to realize that such a program would not significantly alter the present pattern of providing medical service. Rather, it is primarily a mechanism for improving the method of financing medical care for the aged.

Thus, as practicing physicians we believe that the social security approach to medical care of the aged would be welcomed by the vast majority of the medical profession if they were adequately informed and if they were not intimidated by the American Medical Association. They would recognize, as we do, that the social security approach would give all our elderly patients the financial possibility for personal, continuous, and high quality medical care.

During the present congressional debate on medical care for the aged, little attention has been given to the means available in legislation for protecting and promoting care of high quality. As physicians, we must emphasize that any legislation on this subject will affect quality of care. It would be a great disservice to the aged and to America's health services to enact legislation which ostensibly ignores quality considerations and consequently, in practice, finances and extends services of poor quality.

First of all, we strongly urge that the legislation call for effective Federal, State, and local advisory councils which would assure carefully considered and professionally guided advice on quality issues, including the formulation of sound standards for participating personnel and institutions.

Second, we strongly urge that participation be limited to hospitals which are accredited by the Joint Commission on Accreditation of Hospitals (American Medical Association, American College of Physicians, American College of Surgeons, and American Hospital Association). Most hospitals have met the minimum standards of facilities, services, and organization required for accreditation. Accreditation is universally accepted in the health field as a well functioning, fair, and necessary mechanism for protecting the public against poor quality of hospital care. The aged are no less deserving of such protection.

Similar protection against poor quality nursing homes is also imperative. Most nursing homes, unlike hospitals, are privately owned and receive limited payments from existing welfare programs for many of their residents. Although State licensure laws set forth minimal requirements, adequate medical and nursing care in nursing homes is the exception rather than the rule. Moreover, some nursing homes have little or no concern for the welfare of their patients and are primarily profitable businesses exploiting the financial resources of aged and chronically ill individuals. To make Federal funds available to these types of nursing homes would only perpetuate and expand inadequate nursing home

care. To limit Federal funds to accredited nursing homes would be a strong and much needed stimulus to the development of good nursing home care.

Third, we strongly urge that from the start, the medical-care benefits be as comprehensive as possible—especially that they include all necessary services of specialists and general practitioners, and diagnostic laboratory and X-ray procedures for nonhospitalized patients.

In order that services of poor quality can be eliminated and systematic improvement of quality can be promoted, administration at all levels must be medically oriented. We, therefore, recommend that the U.S. Public Health Service and the State health departments should share the governmental administrative responsibilities.

We also recommend that the financial resources of the program be utilized for improving quality of care. Among the ways this can be done is through encouraging group medical practice and professional audits, acknowledging tuition and educational leave costs as proper components of professional compensation, financing demonstration and research on quality improvement, and rewarding recognized high-competence ratings and high levels of performance.

Speaking for the many thousands of physicians who favor the addition of medical-care benefits to the Federal social security system, we sincerely hope the Senate Finance Committee will formulate and approve of a program of medical care for the aged, based on the right of each aged person to necessary medical care, available with dignity, without financial barriers, and with good quality assured.

Report of the National Lawyers Guild on Health Insurance Benefits for the Aged—the Forand, McNamara, and Javits Bills and the Administration's "Medicare Program for the Aged"

Our country, 25 years ago, determined, as a matter of national policy, that it was in the interest of the Nation that old-age security should be provided for. The old-age and survivors' insurance system, created by the Social Security Act, does not, however, provide sufficient income to enable aged beneficiaries to purchase or otherwise obtain the medical and hospital care which they need. This has led to a widespread demand for amendments to the Social Security Act or other provisions which would meet this need. Currently, the Congress is considering a number of measures which are concerned with this problem. This report is intended to review the most important of these measures.

I. THE NEED

Rising costs for medical care, especially hospitalization, have seriously affected the health and economic security of persons of all ages. The aged have been particularly hard hit because their advanced age and the infirmities usually accompanying it, while interfering with the ability to pay for more medical care, at the same time creates the need for more medical care. Since 1947–49, the overall consumer price index has increased about 24 percent. Medical-care costs have risen about twice as fast, or 49 percent.[1]

Hospital room rates have increased 71.2 percent from 1948 to 1956, while all medical care costs increased 31.7 percent. Private expenditures for hospital services have increased from 1 percent of per capita disposable income in 1948 to 1.16 percent in 1952, 1.33 percent in 1954 and 1.43 percent in 1956, a 43 percent increase from 1948.[2]

Seventy-four percent of the aged (those over 65) have annual incomes of $1 to $1,000; 11 percent have annual incomes of $1,000 to $2,000, and 15 percent incomes of $2,000 or more.[3]

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[1] Department of Health, Education, and Welfare report dated Apr. 3, 1959 (hospitalization insurance for OASDI beneficiaries); statement of Wilbur J. Cohen, representing the American Public Welfare Association submitted July 15, 1959, to the Committee on Ways and Means of the House of Representatives, hearings on H.R. 4700, July 13–17, pp. 310–347.

[2] Department of Health, Education, and Welfare report and statement of Wilbur J. Cohen. See footnote 12.

[3] New York Times, Mar. 20, 1960; see also statement of Arthur S. Flemming, Secretary of Health, Education, and Welfare, before the House Ways and Means Committee of the U.S. House of Representatives, Wednesday, May 4, 1960.

The Honorable Arthur S. Flemming, Secretary of Health, Education, and Welfare, in testifying before the Committee on Ways and Means of the House of Representatives, on the Forand bill on July 13, 1959, aptly summarized the problem:

"There is general agreement that a problem does exist. The rising cost of medical care, and particularly of hospital care, over the past decade has been felt by persons of all ages. Older persons have larger than average medical care need. As a group they use about 2½ times as much general hospital care as the average for persons under age 65 and they have special need for long-term institutional care. Their incomes are generally considerably lower than those of the rest of the population, and in many cases are either fixed or declining in amount. They have less opportunity than employed persons to spread the cost burden through health insurance. A larger proportion of the aged than of other persons must turn to public assistance for payment of their medical bills or rely on free care from hospitals and physicians.

"Because both the number and proportion of older persons in the population are increasing, a satisfactory solution to the problem of paying for adequate medical care for the aged will become more rather than less important."[4]

Experience has clearly demonstrated that currently available health insurance has not adequately met the cost of good medical care for the aged. Even those able to obtain health insurance coverage suffer considerable financial hardship because benefit payments are usually inadequate. The OASI beneficiary survey of 1959 established that 54 percent of social security beneficiaries did not have any health insurance and 36 percent of all these beneficiaries had never had any health insurance whatsoever. Those who had no health insurance stated that they could not afford it or had been refused insurance. About one-third of the beneficiaries had at one time had policies which had been dropped or canceled either because of financial inability or because their coverage was on a group basis which had been terminated upon retirement.[5]

On March 12, 1959, the Division of Program Research of the Social Security Administration published an analysis of Blue Cross provisions for persons aged 65 and over. This analysis shows that, in 1958, 29 of the 78 Blue Cross plans increased their premiums. Under group contracts, the median annual premium was $30 per person, with a range of $16.20 to $70.80. For persons who had left employment or had entered into a nongroup contract, the median charge was $42, and the highest charge was $87 per person. One of the most extensively advertised health policies for persons over 65 charged $6.50 per month for coverage providing $10 maximum allowance per day for hospital (about one-half of the national average), coverage for maximum of 31 days, and a maximum payment for hospital extras of $100 (X-ray, diagnostic procedures, etc.).[6] Of course, the problems posed by the foregoing statistics are compounded when one considers the additional costs of physicians services in the hospital, diagnostic procedures, and therapy.

II. THE FORAND BILL

A. Provisions of the Forand bill

The Forand bill[7] is intended to amend the existing social security law to provide that the social security system shall pay for the cost of hospitalization, nursing home care and surgical services for the group now covered by the present old-age and survivors insurance program.

The bill would amend section 10(a) title 2 of the Social Security Act by adding after section 225, a new section 226 which would provide in substance the following:

The social security system would pay the cost of hospital or nursing home service furnished to an individual during any month such person would be entitled to monthly benefits under section 202 of the Social Security Act, or the cost of such services furnished during the month of said persons death and the cost of surgical services which are not of an elective nature, which payments are to be paid from the Federal old-age and survivors insurance trust fund to the hospital, physician, or nursing home which furnished the services.[8]

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[4] Hearings on H.R. 4700, July 13–17, 1959, pp. 9–10.
[5] Old-Age and Survivor Insurance Beneficiary Survey, 1959, by Department of Health, Education, and Welfare.
[6] See testimony of Nelson H. Cruikshank, hearings on H.R. 4700, July 13–17, 1959, p. 80.
[7] H.R. 4700, 86th Cong., 1st sess., introduced Feb. 18, 1959.
[8] Sec. 101(a) amending sec. 10(a), title 2 of the Social Security Act, sec. 226(a), subsecs. (1), (2).

The period of eligibility would be the first 60 days of hospitalization in a 12-month period, beginning with the first day of hospitalization and the first 60 days in each succeeding 12-month period; and nursing home services furnished upon transfer from a hospital providing that the same are associated with such hospital services, for 120 days in any 12-month period less the period of hospital confinement.[9] The bill broadly defines "hospital services" but excludes care in any tuberculosis or mental hospital. "Nursing home services" is defined as meaning skilled nursing care operated in connection with a hospital or performed under the general direction of a licensed physician in connection with a nursing establishment. Home nursing services or private nursing homes are not included. "Surgical services" would cover any surgery medically required, including emergency and oral surgery which is medically required.[10]

The bill provides that the eligible individual shall have free choice of any hospital or nursing home or the services of any certified surgeon who has entered into an agreement with the Social Security Administration under this act.[11]

The bill requires that the institution be licensed pursuant to the laws of the State where located. The services shall be rendered in semiprivate accommodations. No additional payment shall be reqeusted from the recipient unless medically required, but the patient may voluntarily pay the difference for more expensive accommodations. No payment shall be made from the fund if the patient is eligible for Federal or State hospitalization service.[12]

The bill further provides that the Secretary of the Department of Health, Education, and Welfare shall have no authority over hospital administration, treatment, or personnel, exercise any control over the practice of medicine,[13] and specifically preserves the confidential and privileged relationship between patient and doctor or institution.[14]

H.R. 4700 would also amend the Internal Revenue Code of 1954, by changing the tax schedules on the self-employment income, the tax on employees and the tax on employers, by increasing the present schedule of contributions by three-eighths of 1 percent for self-employed individuals,[15] and one-fourth of 1 percent by employees,[16] and one-fourth of 1 percent on employers.[17]

B. The advantages of the Forand bill as compared with voluntary insurance

The old-age and survivors' insurance program at the present time covers almost the entire working population of the United States. Some 75 million employees and self-employed persons and some 4 million employers currently pay social security taxes. As of December 1959, some 13.7 million persons were receiving benefits.[18] The Forand bill would add on to the present benefits the additional benefits described above.

The advantages of the Forand bill, as compared with voluntary insurance are:

(1) Coverage is paid for while the person is actively employed and best able to meet the cost of insurance coverage, while conversely, during any period of nonemployment no payment is required. This is an immediate advantage over voluntary programs which require payment of premiums regardless of the employment status.

(2) To some extent, the cost of this coverage is based upon the ability to pay. Voluntary plans require payments on a flat basis in relation to the number of dependents and further distinguish between group coverage and individual coverage.

(3) Benefits may not be canceled under the Forand bill. This bill in effect provides for paid up policy backed by the Federal Government. It gives patients and hospitals assurance of payment and protection superior to that of most private plans because there can be no termination since covered persons

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[9] Sec. 101(a) amending sec. 10(a), title 2 of the Social Security Act, sec. 226(a), subsec. (4).
[10] Sec. 101(a) amending sec. 10(a), title 2 of the Social Security Act, sec. 226(b), subsecs. (1), (2), (3).
[11] Sec. 101(a) amending sec. 10(a), title 2 of the Social Security Act, sec. 226(c), subsecs. (1), (2).
[12] Sec. 101(a) amending sec. 10(a), title 2 of the Social Security Act, sec. 226(d), subsecs. (1), (2), (3), (4).
[13] Sec. 101(a) amending sec. 10(a), title 2 of the Social Security Act, sec. 226(d), subsec. (5).
[14] Sec. 101(a) amending sec. 10(a), title 2 of the Social Security Act, sec. 226(e).
[15] Sec. 201(a) amending sec. 1401 of the Internal Revenue Code.
[16] Sec. 201(b) amending sec. 3101 of the Internal Revenue Code.
[17] Sec. 201(c) amending sec. 3111 of the Internal Revenue Code.
[18] Social Security Bulletin, April 1960, pp. 1–2.

are entitled to receive the maximum benefits allowable. There is no premium payable by the beneficiary and therefore there cannot be a termination because of inability to meet premium payments.

(4) In most private plans, on the death of the insured person, coverage is not extended to his survivors, dependents, or other immediate members of his family.

(5) The benefits under the Forand bill are much more extensive than most benefits provided under most private health insurance programs.

(6) The cost of administering the plan would be less than the administrative cost under existing private insurance plans, because contributions would be collected as part of the regular social security contributions and would require no new machinery. There would be no advertising, salesmen, or acquisition costs as in private insurance.

(7) Under the Forand bill, employers pay a payroll tax which contributes one-half of the cost. Under private insurance policy purchased by an individual he, of course, bears the whole cost.

In addition to the foregoing advantages of the Forand bill over private insurance coverage, certain important benefits would flow to the community at large from the enactment of this bill:

(8) It would ease the financial problems of hospitals by providing payment for much of the care that now they must give to charity cases without charge or below actual cost.

(9) Individuals would not be required to apply for or receive public assistance or private charity, and would relieve such organizations and Government agencies of a welfare load now financed by taxpayers or private donations.

(10) The bill would stimulate an increase in the supply of medical personnel and facilities required to make good care available to all concerned. Thus, an assured market for skilled nursing care, for example, would result in an increase in the supply of nursing homes and competent nursing personnel.

(11) Uniform and ever increasing standards of hospital and medical care and treatment would inevitably result from the adoption of this bill.

(12) Since the Forand bill would provide insurance coverage for the highest cost and highest risk group, Blue Cross plans would be relieved of the high cost load and would be better able to hold down their rates and compete more effectively with commercial insurance plans.

C. The arguments against the Forand bill

The American Medical Association and others have opposed the Forand bill on the ground that it is a socialized medicine proposal, or would lead to socialized medicine. This criticism is without basis. The Forand bill specifically prohibits the Secretary from interfering in any way with the practice of medicine, the administration of hospitals or nursing homes, or otherwise interfering with the administration of the institutions involved. The bill would not disturb existing physician-patient relationships or the freedom of doctors to choose the institutions which would furnish the care.

Opponents of the bill contend that the bill would increase the centralization of the functions of the Federal Government and foster paternalism. Such a contention completely overlooks the fact that the people of the United States chose 25 years ago to set up the vast social security administration in an effort to provide for old-age security. Under the Social Security Act of the present time, Federal grants are made to the States to meet the cost in part of medical care needed by persons receiving public assistance. The Forand bill thus is entirely consistent with the policy and program of the Federal Government as now set forth in the Social Security Act.

Several of the foregoing arguments have been urged against all forms of and extensions of social security from the very inception of the social security program and are no more applicable now than they were then.

Life magazine, in an editorial rebuts these arguments as follows:

"Another question of principle is whether it is the proper function of a free government to offer special help to its older citizens. That principle was accepted when social security itself became effective in 1937. The presumption against any extension of Federal activity and expenditure, though Jeffersonian in origin, is now championed, though weakly, by the Republicans, who don't want to be tagged as enemies of the aged. But an extension of an established system like social security is not a violation of principle." [19]

[19] Apr. 25, 1960.

Opponents of the bill also argue that it would burden the younger and productive members of our society with the costs and expenses of the aged and nonproductive persons. The fact is, of course, that under the Social Security Act, as it now stands, billions of dollars are being collected annually by the Federal Government and paid out by the Federal Government to meet the costs and expenses of the aged. No new principle is involved in the further extension which is provided by the Forand bill which, in essence, would collect additional taxes and use them for meeting a needed cost which is not now being met.

Obviously, all members of the community must share in the cost of providing minimal assistance to the aged and the infirm, be this by taxation, charitable donations or direct payments. The Forand bill would, for a nominal cost of $12 per each covered person, eliminate this haphazard and costly catch-as-catch-can method of assistance to the aged and would assure better and more adequate assistance to these persons.

Opponents of the Forand bill argue that voluntary private health insurance plans are fully capable of meeting the medical needs of the aged. They claim that 43 percent of our citizens 65 years of age already are covered by health insurance, the majority of these having acquired such insurance during the past few years. The Health Insurance Association of America expects this trend to grow until 75 percent of the aged who need such protection can be covered by voluntary health insurance by 1965, and 90 percent by 1970.[20] Of course, they do not state how assistance shall be provided to the 57 percent presently not covered by health insurance or the 25 percent by 1965. Even the best of the voluntary insurance plans have many severe limitations. Premiums cost more than the contributions required under the Forand bill; benefits for the most part are less than those provided under the Forand bill; undesirable risks are excluded from participation; premiums must continue to be paid after retirement and regardless of economic ability.

Prof. Wilbur J. Cohen, in presenting a statement of the American Public Welfare Association to the House Ways and Means Committee, pointed out that voluntary insurance can at best eventually reach and cover only 70 percent of the aged, since some 30 percent have either no income at all or so little income that they could never, without governmental help or subsidy, purchase insurance. He pointed out:

"Now the problem is, that voluntary insurance, unless it is either subsidized or some other method is introduced like requiring the employer to pay it all or some other manner of financing it over the lifetime, we are going to find that the lower income people are not going to have voluntary insurance even if we reach 70 percent as has been predicted. The 30 percent without insurance will be the people who will have to go on public assistance and this committee will be financing that cost out of general revenues because you have already committed yourselves to the principle in the 1950, 1956, and 1958 legislation to pay part of the medical care that State public assistance agencies now give." [21]

Opponents of the bill also claim that the costs of the program would be excessive and would jeopardize the financial stability of the entire social security system.

The increase in contributions would yield upwards of $1 billion a year based upon taxable payrolls of approximately $200 billion a year. The Department of Health, Education, and Welfare report estimates that hospitalization benefits of 60 days for the aged and survivors would cost about $900 million in 1960. Skilled nursing benefits would partly offset the cost of hospital care so that their net cost is estimated as negligible at the outset. The Department's estimate was that surgical benefits would cost less than $100 million per year for these same persons.[22]

Secretary Flemming of Health, Education, and Welfare submitted to the House Ways and Means Committee a memorandum entitled, "Estimated 1960 Costs of H.R. 4700," which stated its estimate at $1.1 billion and stated the percent of the taxable payroll at 0.53 percent. The increase in the payroll tax and the wage tax of one-fourth of 1 percent each would approximately cover this cost.

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[20] See statement of E. J. Faulkner for Health Insurance Association of America, hearings H.R. 4700, July 13–17, 1959, pp. 434 et seq.
[21] Hearings on H.R. 4700, July 13–17, 1959, p. 323.
[22] Hearings on H.R. 4700, July 13–17, 1959, p. 23.

D. The deficiencies of the Forand bill

1. A severe limitation of this bill is the exclusion of general medical services. The major ailments affecting the aged do not necessarily require surgery, such as diseases of the heart and blood vessels and nervous system and degenerative disorders and a wide range of other medical conditions. Even where the individual requires surgery, he frequently must receive care from a nonsurgical specialist or general practitioner before or after surgery. Regular medical supervision and preventive services are essential to minimize or prevent the impaired health and major disabilities caused by the aging process and chronic diseases.

Since the underlying purpose of the Forand bill is the improvement of the health of the aged and the prepayment of their major medical expenses, the benefit should also include all doctors' services. The bill should also provide for nondoctor services such as nursing, whether in the home or private nursing establishments, medicines, prostheses, and dentistry. In particular, the omission of diagnostic labatory and X-ray procedures for nonhospitalized patients decreases the medical effectiveness of the program and also encourages unnecessary hospitalization. It is noteworthy that Secretary Flemming has estimated that hospital and surgical costs constitute only 25 to 30 percent of the cost of the whole program of medical care.[23] Thus, the Forand bill still would leave uncovered almost three-fourths of the health costs which must be met.

2. The costs of the bill are financed through an additional payroll and wage tax. The National Lawyers Guild, as a matter of general policy, favors the principle that social security should be financed through general revenues, rather than through the present contributory system of taxes on wages and payrolls. The Forand bill would involve, to some extent, expenditures which are presently being financed out of general revenues. At the present time, it is estimated that $400 million is being expended by the Federal Government annually in the grants-in-aid program of the Social Security Act for public assistance to meet the needs of medical care. Approximately $150 million of this was used in 1958 to meet medical care needs of aged persons receiving public assistance. All of this was derived from general revenues.[24] If the Forand bill were not enacted, these public assistance costs would rise and it has been estimated that they would reach $1 billion over the period of the next 10 years.[25] The Forand bill expenditures would thus be substituting for general revenue expenditures. The financing program would be more equitable if general revenues were the source of funds; for general revenues are provided by taxes on all incomes in accordance with ability to pay, whereas social security taxes do not reach incomes over $4,800.

3. The Forand bill applies only to persons now receiving OASI benefits. Of the 16 million persons now in the population who are 65 years of age or over, some 5 million persons are not now receiving OASI benefits. The need of these persons may well be as great, if not greater than those now receiving OASI benefits. And the Forand bill ought not to exclude them from its benefits.

III. THE MC NAMARA BILL

On May 6, 1960, Senator McNamara introduced, with the joint sponsorship of Senators Kennedy, Clark, Randolph, Symington, Humphrey, Williams of New Jersey, Magnuson, McGee, Young of Ohio, Douglas, Gruening, Long of Hawaii, Murray, Hart, and Morse, a bill entitled "Retired Persons' Medical Insurance Act."[26]

The McNamara bill represents the results of 18 months of study by the Senate Subcommittee on the Problems of the Aged and Aging, of which Senator McNamara has been chairman.

The McNamara bill is generally similar to the Forand bill with these important differences:

(1) *Coverage.*—Whereas the Forand bill would provide medical care benefits for all persons who are entitled to receive benefits under the OASI provisions of

[23] Report of Secretary of Health, Education, and Welfare. See footnote 12, p. 2.
[24] Report of U.S. Department of Health, Education, and Welfare, Social Security Administration, Division of Program Research on "Public and Private Expenditures for Hospital Care in the United States, 1953–55, Jan. 8, 1957."
[25] Statement of the American Public Welfare Association to the House Ways and Means Committee, hearings on H.R. 4700, July 1959, p. 326.
[26] S. 3503.

the Social Security Act, including underage survivors and dependents, the McNamara bill benefits would be limited to OASI beneficiaries who have "attained retirement age" and "are retired," provided they (*a*) had total annual wage earnings of less than $2,000, or (*b*) did not render services for wages of more than $100 and did not engage in self-employment in at least 3 months of the year, or (*c*) attained the age of 72. Senator McNamara estimates that his bill, on this basis, would provide benefits for some 11.3 million OASI beneficiaries.

The McNamara bill, however, extends coverage to persons who are not entitled to OASI benefits, again provided they (*a*) had total annual wage earnings of less than $2,000, or (*b*) did not render services for wages of more than $100 and did not engage in self-employment in at least 3 months of the year, or (*c*) attained the age of 72. Senator McNamara estimates that these coverage provisions would provide coverage for 1.7 million aged persons who are now receiving old age assistance but who receive no OASI benefits, and an additional 1.8 million other retired aged persons, men over 65 and women over 62, who receive neither OASI benefits nor old age asistance, but meet the low-income requirements of the bill.

In essence, the McNamara bill covers all aged persons who are not working full time and are retired and who have income of less than $2,000 a year and without regard to whether or not they receive old-age insurance or old-age assistance.

(2) *Benefits.*—The benefits would cover the cost of five categories of services and expenses: (1) hospital services up to 90 days; (2) nursing home services up to 180 days; (3) home health services, such as professional nursing care up to 240 days; (4) certain diagnostic outpatient services; and (5) very expensive drugs as specified by regulations to be promulgated.

(3) *Financing.*—The benefits to insured persons would be financed in the same way as the Forand bill benefits are financed, i.e., by an increase in payroll taxes, wage taxes and self-employment taxes. The benefits for the aged who are not insured would come from general revenues.

Senator McNamara, in his statement accompanying the introduction of the bill, estimates the total cost "computed as conservatively as possible" at $1,578 million, or $106 per retired person. The benefits to 11.3 million OASI beneficiaries would be financed by a one-fourth of 1 percent increase in the social security tax on both the employer and employee. Senator McNamara estimates that the benefits to 1.7 million old-age assistance recipients would cost $180 million and the benefits to the 1.8 million other aged retired persons would cost $190 million. Thus, approximately $370 million would have to be derived from general revenues. However, partially offsetting the appropriation of $370 million are current Federal expenditures of $238 million for medical care under old-age assistance or other federally aided programs. Thus, the net additional cost to the Federal Government would be approximately $132 million.

The McNamara bill would also direct the Secretary of Health, Education, and Welfare to conduct research on the health care of older persons and on improvements in the quality and efficiency of health services. The bill authorizes the Secretary of Health, Education, and Welfare to administer the act with the assistance of a national health service advisory council and to utilize the services of private nonprofit organizations in administering the program.

Comment

The case for the Forand bill applies as well to the McNamara bill.

As to the three deficiencies noted above with respect to the Forand bill, the McNamara bill meets some of them.

Thus, the McNamara bill applies to the aged who are not insured under the Social Security Act, whereas the Forand bill excludes them.

The McNamara bill, in its benefit provisions, excludes surgical benefits. The bill does, however, include other benefits, such as care at home in a supervised home health program, diagnostic outpatient services, such as laboratory tests and X-rays, and a portion of the cost of very expensive drugs. The inclusion of these benefits is essential to a sound medical program for the aged. As was pointed out above, the medical effectiveness of the entire program would be increased by the diagnostic outpatient services and home care. We do not, however, believe that surgical benefits should be eliminated, and urge that the McNamara bill benefits be further broadened to include surgical, dental, and medical services.

So far as financing is concerned, the McNamara bill is subject to the same criticism as the Forand bill with respect to financing benefits to persons now insured under the OASDI provisions of the Social Security Act. The financing of benefits to persons not insured under the OASI provisions of the Social Security Act from general revenues, is, of course, entirely appropriate.

We believe, too, that the denial of eligibility to OASDI beneficiaries who earned more than $2,000 in wages or who engaged in self-employment for 3 months in the preceding calendar year is unwarranted. Persons entitled to all other social security benefits should be entitled, as well, to the medical care benefits. The hardship involved in the cost of hospital and health care may bear heavily upon such persons if excluded.

IV. THE JAVITS BILL

A. Provisions of the Javits bill

On April 7, 1960, Senator Javits for himself, Mr. Cooper, Mr. Case, Mr. Scott, Mr. Fong, Mr. Aiken, Mr. Keating, and Mr. Prouty, introduced a bill to provide a program of Federal matching grants to the State to enable the State to provide health insurance for individuals aged 65 or over at subscription charges which such individuals can pay. The bill is known as the Health Insurance for the Aged Act.[27]

Section 2 of the Public Health Service Act is to be amended by inserting at the end thereof a new title 8, "Health Insurance for the Aged." The bill is not linked to the social security system. It could potentially reach 16 million Americans over 65 including 4 to 5 million who are not eligible under social security. Only those wishing to participate would do so.

Under the bill, each State could provide health insurance coverage for all persons aged 65 or over and their spouses. Cooperative health programs or private health insurance plans would be the means through which the State plan would provide broad medical and hospital coverage. The bill would provide 60 days of full cost, semiprivate hospital care or the equivalent cost care in a nursing home for the aged and would also cover office visits, laboratory tests, diagnostic X-rays and procedure, specialist consultations, visiting nurse in the home.

Under the bill, monthly subscriptions fees for individuals would range from 50 cents to $13 depending on the subscribers income. The difference between the total subscription paid by beneficiaries and the full premium costs would be shared by the State and Federal Government. The Federal contribution would be based on a formula used in Hill-Burton Hospital Construction Act under which the Federal Government's share to the States ranges from a maximum of 75 percent to a minimum of 33⅓ percent. Senator Javits estimated that "based on the likelihood that 70 percent of those eligible would join the plan, because the others are carried now in suitable health plans or other reasons, the estimated medium average cost per year of this program to the Federal Government (based on expected allocation by States) would be about $480 million, to the States $640 million, and $400 million to the subscribers."[28]

B. The deficiencies of the Javits bill

1. The Javits bill would set up an administration separate from and outside of the social security system, whereas the Forand bill would utilize the entire administration of the Social Security Act and merely add an additional benefit to be administered through the existing social security system. The Javits bill would create a new Federal-State administration. This would add to the complexities and difficulties and unnecessarily increase costs.

2. The Javits bill depends upon State action. If a State does not set up an administration and does not appropriate the moneys necessary, none of its residents receive any benefit. On the other hand, the Forand bill, as a Federal measure, would operate immediately and directly for the benefit of all the beneficiaries of the existing social security system.

3. The Javits bill coverage is limited to those who are 65 or over or are married to an individual 65 or over. It would provide subsidies for those aged persons who obtain insurance. The Forand bill, on the other hand, provides insurance for the entire working population.

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[27] S. 3350, 86th Cong., 2d sess., introduced Apr. 7, 1960.
[28] Statement of Senator Javits, Thursday, Apr. 7, 1960, as reported in the New York Times, Apr. 8, 1960.

4. Under the Javits bill, those who are 65 or over would be paying premiums, whereas under the Forand bill, those 65 or over would be receiving benefits with the premiums (taxes) being paid by the working population and the aged beneficiaries would pay no premiums.

5. The administration costs of the present social security system are very low, averaging about 2 percent. It is the estimate of the Government that administration costs under the Forand bill would approximate 5 percent. This is a very much smaller cost than the cost of private insurance, which must cover the costs of sales, collection, and administration.

6. Whereas the Forand bill would spread the costs of the entire insurance program over the entire working population, the Javits bill would be financed in part by the premiums of those over 65 who purchase the insurance and in part from State revenues and in part from Federal revenues.

Several aspects of the Javits bill are considerably more favorable than the Forand bill. Certainly, the most important of these is the extension of benefits to include generally all physicians' services to the aged as well as diagnostic procedures, home nursing services, etc. The Javits bill requires premiums based upon the individual's ability to pay starting with a monthly subscription rate of 50 cents per month for those earning between $500 and $1,000 (no premiums collected from those earnings under $500) and rising progressively to $13 per month for those earning $3,600 per year and over.

V. THE ADMINISTRATION'S MEDICARE PROGRAM FOR THE AGED

In May of 1960, the administration announced its medicare program for the aged, which is intended to meet the needs of the aged for protection against long-term illnesses, and meet certain criteria established by the administration for Federal assistance or participation in this field. Secretary Flemming of Health, Education, and Welfare, on May 4, 1960, appeared before the House Ways and Means Committee and presented the administration's plan to provide health and medical care for the aged. This plan has not been formulated in terms of a specific bill at this writing (May 24, 1960) and this report is addressed to the plan as formulated by Secretary Flemming in his formal statement to the committee.

The statement opens with the following significant declaration:

"The executive branch of the Government fully recognizes and accepts the fact that the Federal Government should act in this field."

The program would be open to all persons aged 65 and over who either did not pay an income tax in the preceding year and/or taxpayers 65 and over whose adjusted gross income, plus social security, railroad retirement benefits and veterans' pensions, in the preceding year did not exceed $2,500 or $3,800 for a couple. Those persons qualified would be entitled to receive benefits if an enrollment fee of $24 per year had been paid and after they had incurred health and medical expenses of $250, or $400 for a couple. Those on public assistance would be entitled to benefits without paying the enrollment fee and if the States paid the initial $250 of expense under their regular public assistance programs.

The medicare program would pay 80 percent (100 percent for public assistance recipients) of the cost of comprehensive health and medical services to those who were eligible to receive same, and where such services were determined to be medically necessary. These covered services would include hospital care for 180 days; skilled nursing home care for 365 days; organized home care services for 365 days; surgical procedures; laboratory and X-ray services up to $200; physicians' services; dental services; prescribe drugs up to $350; private duty nurses; and physical restoration services.

The plan provides for a continuity of eligibility by the payment of the annual fee. If the person's income rises above the eligibility maximum, once that person has qualified on an income basis, the fee would be raised on a graduated basis for each $500 of increase in income until the fee equalled the full per capita cost of coverage. Each State would provide that an eligible person could elect to purchase from a private company a major medical expense policy, 50 percent of the cost of which would be paid from the Federal-State matching funds up to a maximum of $60. The program would be administered by the States, under a State plan approved by the Department of Health, Education, and Welfare. The plan would be financed by the Federal Government and the State on a matching basis. Secretary Flemming estimates that the cost of this plan would be $1.2 billion with the Federal share being estimated at $600 million.

The administration believes that the following results would be achieved through the medicare program:

1. It would make participation in such a program optional with the individual. It would allow private insurers to continue to develop medical and health insurance programs for the aged.

2. It would make available a system of comprehensive health and medical benefits which provide adequate protection against the cost of long-term and other expensive illnesses.

3. It would divide the cost of such program equitably among the entire population by providing for financing the Federal share out of general revenues, contrasted with a payroll tax that places the burden on earnings of working persons under $4,800.

4. It would relieve the States of the burden of providing extended medical assistance to a large portion of public assistance recipients and would be extended to all persons in the lower income brackets, regardless of whether they happen to be covered by social security or without subjecting the individual to a detailed or involved income or means test.

The deficiencies of the administration's medicare program are in many respects similar to those of the Javits bill, in that—

1. The medicare program requires an administration separate from and outside of the social security system, which would add to the complexity and difficulty of such a program and unnecessarily increase costs.

2. The administration's program depends upon State action.

3. The medicare program is limited to those who are over 65, and would specifically exclude from coverage the survivors and dependents of the persons who comprise the entire working population. Under the administration's plan, retired persons would still be required to pay premiums.

4. The administration's program in its benefit provisions is subject to serious criticism. While, on its face, the 10-point benefit program of the administration is broader and more comprehensive than the benefit provisions of the Forand bill, the McNamara bill, and the Javits bill, the administration's program, unlike these bills, does not cover the first dollar costs up to a specified maximum; instead, it is subject to the deduction of the first $250 in costs, which must be borne by the insured person, and then it covers the excess over $250 to the extent of 80 percent.

Secretary Flemming, in his statement to the House Ways and Means Committee, made the following report concerning the estimated health costs of the aged:

"A 1957–58 study shows that the average annual expenditures of this group for health and medical expenses was $177, not including nursing home care, as compared with $84 for the rest of the population. But it is important to note that 15 percent of the persons 65 and over, or 2.25 million, had total medical expenditures, on the average, of $700 per year, not including nursing home care. The expenditures for this group represented 60 percent of the total medical care expenditures of the aged. Since 1957, costs for medical care have increased at least 20 percent. Also, it should be noted that the high average expenditure for the aged is attributable to the fact that $6,000 is a conservative estimate of total medical expenditures incurred by persons who are continuously ill for an entire year."

Clearly, the $250 deductible provision would eliminate average medical expenditures of $177 (1957–58 prices). Thus, the Administration's program is really not designed to cover average health costs, which the aged would be expected to take care of themselves. It is, instead, concerned with heavier costs. The 15 percent of the aged whose average medical expenses of $700 per year (1957–58) prices) would be required, on the average, to meet over half of their average costs out of their income. Such costs would constitute a very heavy burden on aged persons whose income is low.

VI. THE POSITION OF THE NATIONAL LAWYERS GUILD WITH RESPECT TO THE FORAND, JAVITS, AND M'NAMARA BILLS, AND THE ADMINISTRATION'S MEDICARE PROGRAM

The National Lawyers Guild has for 20 years urged the adoption by Congress of a Federal comprehensive health insurance program providing complete medical, surgical, and hospitalization insurance for the entire population. The measures analyzed in this report are concerned with an important part of the population, the aged.

The National Lawyers Guild disapproves the Javits bill and the administration's medical program, for the reasons set forth above.

Notwithstanding the criticism stated above with respect to the financing and limitation on benefits of the Forand and McNamara bills, it is the position of the National Lawyers Guild that the enactment of either the McNamara bill or the Forand bill would be so important a forward step in the effort to meet an urgent health need that the National Lawyers Guild would favor the enactment of either the McNamara bill or the Forand bill in their present form, leaving to a later date a further consideration of ways in which the measure could be expanded and improved.

STATEMENT OF JOSEPH A. SCHAFER, CERTIFIED PUBLIC ACCOUNTANT, TO THE SENATE COMMITTEE ON FINANCE FOR HEARINGS ON H.R. 12580—SOCIAL SECURITY REVISION BILL

Having testified before the commitees in past years on some of the shortcomings of our social security system, may I respectfully request that my statement be included in the record of the hearings in order that consideration may be given to the correction of certain unfavorable situations.

INSURED STATUS REQUIREMENT

Many surviving spouses are denied benefits because of the stringent requirement that a certain number of quarters of work must be credited to obtain an insured status. This is inequitable, discriminatory, and a severe hardship to the aged. There are many cases where a worker was able to earn five, or four, or three quarters of coverage, but because of illness or other disability it was impossible for such a person to acquire additional credit. It therefore is a certainty that these people will never be able to qualify for benefits of any kind and they will forever be barred from relief in their old age. This is a grave injustice to these forgotten people.

It should be realized that the aged who have not completed enough quarters of coverage could not get a job even if they ever become able to work because no employer would hire them. At this time we have about 5 percent of our able workers unemployed. Otherwise, the Government should guarantee the old people jobs so that they can qualify for benefits.

Recommenadtion: Work requirements should be waived in the case of persons over 65 years who have not acquired and been credited with an "insured" status. Cr, they may be permitted to claim a disability status because they really are unable to work. At the least, they should be allowed to pay the equivalent social security tax so that they can register as qualified for benefits.

INCREASED COVERAGE—PHYSICIANS

The medical profession has been able to stay out of the social security system on one pretext or another. In effect they have been avoiding the payment of social security taxes amounting to millions of dollars each year. Over the years one group after another has been led into the ssytem, and because of that hit or miss treatment the social security fund has been deprived of billion of dollars.

Doctors need social security no less than other professional groups or self-employed persons. In a short period of a few months sometime ago several outstanding leaders (from 35 to 53 years) in the profession of medicine presented tragic evidence that physicians can die young. These doctors left families behind them, in some cases a wife and four children and aged parents, presumably not entitled to survivors' benefits. Perhaps that is why both the Philadelphia County and Pennsylvania State medical societies voted overwhelmingly in favor of compulsory coverage.

Recommendation: There should be no further delay in bringing physicians into the social security system. No special group should be permitted to stay out of the system if it is to operate equitably for all citizens. More than $20 million per year would be paid into the fund if 150,000 physicians are included.

ADEQUATE BENEFITS

The minimum monthly benefits should be raised to $70 in order that the aged would receive enough income to provide them with a suitable subsistence. They should receive enough for them to become consumers and purchasers of goods in

the quantity that will keep productive processes in motion. That procedure could be considered insurance against recessions, and the effect would be that the "aged" market might supplant the "foreign" market we might have difficulty holding in the future.

Recommendation: Increase the minimum monthly benefit to $70 and also provide that future benefits be adjusted to conform to any increases in the cost of living.

MEDICAL SERVICES FOR THE AGED

Every aged person should be entitled to medical services even though they may not be covered in the social security system. Otherwise, we will have the same inequities and injustices and hardships that have existed because of the lack of universal coverage. If all our old people received $70 per month in benefits, they would be able to pay for their own medical needs, except in certain severe and chronic illnesses when additional aid would be needed.

Recommendation: The provisions for medical aid under H.R. 12580 are satisfactory and adequate to prevent hardship cases. It is inconceivable that any State would not participate in this program.

LIMITATION OF TAX RATE

The maximum social security tax rate should be considered 3 percent, as that would appear to be the point of diminishing returns, considering all-around effects. Any shortage in the fund to pay adequate benefits should come from the general tax funds of the Treasury because the additional benefits paid will generate additional income and excise taxes to the extent of at least 25 percent.

Recommendation: Do not increase social security tax above 3 percent.

DETROIT, MICH., *June 30, 1960.*

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

Would like to appear before committee to testify in support of legislation to provide health benefits to aged through contributory social security system. If personal appearance would delay completion of committee work, would you record in the committee record that I favor adding health benefits to the OASDI system.

LEONARD S. ROSENFELD,
General Director, Metropolitan Hospital and Clinic.

U.S. SENATE,
June 28, 1960.

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

DEAR SENATOR BYRD: The purpose of this letter is to express my special interest in a small bill which I have cosponsored with Senator Eastland, S. 2903, which would deem teachers in the State of Mississippi to be employees of the State for purposes of title II of the Social Security Act.

This legislation is necessary to implement an agreement which has been worked out between the State of Mississippi and the Social Security Administration to include these deserving State employees under title II of the act.

I have been advised that this bill has the full approval and support of the Department of Health, Education, and Welfare and the Bureau of the Budget. I hope that your committee will favorably report S. 2903 or include it as an amendment to a committee bill.

Your consideration of this request is deeply appreciated, and if you need additional information, please let me know.

Sincerely yours,

JOHN STENNIS.

[S. 2903, 86th Cong., 2d sess.]

A BILL To deem teachers in the State of Mississippi to be employees of such State for purposes of title II of the Social Security Act

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled, That for purposes of the agreeemnt under

section 218 of the Social Security Act entered into by the State of Mississippi with the Secretary of Health, Education, and Welfare, services of teachers in such State performed on and after March 1, 1951, and prior to October 1, 1959, shall be deemed to have been performed by such teachers as employees of the State. The term "teacher" as used in the preceding sentence means—

(a) Any licensed teacher, librarian, registrar, supervisor, principal, or superintendent, who is principally engaged in any one or any combination of, the above-mentioned educational and/or administrative capacity in the public, elementary, and high schools of this State; and

(b) County superintendent of education, county school supervisor, principal of any county or municipal public school and the employees in their offices; and

(c) Any licensed teacher engaged in any educational capacity in any day or night school conducted under the supervision of the State department of education as a part of the adult education program provided for under the laws of Mississippi or under the laws of the United States of America.

STATEMENT BY CHARLES I. SCHOTTLAND, DEAN, FLORENCE HELLER SCHOOL FOR ADVANCED STUDIES IN SOCIAL WELFARE, BRANDEIS UNIVERSITY

Mr. Chairman and members of the committee, I welcome the opportunity afforded to me by this committee to file a statement of my views on the subject of medical care for the aged.

By way of identification, I was Commissioner of Social Security from July 1954, having been appointed to that position by President Eisenhower, to December 1958, when I resigned to become dean of the Florence Heller Graduate School for Advanced Studies in Social Welfare at Brandeis University. Prior to that time, I was director of the California Department of Social Welfare to which position I was appointed by the then Governor, Earl Warren.

Since 1927, when I entered the social welfare field, I have frequently been engaged in programs involving medical care for the aged, and it is out of this experience and study that I have come to some of the conclusions which I am setting forth today.

My statement today will be brief because I think both the problem and the solution can be briefly stated.

THE PROBLEM

The problem is an easily stated one although one of gigantic proportions. The aged in the United States are increasing rapidly. Today we have 16.0 million persons over 65. Tomorrow at this time there will be 1,200 more such persons since that is approximately the daily net increase. But it is not only a question of large numbers of persons over 65. Because of the improvements in medical care and in our standards of living, more persons are living to a ripe old age. Of all persons 65 and over, more than one-third have passed their 75th birthday. One in seven is in the eighties, and most of them are women; the women exceeding the men by nearly 120 to 100. There are, I understand, more than 5,000 persons in the United States over 100 years of age and some of them are actually working and paying their social security taxes.

With old age have come the usual diseases of age and senility—diseases which are long in duration and chronic illnesses which frequently required expensive care in hospitals.

INCOME OF THE AGED

Any casual analysis of the income position of the aged in the United States reveals the very simple truth that by and large the aged in this country cannot afford to pay for expensive medical care. Sixteen percent of the aged receive old-age assistance which means that they meet very strict standards of need. Another million aged persons are receiving pensions because of the death or retirement of a Government employee or railroad worker and almost a million are receiving veterans' pensions because of previous military service. In 1956 and 1957, three-fifths of all people 65 and over had less than $1,000 in money income. The situation today remains substantially the same. Only one-fifth had more than $2,000. Of old couples with a husband age 65 and over, almost half had cash incomes of less than $2,000 in 1956. Half of the aged persons living alone or with nonrelatives had incomes of less than $900. Even this small income is not reasonably certain since much of what goes into these averages comes from employment and other sources which decrease as age increases. Al-

most half (45 percent) of the total income of the aged comes from income maintenance programs, primarily social security and other public programs.

The problem is simply stated. When the aged have expensive hospitalization or nursing home care frequently amounting to as much as $20 to $30 a day or more, they simply are unable to meet this unusual and expensive medical care bill. While I was Commissioner of Social Security, the Social Security Administration conducted a survey of the OASI beneficiaries in 1957. This revealed that among the aged couples 52 percent had medical bills of more than $200 a year; of the single persons, one-third had medical bills of more than $200. Relate these figures of medical expenditure to the limited income of the aged and the problem is clear—the aged in the United States do not have sufficient income to meet the mounting costs of hospitalization or other long-term care.

THE SOLUTION

What is the solution to the problem? In the United States we have developed one of the highest standards of medical care in the world. Our physicians, our dentists, and other members of the healing arts professions have combined to give us a system of medicine equal to any. We have learned much about the prevention, diagnosis, and treatment of disease, and I think that the medical professions and allied medical groups can take just pride in what they have accomplished, and the contributions they have made to our American society. But the prevention, diagnosis, and treatment of disease is one thing, and the economic arrangement under which persons are able to purchase medical care is another. The former is the province of the physician and the allied medical professions. The latter is the problem of all of us.

Medical care today in the United States is just like any other commodity. It is available to those who have the purchase price. If they do not have the purchase price, some may obtain such commodity by going on relief.

Now there are only a few alternative methods of obtaining the funds necessary to purchase medical care. Let me explore with you these several methods.

(1) *The individual.*—The traditional method of paying for medical care is that of payment through the individual's resources. For many aged, this can result in an excellent medical care program. But as already indicated in the few figures I have presented on the income status of the aged, very few can afford extensive hospitalization or nursing home care. For the average aged person, an occasional doctor's bill or dentist's bill or an occasional pair of glasses or drugs may be met from his income or other resources. But for the vast majority the payment of hospital bills or extensive nursing home care is out of the question. We, therefore, must become reconciled to the fact that payment of medical bills by the individual will not take care of the rank and file of aged people.

(2) *Voluntary organizations.*—A second method of handling the problem would be through philanthropic medical and social welfare agencies. Private hospitals have provided yeoman service in giving medical care to the indigent of our country, but they have reached the point where they are no longer able to serve the increasing aged population. I hope that voluntary effort through hospitals, social welfare agencies and other such groups will continue, that the sources of funds for such voluntary effort will increase, and that they will continue to make their contribution as voluntary agencies to the solution of this difficult problem. But I think that the representatives of these voluntary agencies engaged in medical care would be the first to admit that they are in no position to make substantial increased contributions to the medical care costs of the 16 million aged in the United States.

(3) *Public assistance.*—A third method of taking care of the problem would be to provide a very extensive system of public relief or public assistance for persons who cannot pay the medical care bill. This year, almost a half billion dollars will be spent by Federal, State and local communities to care for the medically indigent through public assistance and other programs. Many persons receiving old age assistance are receiving old age assistance almost entirely because of their medical care needs. In other words, were it not for medical care bills, these aged would be self-supporting or living on their old age and survivor's insurance benefits. I wonder how many Americans feel that it is sound practice to force a person to go on public relief in order to receive medical care. It seems to me that this is unsound in theory and is not in accordance with American tradition. Furthermore, public assistance is a State program. In many States, persons without income will not qualify because of

other assets such as real property. In some States, the aged do not qualify until they have been in residence for 5 years; and a variety of other restrictions makes it impractical to think of public assistance as an answer to the problem.

(4) *Voluntary insurance.*—Another approach to the problem would be through voluntary insurance. There is no question that voluntary insurance for the aged has made tremendous progress in the United States. The voluntary prepayment of hospital and medical costs has won wide acceptance and today, some 72 percent of the total population are covered by some form of hospitalization insurance. I believe that the insurance industry has made a yeoman effort to make a contribution to the solution of the problem of costs of medical care among the aged. In the past few years the percentage of aged with some form of medical insurance has risen rapidly. In the 1957 survey previously mentioned 43 percent had some insurance protection and today it is probably about 48 percent.

There is no question in my mind that voluntary insurance can make an even bigger contribution to this problem and that it will continue to do so. There is also no question in my mind that it cannot be the answer to the total problem of medical care for the aged. The reasons will be presented to this committee by others and it is not necessary to labor them here. The high cost of medical care for the aged; the fact that many aged will not be able to afford the premiums; the fact that many aged are such poor risks that the premiums would be very high; the numerous exclusions; the inability of many voluntary insurance programs to carry persons into their eighties and nineties—these and many other factors militate against any voluntary insurance program providing comprehensive medical care coverage for the aged. Furthermore, voluntary insurance cannot finance, without extremely higher premiums the many millions already aged and received medical care.

(5) *Grants-in-aid to assist the medically needy.*—Now before this committee are a variety of proposals for grants-in-aid to the States to assist aged who may not qualify for old age assistance but whose income is insufficient to pay for medical care. Presumably the States would match Federal grants with State and/or local funds, establish eligibility standards more liberal than those applying to old age assistance, and set forth the type of medical care programs to be provided.

It is my considered opinion that such grant-in-aid proposals make little contribution to a solution of this vexing problem of medical care for the aged. Many States do not even have a medical program for old age assistance recipients, or if they do it is very meager and inadequate. If these States will not establish a program for their most needy, it is not likely that they will do so for those whose income is high enough to disqualify them for old age assistance. Furthermore, such proposals proceed in the wrong direction. Our efforts should be directed to helping people out of their distress; not in devising new programs to help them in distress on the basis of a means test. These proposals are nothing more than another relief program, setting forth a means test to apply to persons who do not need or desire relief. Should we foster a program which forces elderly people to undergo a means test because they cannot afford expensive medical care? I do not believe this can ever be a satisfactory solution. It is unnecessary, undignified, contrary to those values which we hold so dearly as Americans, and in the last analysis, it will not work. Even some of the proponents of such grant-in-aid, modified-means-test proposals concede that many States will not be interested in adopting it.

The various modifications proposed to these five methods likewise will not solve the problem—public subsidy to voluntary insurance plans, grants to hospitals for various services—these and many other proposals are stop-gap measures which do not offer satisfactory solutions.

(6) *Social insurance.*—It seems to me that the solution to this problem is clear. We have developed in the United States a method of insuring against widespread social risks. We have insured against industrial accident through workmen's compensation; we have insured against old age through old age, survivor's and disability insurance; we have insured against total and permanent disability through this system, and we have insured against the contingency of death of the wage earner. We have also insured against the contingency of unemployment through unemployment insurance. In four States in the Union, we have insured against temporary disability or sickness. All of these have been done through the mechanism of social insurance.

The social security program has become thoroughly accepted by the rank and file of the people of this country as it has by the rank and file of the people of practically every western industrialized country in the world. It is a sound method of insuring against certain risks and it is in the tradition of American values in that it provides for saving during a person's working and productive years so that when the contingency insured against arises, the person will be able to take care of his problems.

A number of proposals in bills before this Congress embody medical care programs based upon this principle of social insurance. The use of the social insurance mechanism provides an opportunity through a relatively small payroll tax (a tax which I believe the American people are willing to pay) to finance the program contemplated.

I am not impressed with many of the arguments against the proposals to finance medical care for the aged through social insurance. The charge of socialized medicine is not a valid one. The use of the social insurance principle to provide economic arrangements under which medical care bills will be paid has nothing to do with socialized medicine. There is no proposal here for the establishment of Government hospitals or doctors employed by the Government to treat patients. There is nothing here to disturb the traditional patient-physician relationship. When workmen's compensation was first introduced into the United States, the same arguments were used against it as are now used against these present proposals. It was said at that time that it would destroy the physician-patient relationship and introduce socialized medicine into this country. Certainly, this has not occurred because of workmen's compensation. What has occurred is that workmen's compensation has made it possible for the injured workmen to obtain medical care and for the employer to be safeguarded from suits for injuries on the job. In the four States that provide benefits for temporary disability--namely, New York, Rhode Island, New Jersey, and California—such program has not constituted any threat to the traditional American system of medical practice.

As a matter of fact, the use of the social insurance mechanism would not prevent the Secretary of Health, Education, and Welfare from developing arrangements with existing organizations such as Blue Cross or with existing hospitals to pay for the cost of medical care to such hospitals in exactly the same way that Blue Cross now reimburses such hospitals.

CONCLUSION

In my experience I have run across numerous tragedies among the aged because of the high cost of medical care. I have seen persons who saved for their old age, who owned their homes and had substantial assets, reduced to destitution because of prolonged illness; I have seen persons go on relief who had always been self-supporting until they reached their seventies and eighties and medical costs forced them to seek public assistance. I do not believe that a society such as ours, conscious of its medical needs, cannot afford good medical care without such hardship and humiliation. In the distant past, men frequently resigned themselves to such a situation. But today our people have made the discovery that there is a way to insure against various social risks; namely, through the device of social insurance—a device that is now keeping millions of Americans from the hardships and poverty which otherwise would have come because of unemployment, old age, death of the wage earner, disability or industrial accidents. The problems of medical care for the aged are national problems in which all citizens have an interest. The Congress has it in its power to make a contribution to the solution of the financial aspects of these problems through financing a program in the same manner now used to finance cash benefits to the unemployed, aged, widows, surviving children, and disabled. The machinery of social insurance has proved successful and has been administered soundly, efficiently, and economically in connection with old-age, survivor's, and disability insurance. In other democratic and free countries, the extension of this principle to medical care has been found successful. It does not involve any fundamental change in the physician-patient relationship. It would be the beginning of a solution to this very vexing problem, and I respectfully express the hope that the members of this committee, after due deliberation and the weighing of all of the testimony and evidence, will give to this approach to the solution of the medical care problems of the aged, the same favorable consideration which they have given to other social insurance programs which have been approved by this Finance Committee of the Senate of the United States.

U.S. SENATE, *June 28, 1960.*

HON. HARRY F. BYRD,
Chairman, Finance Committee,
U.S. Senate, Washington, D.C.

DEAR SENATOR BYRD: Permit me to submit for your consideration the attached communications which have come to me from the public employees retirement system of Ohio with reference to H.R. 12580, the omnibus social security bill which is presently pending before your committee.

You will note that concern is expressed over the possible amending of the bill in your committee to permit what is known as the divisional method of voting on social security.

Interest is also expressed in the passage of an amendment which would provide that at the option of the public employee who is covered by a statewide retirement system, but not covered by social security, he could secure such social security coverage as if he were a self-employed person.

I hope your committee will give careful consideration to the views expressed by the public employees retirement system of Ohio when this legislation comes up for official action.

With kindest regards, I remain,

Sincerely yours,

FRANK J. LAUSCHE.

PUBLIC EMPLOYEES RETIREMENT SYSTEM OF OHIO,
Columbus, June 16, 1960.

MR. RAY M. WHITE,
Secretary to Senator Frank J. Lausche,
Senate Office Building, Washington, D.C.

DEAR RAY: It was good to see you and Joe on June 3. Too, I want to express to both of you again my appreciation for seeing me even though I had not had an opportunity to ask for an appointment.

Incidentally, through the assistance of some of our friends over in the House we were successful in having deleted from the pending social security legislation the amendment which was so objectionable to our people and to public employees in several other States, particularly Illinois, Colorado, and California. The amendment was another "back door" attempt by the social security staff and a small minority group in these States, including Ohio, to slip social security coverage in for a handful of public employees over the objection of the overwhelming majority.

Here is how it would have worked. It is known as the "divisional" method of voting on social security. The explanation (by the proponents) sounds fair enough—but. It goes like this—all public employees in a given State (any of the 50) would be given an opportunity to vote on social security coverage and those who want it get it and those who don't stay in the local retirement system. This is the fair-sounding part. But—if there are 156,000 public employees in the State (as there are in PERS in Ohio) 1,000 or 100, or theoretically just 1 affirmative vote could affect the future equity of the other 155,000 plus. Why? Because the joker is that while currently only the 1,000 or 100 or 1 who voted for social security coverage would be covered, however the social security law would bind all future entrants into social security instead of into PERS. Consequently, in future years fewer and fewer employees would be covered by PERS and more and more employees would be covered by social security. Too, more and more (as the rates advance and as more employees are covered) of the employers' payments would go to social security instead of to our system.

The only possible end result would be an ever-increasing weakening of our financial structure and the complete loss of our greatest asset, actuarial soundness. The only offset to this destruction would have been to sock the taxpayers of Ohio some $15 million per year (currently—in 1969 or sooner if the rates advance, as most certainly they will, the cost would be above $22 million) by adding social security coverage on and above the present PERS plan. Not only that but if it was added for our people the school teachers and school employees in Ohio would demand equal benefits and boom, the cost would double.

So, I think you and Joe and the Senator can understand why we were so intent on eliminating the cancer in the House. Undoubtedly we will have to guard against the reinsertion of the amendment in the Senate Finance Committee when the bill gets over there.

Yours very truly,

FRED L. SCHNEIDER.

PUBLIC EMPLOYEES RETIREMENT SYSTEM,
Columbus, Ohio, June 16, 1960.

Supplemental Memo No. 1.
To: Mr. Ray M. White.

As I explained to you and Mr. Scanlon in your office on June 3 we (the three State retirement systems—Teachers, School Employees and Public Employees—here in Ohio) together with large groups of public employees in other States are interested in one phase of social security legislation. We feel an amendment inserted in H.R. 12580 (the omnibus social security bill which in some form now seems certain of passage at the current session of Congress) in section 218(d) would provide an equitable and working solution to the problem of social security coverage for public employees, which has been with us in almost every session of Congress since 1945.

This amendment simply would provide that at the option of the public employee who is covered by a statewide retirement system but not covered by social security could secure such social security coverage as if he were a self-employed person. This would mean two things:

First—That only those who were interested would apply for coverage and would pay both the employee and the employer cost. Just as he would if he wanted to go out and buy an annuity.

Second—That the employer would not be saddled with this extra and ever increasing cost. Nor would the actuarial soundness of the System and the equity of the thousands of members be threatened.

Now, we know the Social Security staff will cry discrimination and malarky about unfair selection. I say "malarky" because if ever there is "unfair selection" the "divisional" voting proposal is exhibit A. Too, the history of social security legislation is full of far worse examples of adverse selection.

As I am certain you understand we shall hope to get the amendment to permit public employees to be considered as self-employed for social security coverage purposes included in H.R. 12580 when it is up for consideration by the Senate Finance Committee. At that time we hope you and Senator Lausche will support and guide our actions.

In order to give you some further assurance that there is substantial support for this self-employed status amendment I am attaching a photocopy of a resolution passed on June 4 by the National Conference on Public Employees Retirement at its annual Conference at the Manger Hamilton Hotel, Washington, D.C. Membership in the National Conference includes the retirement administrators of public employees in more than 40 of the States.

Cordially yours,

FRED.

NATIONAL ASSOCIATION OF STATE RETIREMENT ADMINISTRATORS

As you can see here is a national organization which is the largest group of retirement systems interested in the two phases of the Social Security Act mentioned in my letter.

COMMERCE & INDUSTRY ASSOCIATION OF NEW YORK, INC.,
New York, N.Y., June 29, 1960.

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

DEAR SENATOR BYRD: Yesterday we sent you the following telegram on H.R. 12580 because reports indicated your committee was considering this legislation only in executive session:

"Although we are not in accord with every provision of H.R. 12580, as passed by thte House of Representatives, we favor on balance enactment of this legislation. We remain, however, unalterably opposed to a compulsory medical care program of the Forand type."

Since public hearings now are planned, we respectfully request that the following additional views of this association on this important subject be placed in the record for consideration by your committee.

As has been stated, we favor on balance H.R. 12580 as passed by the House. We are firmly opposed, however, to mandatory legislation, financed through

an increase in social security taxes, providing medical care for the aged. Our reasons follow:

Mandatory health insurance would not bring about an increase in either the quality or the quantity of medical care now available. The threat of regulated medicine inherent in such legislation would discourage promising candidates from preparing for the medical profession, thereby aggravating the shortage of doctors and slackening the advances that have been so characteristic of free medicine.

Emphasis has been placed upon the high cost of medical care and the small cash income of the aged. Actually low cash income alone does not necessarily prove inability to pay. A 1957 survey by the Health Insurance Foundation indicated 88 percent of the aged reported that they could pay a medical bill of $500. In the same year, half of the OASI beneficiaries had medical expenses of less than $100 and 88 percent less than $500.

Furthermore, the number of old people who have resources to meet their medical expenses is increasing by reason of the ever-expanding voluntary medical care plans for the aged which are provided by Blue Cross-Blue Shield, individual and group insurance policies of private companies and group practice plans. With so many able to take care of their own requirements it seems unnecessary and wasteful to provide benefits for all regardless of need.

Few realize the amount of medical care of the aged now financed by various levels of government. The Federal-State assistance program, hospital care paid for by State and local governments outside the assistance program, the Veterans' Administration medical program and the medical expense deduction under the Federal income tax law currently benefit 5 million aged at a total annual cost of $900 million. When we add the free care provided by doctors and various charities, it is hard to believe that there are many aged who need medical care they cannot obtain.

As many qualified actuaries have testified, the Forand or similar type bills proposing an increase in social security taxes on both employers and employees appear not to have adequately judged the cost of services to be provided, even in the first year of operation. Undoubtedly, these costs would increase substantially with the passage of time because (a) there would be more eligible OASI recipients and (b) the availability of free hospital service would increase its use, often as a convenience rather than as a necessity among aged persons. Experience in Canada and Britain indicates that utilization rates might increase by 50 to 60 percent. Furthermore, any program of health benefits for all social security beneficiaries will entail, of necessity, substantial increased taxes on active employees. How long will active employees be willing to carry such an increasing tax burden?

Finally, we believe that the OASI program should not provide services—that the individual should be left free to apportion his own resources between food, clothing, shelter, medical care and other requirements. In our system of individual freedom of the citizens to determine his own economic welfare, the Government should provide assistance only where demonstrated individual need makes help imperative. In those instances where the aged individual finds himself in need, the Federal-State assistance program will come to his aid.

If medical care is made "free" for any age segment of the population, we will have taken a significant and irreversible step toward similar medical care for the entire population. Government management of the financing of medical care, no matter what name may be given to the scheme, is in fact a long step toward socialism itself.

Accordingly, Commerce and Industry Association strongly urges that no affirmative action be taken on any mandatory health insurance legislation but that H.R. 12580 as passed by the House of Representatives be enacted.

Sincerely yours,

RALPH C. CROSS, *General Manager.*

CLARKSBURG, W. VA., *March 17, 1960.*

Re the Forand bill (H.R. 4700).

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

HONORABLE SIR: You now have before you the controversial Forand bill and I would like to, if I may, call your attention to a few facts with which, no doubt, you may already be familiar.

The annual income of the Nation's older population, those 65 and over, has increased by at least $6 billion in the aggregate since the midfifties to the neighborhood of $30 billion, a rate of growth in keeping with the general rise and income levels and the progress of the economy during this period. There are some 15 million persons 65 and over as against 13½ million in 1954.

I am approaching retirement and, in fact, in about 2 more years will be eligible for retirement and during my lifetime I should have been able to save a substantial amount of money for retirement but because of the confiscatory taxing situation which the American public has forced upon them by the politicians, I am unable to retire when I should be enjoying the sunset years of life.

Now we have another bill before us (H.R. 4700) which will only burden the American tax people with further unnecessary taxes.

Here's a segment of the population with income of $30 billion and the politicians in Washington want us to further augment that income by furnishing them with free hospitalization, medical, nursing home, and surgical benefits. My question is this: Why should one segment of the population be subsidized at the expense of the rest of the population, and in connection with that, I'm now thinking, not only of this legislation, but also the farm subsidies which, is my estimation, is a crime and a disgrace.

The income figures in connection with those over 65 disclose an outstanding area of growth in the classification of pension plans and individual annuities. Annual benefits paid under these programs, insured and not insured combined, almost doubled in the 1954–58 period, rising from approximately $800 million in 1954 to an estimated $1½ billion in 1958. The number of pensioners 65 and over under private plans was around 1½ million in 1958.

Public programs backed by the taxing power also experienced a marked growth in the 1954–58 period. Benefits under these programs increased from $5.9 billion in 1954 to a range of $10.5 billion to $11 billion in 1958. The major element is old-age and survivors benefits, representing about three-fifths of the total. The other programs are railroad retirement, government employees retirement, veterans programs, and public assistance.

Individual savings and investment programs are contributing a large sum to the income of the 65-and-over group. The 1959 total here was estimated at a range of $3.5 billion to as hight as $8 billion from interest, dividends, rents, and so forth, as compared with under $4 billion in 1954.

The American taxpayers are presently committed to expenditures of over $1 trillion. One-fourth of the total, or upward of $250 billion, is marked for payment of the present social security obligations. The fastest growing item in Federal spending is not defense but social welfare programs which have been increasing at the rate of $1 billion a year since 1953.

Federal welfare spending will amount to more than $20 billion during the next fiscal year. For the year ending June 30, 1958, special welfare expenditures at all levels of government amounted to $44 billion, 10 percent of the national output.

I'm of the old school. I believe the people should support the Government and not the Government the people.

Another point that I would like to make is the fact that this proposal to raise social security benefits would put an unfair tax burden on wage earners, and ultimately would reduce American's power to advanced living standards for everyone. Frankly, I do not believe that these over-age-65 people need aid and assistance from the U.S. Government. They are, of course, indigents. We will always have indigents in our population, and they are being taken care of by the States, counties, and cities to the tune of many billions of dollars every year.

There's no doubt in my mind but what the Forand bill, if passed, will simply be an opening wedge or crack in the door for eventual socialized medicine.

We hear on every hand about creeping socialism. In my opinion, it is no longer creeping, it has now reached a gallop and apparently the two old parties, the

Democrat and Republican are trying to outdo each other in giving away their American taxpayers' hard-earned dollars.

Summing this up you can only reach one conclusion and that is the fact that the politicians in Washington are indirectly trying to buy votes with these handouts and what a shameful and shocking situation where the Senate and Congress are trying to perpetuate themselves in office at the expense of the taxpayer and also with the possibility by adding these burdens to the Social Security Act may eventually cause its complete collapse.

I wonder if the Senate and the Congress of the United States realize that in 10 more years without any additional burdens being placed on the workers of this country, they and their employers will be paying 9 percent of the total wages earned simply to keep social security in the black. When we start adding such bills as the H.R. 4700 and 200 or 300 others which are floating around the Senate and House floors to this already staggering take from the taxpayer you can readily see that in another 10 or 20 years we may be paying as much as 15 to 25 percent to the social security fund.

We earnestly solicit your good help in defeating this class legislation.

Very truly yours,

S. FRANK STOUT.

BROOKLYN BUREAU OF SOCIAL SERVICE AND CHILDREN'S AID SOCIETY
Brooklyn, N.Y., June 24, 1960.

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

DEAR SENATOR BYRD: We are writing to express our strong conviction that any legislation for the inclusion of health benefits for the aged be incorporated within the existing framework of the Social Security Act's Old-Age, Survivors, and Disability Insurance system.

Any other arrangement seems to us to be wasteful and in the long run will defeat the objectives of such legislation.

We would appreciate your incorporating our statement in the official record of any hearing on the matter that the Senate Finance Committee may hold.

Sincerely yours,

FREDERICK I. DANIELS,
Executive Director.

AMERICAN HOSPITAL ASSOCIATION,
Washington, D.C., June 21, 1960.

Hon. HARRY FLOOD BYRD,
Chairman, Senate Finance Committee,
Senate Office Building, Washington, D.C.

DEAR SENATOR BYRD: We are concerned about the provisions of H.R. 12580 which would remove the exemption of medical interns from the provisions of the Social Security Act. As you know, there were no hearings on this bill in the House, and so far as we are aware there has been no consideration of the fact that such interns are primarily students. The proposed coverage of self-employed physicians is not, we believe, sufficient reason to extend such coverage back into the educational period which precedes active practice—which in many States, indeed, is a prerequisite to licensure to practice.

Much effort has been devoted to maintaining and developing internship programs as a part of the educational process, with the American Medical Association prescribing educational standards as a condition for its approval of internships. Though admittedly there is an element of service in the approved internship, we believe it is and should be wholly incidental to the educational aspects. The internship is the period in a physician's education when he receives his basic instruction in patient care; it is an indispensable part of his education and of his preparation for practice. We believe that denominating this period as primarily one of employment, and subjecting the small stipend to an employment tax would jeopardize the educational focus which we think is so important to maintain.

We would accordingly urge the deletion of subsections (c) and (g) of section 104 of H.R. 12580 (p. 46, lines 5 and 6, and p. 47, lines 21 and 22, of the bill as introduced).

Sincerely yours,

KENNETH WILLIAMSON, *Associate Director.*

AMERICAN HOSPITAL ASSOCIATION,
Washington, D.C., June 29, 1960.

Hon. HARRY FLOOD BYRD,
Chairman, Senate Finance Committee,
Senate Office Building, Washington, D.C.

DEAR SENATOR BYRD: Thank you for your acknowledgment of my letter to you of June 21 in regard to H.R. 12580 and the particular provisions of that bill which would remove the exemption of medical interns from OASDI coverage. I reiterate our hope that your committee will delete these provisions from the bill.

There is one other provision of this bill upon which we would like to comment. This is title VI entitled "Medical Services for the Aged."

This provision is in accord with two principles long advocated by this association. The first of these is the earmarking of funds to be spent for health services to needy groups, through the method of vendor payments, so that such funds are not administered in competition with funds needed to meet the other necessities of life of such persons. We believe that this approach is likely to improve health planning for the recipients and will prove an important means of encouraging even greater responsibility on the part of the State and local health agencies in relation to the services to be provided. Thus, improvement in the quality of care rendered should result.

This association has also long advocated that recognition be given to the need for financial assistance in meeting the health care costs of many individuals who do not need assistance for their normal expenses of living. This refers to the group usually called the medically indigent. We are pleased that the bill also would provide further Federal matching to States which improve their health care programs for the indigent aged.

We believe that title VI of H.R. 12580 would further encourage States to develop programs making health services available to the medically indigent as well as the indigent among the aged.

We would appreciate your including this letter in the record of your hearings on the bill.

Sincerely yours,

KENNETH WILLIAMSON, *Associate Director.*

AMERICANS FOR DEMOCRATIC ACTION,
Washington, D.C., June 27, 1960.

Hon. HARRY FLOOD BYRD,
Senate Office Building,
Washington, D.C.

DEAR SENATOR BYRD: We write in support of legislation which would utilize the social security system to provide medical insurance for the aged—the principle contained in H.R. 4700, sponsored by Representative Forand, and S. 3503, sponsored by Senator McNamara.

As a group of physicians, our support for the Forand bill is dictated by a belief that social insurance against the costs of illness is in the best interests of the patient and the medical profession, as well as the Nation.

The facts about the inadequate income and huge medical needs of older people have been presented in detail to congressional committees and are well enough known not to need repetition here. It is equally clear that private insurance plans are not, and cannot be, sufficient to meet the requirements of older people as a group. We have had enough experience with these plans to know that the "poor risk" designation of this group leads inevitably to inadequate coverage, exorbitant premiums, cancellation of insurance, or a combination of all three.

The medical and hospital costs of older people can be made self-supporting only if they can be averaged out by level premiums over the adult lives of the insured and the risk distributed as widely as possible. For such a purpose, the OASDI system is uniquely suitable. Use of the social security system is fair and equitable because no person can claim immunity from the need for protection against the infirmities of age, illness, and loss of income.

Legislation proposed by the administration, Senator Javits, and others as an alternative to the Forand approach is inadequate and impracticable. These measures would impose a means test as a prerequisite for coverage and would place a large financing burden on States unable to meet it. The difficulties

imposed by widely dispersed private administration of the plan and the need to negotiate contracts with a multitude of insurance carriers are overwhelming and unnecessary.

As physicians, we approach this as a problem of health. The prime objective of a health program for any part of the population is to keep people well, out of the hospitals, and to meet their medical needs fully as they arise. Under present conditions of neglect, patients often receive attention only in emergencies when medical treatment may prove least effective and the drain upon the resources of hospitals is a serious threat to the quality and availability of needed services.

In this respect, the hospital coverage provided by the Forand bill, while perhaps a necessary first step, is by no means an adequate solution. If the emphasis is to be upon preventive medicine, a workable program requires the inclusion of outpatient as well as inpatient services, nursing, and personal services in the home and measures for rehabilitation. Senator McNamara's bill, which places more emphasis on preventive medicine, thus is to be preferred. Investment in such a program would be more than repaid in its contribution to the health and human resources of the Nation.

We welcome the Forand-McNamara measures as a useful first step in meeting a paramount problem of our society, and we urge you to work for their passage. We feel confident that Congress will not permit itself to be immobilized by slogans which were outdated when social security became a fact a quarter of a century ago.

Sincerely yours,

Herbert K. Abrams, M.D., Medical Director, Union Health Service, Inc., Chicago, Ill.; E. M. Bluestone, M.D., New York, NY; Morris Brand, M.D., Medical Director, Sidney Hillman Health Center, New York, N.Y.; Allan M. Butler, M.D., Professor of Pediatrics, Harvard Medical School, Chief of Children's Medical Service, Massachusetts General Hospital, Boston, Mass.; Martha M. Eliot, M.D., Professor of Maternal and Child Health, Emerita, Harvard School of Public Health, Cambridge, Mass.; Frank F. Furstenberg, M.D., Medical Director, Outpatient Department, Sinai Hospital of Baltimore, Md.; Palmer H. Futcher, M.D., Baltimore, Md.; Franz Goldman, M.D., Associate Professor of Medical Care, Emeritus, Harvard School of Public Health, New York, N.Y.; Alan F. Guttmacher, M.D., Obstetrician & Gynecologist-in-Chief, the Mount Sinai Hospital, New York; Manfred Guttmacher, M.D., Chief Psychiatrist, Supreme Court Bench, Baltimore, Md.; Ursula M. Hober, M.D., Chief, Department of General Practice, Woman's Hospital, Philadelphia, Pa.; Philip M. LeCompte, M.D., Pathologist, Faulkner Hospital, Clinical Assistant Professor, Harvard Medical School, Boston, Mass.; Louis Leiter, M.D., Chief of Medicine, Montefiore Hospital, New York, N.Y.; Edward C. Mazique, M.D., President, National Medical Association, Washington, D.C.; Raymond C. McKay, M.D., Associate Clinical Professor of Medicine, Western Reserve University, Cleveland, Ohio; James Howard Means, M.D., Professor Emeritus, Harvard Medical School, former Chief of Medical Services, Massachusetts General Hospital, Boston, Mass.; Frederick D. Mott, M.D., Executive Director, Community Health Association, Detroit, Mich.; Milton I. Roemer, M.D., Associate Professor of Administrative Medicine, Cornell University, Ithaca, N.Y.; Leonard S. Rosenfeld, M.D., Metropolitan Hospital, Detroit, Mich.; William A. Sawyer, M.D., Medical Consultant, International Association of Machinists, Washington, D.C.; Alfred S. Schwartz, M.D., Clayton, Mo.; George Silver, M.D., Chief of Social Medicine, Montefiore Hospital, New York, N.Y.; Benjamin Spock, M.D., Professor of Child Development, Western Reserve University, Cleveland, Ohio; Park J. White, M.D., St. Louis, Mo.; Ernst Wolff, Senior Pediatrician, Mount Zion Hospital, San Francisco, Calif.; Harry Zimmerman, M.D., Chief of Pathology, Montefiore Hospital, New York, N.Y.; Martin Cherkasky, M.D., Director, Montefiore Hospital, New York, N.Y.; Richard L. Riley, M.D., Baltimore, Md.; Albert I. Mendeloff, M.D., Baltimore, Md.

BELLAIRE, OHIO, *June 29, 1960.*

HARRY BYRD,
Chairman, Senate Finance Committee,
Washington, D.C.:

Would like to appear before committee to testify for health care for aged through contributory social security system. If committee schedule too busy for me to be heard would like this wire read into record.

Dr. MURRAY B. HUNTER, *Bellaire Clinic.*

AMERICAN NURSES' ASSOCIATION, INC.,
New York, N.Y., June 24, 1960.

Hon. HARRY FLOOD BYRD,
Chairman, Committee on Finance,
U.S. Senate, Washington, D.C.

DEAR SENATOR BYRD: In 1958, the House of Delegates of the American Nurses' Association, recognizing that certain groups in our population, the aged, retired, and disabled, do not have adequate protection against the financial hazards of illness, adopted a position supporting the extension of the social security system to include health insurance coverage for these beneficiaries of the program. In May of this year, in convention, the house of delegates emphatically reaffirmed this position.

In 1958 and 1959, ANA testified on bills sponsored by Representative Forand (Democrat, Rhode Island), approving in principal the proposals in these bills but pointing out the need for including nursing benefits under social insurance and calling attention to the lack of standards for nursing homes and effective regulations to insure safe care. A copy of our 1959 testimony is attached to this letter and we request that both be included in the hearings you are conducting.

We have been gratified that recent proposals introduced in the Senate have included nursing benefits and diagnostic, preventive, and rehabilitation services. We are also pleased that legislators are aware that the quality of care in nursing homes needs to be upgraded substantially.

In taking the position in support to the extension of social security to include health insurance coverage, the ANA indicated its concern for the health needs and related financial problems of many millions of Americans and its recognition that nurses have small incomes and on retirement will also be faced with the problem of maintaining a decent standard of living and securing needed medical care services.

We believe that using the social security mechanism to solve the problem of financing health care is more reasonable, dignified, and appealing to the people of this country than a solution that requires the States to participate in what is another, and very limited, program of public assistance.

Sincerely yours,

Mrs. JUDITH G. WHITAKER, R.N.,
Executive Secretary.

STATEMENT OF JULIA C. THOMPSON, WASHINGTON REPRESENTATIVE, AMERICAN NURSES' ASSOCIATION

The American Nurses' Association is the national organization of over 190,000 registered professional nurses in 54 constituent State and territorial associations. As one of the professional groups deeply concerned with providing health care for the American people and as the largest single group of professional persons giving that care, we welcome this opportunity to present our views on the proposal before this committee.

In the interest of society at large and in the interest of its members, the American Nurses' Association has supported the Social Security Act and extensions and improvements in the contributory social insurance which it provides. In 1956, the ANA supported the eligibility of insured individuals over 50 years of age for disability benefits and at the same time supported the proposals for lowering the retirement age limit for women to 60.

The American Nurses' Association now supports the extension of contributory social insurance to provide health insurance benefits for the beneficiaries of old-age, survivors, and disability insurance. The position of the ANA on the meas-

ure before you can best be stated by reading to you a resolution, approved by the ANA House of Delegates at its convention in June 1958:

Whereas necessary health services should be available to all people in this country without regard to their ability to purchase; and

Whereas prepayment through insurance has become a major and an effective method of financing health services; and

Whereas certain groups in our population, particularly the disabled, retired, and aged, are neither eligible nor able to avail themselves of voluntary health insurance: Therefore be it

Resolved, That the American Nurses' Association support the extension and improvement of the contributory social insurance to include health insurance for beneficiaries of old-age, survivors, and disability insurance; and be it further

Resolved, That nursing service, including nursing care in the home, be included as a benefit of any prepaid health insurance program.

The benefits of modern medical science should be available to all citizens of this country. Health services which are essential to social well-being are expensive and likely to become more so in the years ahead. Without insurance protection against the costs of illness, the disabled, retired, and aged must often depend on public relief in times of sickness. As the number of retired aged in our population increases, a larger and larger financial burden for their medical care will have to be borne by the public. Certainly, insurance coverage against the costs of illness which may occur after retirement, which insurance can be paid for during the working years, would be less costly to the public than tax-supported public relief for health care—a dependency which is distasteful and degrading for citizens of this country.

Insofar as it provides health insurance coverage for beneficiaries of old-age, survivors and disability insurance, ANA supports H.R. 4700. However, we wish to point out that health insurance, particularly for the aged, should be broader than coverage of the costs of hospital, nursing home and surgical services. With the increase in experimentation in outpatient clinics and the growth of home-care programs, we believe health insurance should cover such care as well. Home-care programs are particularly useful for the long-term illnesses of the aged, such as heart disease, cancer, arthritis—and the cost to the individual of such care should be covered by health insurance.

Coverage also must include nursing care. Nursing is an essential component of modern medical care and must be available if the benefits of medical science are to be provided for the aged and disabled. Beneficiaries of any health insurance should be insured against the costs of needed private duty nursing services no less than they are insured against surgical costs. Coverage also should include public health nursing care in the home as well as nursing home costs.

An indication of the need for coverage of nursing care received by the aged is the amount of such care provided by visiting nurse associations. In the District of Columbia, for example, during the first 5 months of this year, 35 percent of the nursing care visits of the Visiting Nurse Association were made to patients over 65 years of age. Yet, according to the 1950 census, persons 65 and older made up only 7 percent of the district population.

A breakdown of cases seen by the Visiting Nurse Association of Houston during 1 week in February 1958 shows that of the 366 nursing visits made, 272 were to persons 60 years of age and older, and 195 of these were to patients 70 and older.

The Visiting Nurse Service of New York reports that in 1958, persons 65 years of age and older made up 25 percent of the patients of the Visiting Nurse Association of New York and the Visiting Nurse Association of Brooklyn. These older patients received half of the 485,000 visits made by the nurses of these two agencies.

We cite these examples merely as an indication of the extent of home nursing care needed by aged persons. We believe such care will increase as more emphasis is placed on home-care programs and care of the chronically ill outside the hospital.

Recognizing the many problems involved, we urge the inclusion of nursing service as a benefit of health insurance for beneficiaries of OASDI. The ANA is, at this time, developing principles which should govern nursing services in prepaid medical care plans which we will be anxious to share with this committee or any administrative agency responsible for such a plan as soon as the statement is completed.

At this time, we wish to call attention to the poor conditions prevalent in nursing homes throughout the country. To provide a means of payment for nursing home care through social insurance will not be enough. All groups concerned with meeting the health needs of the aged in our population must work to raise the levels of care provided in nursing homes, the majority of which are proprietary institutions.

We note that in H.R. 4700 a nursing home, to be eligible for payment under OASDI, must be licensed according to the law of the State in which it is located. Unfortunately, in many cases such State regulation is not adequate to insure safe nursing care in the homes licensed.

Our concern in this matter is obvious, since nursing is the primary and largest service offered by these homes, and the nursing profession is responsible for standards of nursing practice no matter where that practice is carried out.

To protect both the insurance system and the beneficiaries, provisions for payment for nursing home services should clearly define the type of service to be covered. Every precaution should be taken to prevent the financing of substandard institutions through social insurance payments.

We believe that the term "nursing home" should apply only to that facility which provides skilled nursing care on a 24-hour basis under the supervision of a professional nurse. When a nursing home offers intensive and complicated nursing care, requiring professional skill and judgment, it must be prepared to employ professional nurses to give such service. We urge your careful consideration of the type of nursing home care which is to be covered by social insurance.

Insurance protection against the financial hazards of illness in retirement is not now available to the majority of those who need it. Neither voluntary nonprofit nor commercial insurance programs offer the needed protection at the cost and method of payment possible for those living on a limited retirement income. Extension of the most universally held insurance, the old-age, survivors, and disability insurance, would appear to be the most feasible method of providing this coverage.

This committee must have a great deal of data from many sources on the need for health insurance for our growing aged population. However, I would like to mention the situation which employees face in the hospital industry, in which the largest group of our professional nurses are employed.

American hospitals employ a total of approximately 1,300,000 workers. This is more than major industries such as basic steel, automobile, and interstate railroads. More than one-half of these workers are employed in nongovernmental hospitals. During 1956 and 1957, the Bureau of Labor Statistics conducted a study of "Salaries and Supplementary Benefits in Private Hospitals" in 16 metropolitan areas covering 400,000 full-time hospital employees. At the time of the study, fewer than half of these employees were covered by pension plans other than OASDI. In one city, the number of employees covered by retirement plans in which the hospital participated was as low as 2½ percent.

This situation, coupled with the well-known fact that salaries in hospitals are low, means that the majority of these employees will be dependent, after retirement, on OASDI benefits for their income. With the low wages prevalent in the hospital industry and many nonprofessional workers earning less than the Federal minimum, these employees cannot save for retirement and will not be able to pay for health insurance after their retirement.

I wish to thank the committee for this opportunity to present the views of the American Nurses' Association on the extension and improvement of the Social Security Act. The ANA will be happy to furnish any additional information within the scope of its activities which the committee wishes to have.

ASSOCIATION OF CASUALTY & SURETY COMPANIES,
New York, N.Y., June 24, 1960.

Re H.R. 12580, duplication of workmen's compensation and social security disability benefits.

Hon. HARRY F. BYRD,
U.S. Senator, Senate Office Building,
Washington, D.C.

DEAR SENATOR BYRD: The above captioned bill would, among many other amendments to the Social Security Act, considerably increase the area of duplication of social security benefits and workmen's compensation. On behalf of our

member companies we respectfully urge reenactment of the offset provision which would avoid such duplication.

In view of the concern which has been expressed over the cost of broadening social security benefits in areas where protection is presently lacking, it seems particularly inappropriate to duplicate benefits already provided by State laws. You are respectfully urged to avoid this unnecessary tax burden.

A somewhat more detailed memorandum on the subject is attached.

Sincerely yours,

J. DEWEY DORSETT, *General Manager.*

MEMORANDUM CONCERNING H.R. 12580 BY MR. MILLS AND THE DUPLICATION OF WORKMEN'S COMPENSATION AND SOCIAL SECURITY DISABILITY BENEFITS

This memorandum is being submitted on behalf of the Association of Casualty and Surety Companies, an organization with a membership of 133 stock insurance companies most of which write workmen's compensation insurance throughout the United States.

The above captioned bill, by greatly liberalizing the eligibility requirements for social security disability benefits, would newly make compensable under that act a great many cases presently covered by State workmen's compensation laws. This would constitute an inequitable duplication of benefits for the same injuries. The new application of the Social Security Act to such cases would also be a long step toward the federalization of the State workmen's compensation system. For close to 50 years compensation for industrial injuries has been provided under State workmen's compensation laws. The interests of employees and employers would best be served by the retention of that system.

Disability payments were first provided under the Social Security Act in 1956. However, at that time an offset provision was included (sec. 224) with respect to payments under workmen's compensation laws. Thus no duplication existed in this area. However, in 1958 this offset provision was repealed as part of extensive amendments to the Social Security Act. No hearings were held on the measure that was enacted. Moreover, no hearings have been held at any time, either by a Senate or House committee, where the serious impact of an elimination of the offset provision has been discussed from a workmen's compensation viewpoint.

Up to the present, however, the impact of this duplication has been relatively limited. The eligibility requirements presently contained in the Social Security Act have been such as to restrict the area of duplication to comparatively few cases. No benefits are payable to persons under 50 years of age, a 6-month waiting period is required and the definition of disability limits payments to actual cases of permanent total disability. No attempt has, therefore, been made up to the present to restore the offset provision.

H. R. 12580, presently before you for consideration, would eliminate the requirement that one must attain the age of 50 to be entitled to disability benefits. It would also make exceptions to the requirement of a 6-month waiting period and provide for a trial period after return to work during which benefits would have to be paid. This legislation, if enacted, would greatly enlarge the area of duplication. The added cost of social security benefits as a result of these changes has been estimated for the year 1961 at $200 million by the House Committee on Ways and Means (H.Rept. 1799, 86th Cong., 2d sess., p. 43). This makes restoration of the offset provision imperative.

Social security benefits when pyramided on top of workmen's compensation benefits, which are large in a number of States, would impose a completely unnecessary cost on the public, including both individual taxpayers and industry. We also believe it is socially undesirable to provide systems of disability benefits producing such substantial sums of income that there is no incentive to return to work.

In Arizona, for example, if social security benefits were added to workmen's compensation a tax free income of $904 a month could be produced, payable for life. In Hawaii, weekly compensation alone for partial disability can amount to $112, and for total disability $75. In Alaska $100 is payable for temporary total and partial disability and $52.65 for permanent total. In California, maximum weekly compensation is set at $65 for temporary total and $52.50 for permanent. Compensation is generally payable at the rate of two-thirds of average weekly wage, subject to a weekly maximum which ranges from $150 in Arizona to $30 in only one State. These benefits are constantly being increased.

Let us take a specific example: In Massachusetts, according to the U.S. Department of Labor (Monthly Labor Review, June 1959, p. 720) the average weekly earnings for production workers in manufacturing is $79. For an employee, who is totally disabled, with a wife and two children, his compensation would amount to $63 a week. If social security were added to his compensation, the total would exceed his average weekly wage, all tax free. He would lose considerable income by returning to work. Monthly social security disability benefits for an employee with a young wife and one or more children average $167.80 and with an old wife and one or more children $197 (Annual Statistical Supplement, 1958, Social Security Bulletin, March 1960, p. 41). It is likely that in many States social security benefits if added to compensation would often approach or exceed average weekly wages or, at least, take-home pay. This would hardly encourage rehabilitation.

Industry already has expressed serious concern about the burden being placed on the national economy by the social security system. The New York Journal of Commerce, March 7, 1960, page 10, quotes the National Association of Manufacturers as indicating that "the liabilities against the old age and disability insurance fund now stand at some $360 billion. Of this enormous sum, only about $21 billion is funded. The unfunded part—some $340 billion—exceeds the national debt by about $50 billion." It hardly seems appropriate to add to this burden by duplicating payments under State workmen's compensation laws. In this connection, it is worth noting that total workmen's compensation payments in the United States for the year 1958 amounted to $1,113,253,000 (Social Security Bulletin, December 1959, p. 15). Moreover, the report of the House Committee on Ways and Means on Social Security Amendments of 1960 (H. Rept. 1799, 86th Cong., 2d sess., p. 49) gives a low estimate of social security disability payments for 1965 (the most recent indicated) of $820 million and a high estimate of $1,231 million.

The cost to the taxpayer cannot be ignored. Already 6 percent of taxable payrolls are funneled into the social security system. Even at present benefit levels it is scheduled to be raised to 9 percent after 1968. In considering the imposition of additional obligations upon the system the avoidance of undesirable duplication should deserve careful consideration.

In the report of the Committee on Finance on Social Security Amendments of 1958 (S. Rept. 2388, 85th Cong., 2d sess.), it is stated that the national social security system should be looked upon as providing the basic protection against loss of income due to disabling illness and that it is incompatible with the purpose of this program to reduce these benefits on account of disability benefits that are payable under other programs. It is respectfully submitted that the State workmen's compensation system rather than the Social Security Act is the basic system of income protection with respect to industrial injuries. It provides for medical care, unlimited in amount in most States, compensation for permanent injuries, temporary injuries, total disablement, partial disablement, and death and funeral benefits. Not even the most ardent advocates of social security can reasonably contend that comparable benefits are likely to be provided under the social security system in the foreseeable future. It is the latter that is supplementary, not basic. It is completely impractical to undertake amendment of the laws of the 50 States and other jurisdictions having compensation acts to mold them around the variable benefits which are or may be provided under the Social Security Act. Yet, as indicated above, if social security benefits are to be added to compensation, adjustment of benefit levels will be essential. Little would be gained and possibly a great deal lost if adequate compensation levels were made excessive.

Restoration of the offset provision with respect to workmen's compensation would avoid this possibility. If it is the purpose of this legislation to provide a floor for work injury benefits, an offset provision would most equitably accomplish this objective. A minimum would be established, but an undesirable accentuation of benefit differences between States would be avoided. It seems difficult to justify substantial additions to benefits which are already adequate.

H.R. 12580 also contains provisions relating to medical care for the aged. Since eligibility for such care under the bill is based on need, duplication with the medical care provisions of workmen's compensation laws would seem to be avoided. However, an express offset provision in this area also would be helpful. It is to be noted that S. 2015, by Mr. Kennedy, which also relates to this subject does contain such an offset provision.

Whether or not the above-captioned legislation is to be enacted at this session of the Congress, avoidance of duplication is necessary. It is most prob-

able that as time progresses the Social Security Act will be given broader application. Even now there are several other bills[1] pending before the Congress which would greatly liberalize the definition of disability. It is important that duplication of social security disability benefits with workmen's compensation be avoided.

We would like to emphasize also that our recommendation does not contemplate restoration of an offset provision as to veterans and other Federal periodic disability benefits. These are within the control of the Congress which can establish with respect thereto the overall level which it deems appropriate. In workmen's compensation, however, this combined level is beyond congressional control. Without an offset provision, it would likewise be beyond the control of the States. In such a situation serious inequities are bound to arise.

It is, therefore, respectfully recommended that the offset provision with respect to workmen's compensation be restored to the Social Security Act.

Respectfully submitted.

J. DEWEY DORSETT,
General Manager.

U.S. SENATE, *June 29, 1960.*

Hon. HARRY FLOOD BYRD,
Chairman, Senate Finance Committee,
U.S. Senate,
Washington, D.C.

DEAR SENATOR BYRD: I submit herewith a statement in support of S. 3503.

I would appreciate it if you would make it a part of the record of your hearings on H.R. 12580 and call it to the attention of your colleagues for their consideration.

Sincerely yours,

JAMES E. MURRAY.

STATEMENT BY SENATOR JAMES E. MURRAY BEFORE SENATE FINANCE COMMITTEE, JUNE 29, 1960

My statement for your committee, perhaps the last one before any Senate committee in this, my last term in the Senate, is obviously not motivated by any need to get votes in the next election. Nor can it be explained in terms of any eligibility for old-age social security benefits, since I am not covered by OASDI. Indeed, it might be said that I am in an enviable position, because my position cannot be compromised by pressures from any organized group.

Nor am I a late arrival on any bandwagon for action in the area of legislation for the health needs of our great Nation. The Murray-Wagner-Dingell bill of more than a decade ago should remind you of that fact.

Furthermore, only 8 years ago, I introduced the first bill to provide medical care benefits for beneficiaries under the social security system. I believe that I speak with authority on this subject.

Today, because of our previous failures to meet the problems, the needs and the gravity of the health care of America's senior citizens have resulted in the undavoidable clamor for a solution. I must also pay tribute to the work of Congressman Forand on the House side in keeping the issue before us. And, of course, on the Senate side we have the pioneering efforts of the Subcommittee on Problems of the Aged and Aging, under the assertive leadership of Pat McNamara. Regardless of the final version of the legislation that must come out of your committee, these two men and their colleagues deserve the credit for making Congress come to a decision.

Twenty-five years ago, in my first term as a Senator, we enacted the one great piece of legislation that still thrives, unexpurgated and undefiled, since the New Deal of Franklin D. Roosevelt. Historians make that legislation the outstanding feature of that period of our national life.

What will they say about 1960 if we fail miserably and uncourageously to provide health care benefits for the retired Americans who were in their prime of life in 1935? Nations are not judged in terms of their productivity and novelty of their gadgets: they are judged in terms of the dignity and well-being that they make possible for the widest number of their citizens.

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[1] H.R. 9684, 9686, 9687, 9743, and 9915.

In signing the Social Security Act in 1935, President Roosevelt described it as the "cornerstone in a structure which is being built but is by no means complete." The passage this year of legislation assuring basic health benefits for senior citizens through the most efficient and sensible mechanism at our disposal, the social security system, would epitomize the principle stated by President Roosevelt.

Through such legislation, working people would contribute during their working years to a fund assuring them of medical benefits when they have retired. While private insurance programs—especially through the accomplishments of collective bargaining—have basically met the need to protect the younger population, they simply cannot afford to offer protection against the higher risks of the aged at premiums the aged and their families can afford. The insurance companies' fears are simply unfounded, just as were their fears of 25 years ago, when they prophesied the collapse of the private pension movement if a program of old-age benefits were established in the land.

You have before you the retired persons medical insurance bill, S. 3503, introduced by Senator McNamara and 23 cosponsors, including myself. It should be approved as a substitute amendment for title XVI of H.R. 12580.

The McNamara bill is not socialized medicine. It does not nationalize the country's hospitals. It does not put doctors on Government payrolls. Individuals would not be forced to accept a doctor or a hospital designated by some bureaucrat in Washington.

The McNamara bill, in fact, omits any payments to doctors and surgeons. It will not result in the flooding of hospitals with hypochondriacs and unnecessary operations. The contributions by employees and employers will be no more compulsory than the public's support for schools, firemen, and policemen. Indeed, if we don't enact such legislation, we will only be forcing the local communities and States into assuming the impossible burden of relief—and real State medicine, with its less than adequate standards.

In other words, just as will old-age benefits under social security, the McNamara bill would establish a basic foundation of medical protection for the retired aged of this growing Nation. I expect to be around 10 years from now, when all the vested interests now childishly fighting this and similar proposals will be accepting—indeed praising—old-age medical benefits as a normal part of American life—as a basis for improving through private techniques the living conditions of Americans in their retirement years. I fervently hope that the members of the Finance Committee will also be around to witness the fruits of positive action on their part in the next few days ahead. Whether they will be in Washington or not may well depend, in large measure, on their decision about this particular issue.

AMERICAN FARM BUREAU FEDERATION,
Washington D.C., June 29, 1960.

Hon. HARRY FLOOD BYRD,
Chairman, Senate Finance Committee,
U.S. Senate, Washington, D.C.

DEAR SENATOR BYRD: This is to express to you Farm Bureau's position with regard to certain provisions of H.R. 12580, a bill that amends the old age and survivors insurance program and adds certain new provisions.

This legislation has some desirable features; however, we are deeply concerned about the implications of title VI of this legislation which would amend the Social Security Act by adding a new title under which medical services would be financed for certain individuals 65 years of age or over who are determined to be medically indigent.

We recognize that the approach taken in this title is different from, and perhaps has less far-reaching implications than, the original proposal known as the Forand bill. However, we believe that the enactment of title VI will (1) be the opening wedge for Forand-type proposition, (2) be very costly to both Federal and State Treasuries, (3) slow down progress being made to provide medical care for aged through nongovernmental programs.

Any such permanent new program costing billions of dollars, where there is so much disagreement as to a possible solution, should not be drafted and launched in haste and in an atmosphere supercharged with election-year politics. We believe this proposal deserves more adequate consideration.

Since there have been no hearings in the House and since there is insufficient time for the Senate Finance Committee to give adequate consideration to the provisions of title VI of this bill, we recommend that the committee strike this title in order to give time for thorough study of the implications of this legislation.

We respectfully request that this letter be made a part of the hearing record with regard to H.R. 12580.

Sincerely yours,

JOHN C. LYNN, *Legislative Director.*

AMERICAN ASSOCIATION OF UNIVERSITY WOMEN,
Washington, D.C., June 27, 1960.

HON. HARRY FLOOD BYRD,
Chairman, Finance Committee,
U.S. Senate,
Washington, D.C.

DEAR SENATOR BYRD: For many years the American Association of University Women, an organization of over 144,000 women organized into 1,464 branches in all of the States of the Union, Guam, and the District of Columbia, has followed social security legislation with keen interest. For this reason we feel that you would be interested in knowing that the proposed revision of the Social Security Act which has proven to be of greatest concern to our members is that to increase the present $1,200 ceiling on earning of OASDI beneficiaries.

We find this present earning level works hardship upon numbers of our members who accept teaching positions which are frequently not located in the community of their permanent residence. The financial hardship of travel and of maintaining temporary dual residence has in some instances led to resignation when earnings over the $1,200 ceiling meant loss of social security benefits. Other retired teachers are inhibited from ever taking post-retirement positions for which they are intellectually and physically qualified. In view of the alarming shortage of classroom teachers at the elementary, secondary, and college levels, it is our hope that this unnecessary financial hurdle to the augmentation of the supply of teachers will be removed.

We have cited this illustration because of its applicability to our own membership. We could pick others which also demonstrate the needless limitation on the contributions which could be made by older citizens.

In conclusion, we should like to point out that as the cost of living index continues to rise the present $1,200 ceiling, enacted some years ago, becomes increasingly unrealistic.

Sincerely yours,

KATHERINE BAIN,
Chairman, Legislative Program Committee.
YSABEL FORKER,
Chairman, Status of Women Committee.

FEDERATION OF JEWISH CHARITIES OF ATLANTIC CITY
Ventnor City, N.J., June 27, 1960.

U.S. Senator HARRY FLOOD BYRD,
Chairman, Senate Finance Committee,
Washington, D.C.

DEAR SENATOR BYRD: The questions of medical services for the aged is one in which there is considerable interest in our Federation Family Welfare Service. This body has gone on record as approving the use of the social insurance principle to meet the health needs of older citizens. We have come to support this conclusion on the basis of an actual case-by-case study of individuals and families in the aged category whose lives are troubled, and whose present and future outlook is uncertain largely because of the failure to provide for their medical needs in their old age. We believe, too, that it is more dignified for the individual to provide for his needs during the earning years of his life than to be subjected to the indignities of a means test for medical care.

We would very much appreciate that this statement be incorporated in the official record of hearings, if they are to be held.

Sincerely yours,

IRVING T. SPIVACK, *Executive Director.*

HOUSE OF REPRESENTATIVES,
Washington, D.C., June 25, 1960.

Hon. J. ALLEN FREAR, Jr.,
U.S. Senate, Washington, D.C.

DEAR SENATOR FREAR: It is my understanding that the Senate Finance Committee will begin consideration of the proposed 1960 amendments to the Social Security Act next Tuesday. For that reason, I wish to call to your attention an unfortunate problem which has arisen in the administration of the law relating to benefits for the dependents of disabled persons authorized in the 1958 amendments to the act.

As you know, neither the Congress nor the Social Security Administration set up procedures for the automatic inclusion of dependents of disabled beneficiaries. Even so, applicants after September 1, 1958, were advised of the eligibility of dependents in the event their own entitlement was established. However, for those persons who filed before September 1, 1958, and whose cases were approved after the passage of considerable time find that their dependents are precluded from obtaining retroactive benefits for more than the 12-month period provided in the law. For example, a disabled person who filed an application in June 1958 and obtained final approval of its in February 1960, found that such approval conferred entitlement upon certain of his dependents. However, under the law, his application for these benefits in March 1960 would result in the approval of payments effective in March 1959 rather than September 1, 1958, the effective date of the 1958 amendments which, I believe in all good conscience, should apply in such cases.

I have introduced a bill, H.R. 12807, intended to correct this situation in instances of the kind I have cited above. A copy of the bill is attached. Unfortunately, this situation did not come to my attention soon enough to allow the introduction of the bill at an earlier date. Although my proposed amendment would apply to a limited number of cases, I believe it important that a change be made in the law to allow for equitable treatment. Therefore, I should sincerely appreciate any consideration the Finance Committee would give to this matter during its deliberations next week.

With best regards.

JOHN E. HENDERSON.

[H.R. 12807, 86th Cong., 2d sess.]

A BILL To provide in certain cases for the payment of additional monthly insurance benefits under title II of the Social Security Act to the dependents of a disabled individual, where timely application for such benefits was in effect prevented by delays in the final determination of such individual's disability

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled, That in any case where—

(1) an individual filed application for disability insurance benefits under section 223 of the Social Security Act before August 28, 1958,

(2) such individual was determined to be entitled to such benefits but the final determination of such entitlement was not made until on or after such date,

(3) any other person became entitled to monthly insurance benefits under subsection (b), (c), or (d) of section 202 of such Act on the basis of the wages and self-employment income of such individual and pursuant to an application filed within 12 months after the date of such final determination, and

(4) the month with which such person's entitlement to such benefits became effective (taking into account section 202(j)(1) of such Act) was later than the first month for which such entitlement would have been effective if application for such benefits had been filed at the earliest time permitted under section 202(j)(2) of such Act,

then the entitlement to such benefits of each person described in paragraph (3) shall be deemed to have become effective with the month in which it would become effective if application therefor had been filed at the earliest time permitted under section 202(j)(2) of the Social Security Act; and such person, upon filing with the Secretary of Health, Education, and Welfare an application under this Act within 12 months after the date of the enactment of this Act (or, if later, within 12 months after the date of the final determination described in paragraph (2)), shall be entitled to receive in a lump sum an amount equal to the aggregate of the monthly insurance benefits under section

202 of the Social Security Act which he did not receive but would have received if his application for such benefits had been filed at the earliest time so permitted.

STATEMENT OF THE NATIONAL ASSOCIATION OF MANUFACTURERS WITH RESPECT TO H.R. 12580 AND RELATED PROPOSALS

This statement of the views of the National Association of Manufacturers on H R. 12580 and related proposals is submitted pursuant to the invitation of the Senate Finance Committee for comments of interested organizations.

The National Association of Manufacturers is a voluntary organization of over 20,000 member companies, representative of every segment of the manufacturing community of every section of the Nation. Its membership includes companies of every size from the smallest to the largest of enterprises. In fact, 83 percent of association members employ fewer than 500 persons and thus come within the accepted definition of small business.

As representatives of businessmen and citizens, the association is concerned with the financing and benefits of all public programs which are designed to provide a measure of security to individuals against the economic hazards of old age, death, disability, and involuntary unemployment. We are likewise concerned with the implication of these programs to the well-being of our country.

The issues involved are vital. They should not be considered in a hasty and ill-considered manner during the heated and pressure-filled atmosphere of an election year. Some of thhe changes proposed in the various bills before the Congress can drastically and permanently affect every individual in the country, as well as the generations to come.

Therefore, we most strongly recommend that further consideration of these bills be postponed to a time when they can be given the traditional judicious and deliberate treatment with which the Congress rightfully handles issues of such fundamental importance, and when the Congress has before it all the pertinent facts which bear upon the issue.

Specific provisions or details of the various proposed bills will not be discussed in this statement. Rather it is confined to setting forth the basic issues and the broad and far-reaching implications inherent in the proposals.

FINANCING

One of our major areas of concern is the fiscal questions. We recognize that the achievement of individual economic security is a laudable objective. We recognize that society has a responsibility toward the destitute aged, toward the disabled, and toward all those who become dependent at any age. This responsibility is being discharged in an humane manner responsive to their needs through private and public means. Our concern in the fiscal area arises from our deep conviction that unwise Federal fiscal or monetary policies—in this or in any other area—will undermine the security of all of us since our financial provision for our retirement security and for protection against misfortunes at all ages, depends upon a stable and sound dollar.

The various pending proposals involve commitments which reach far into the future—for unknown amounts—but in the magnitude of billions of dollars. Welfare expenditures to date show that any commitments made today will rapidly increase over the presently estimated amounts.

Federal grants for public assistance increased over 400 percent between 1945 and 1958—from $401 million in 1945, to $1,728 million in 1958. Currently these grants are at some five times the 1945 rate. Large grants for other welfare purposes have been made and still more are under current consideration.

This phenomenal growth in federal grants has occurred despite the Federal OASDI system's benefits, which in 1958 were 31 times those paid in 1945, and which this year will be some $11 billion dollars—40 times the amount paid in 1945.

H.R. 12580 and other pending social security measures would greatly increase Federal expenditures both for public assistance grants and for OASDI benefits, despite the fiscal position of the Treasury and of the social security trust funds.

The major pending proposal is that of providing medical care to older persons. The approximate cost of this program is presently unascertainable, but without question would add tremendously to welfare expeditures. The cost must inevitably be borne by the public in the form of inflated prices for goods and services, as well as by increased taxes.

Some idea of prospective medical care costs under present programs may be gained from an analysis of present expenditures for so-called vendor medical care provided old-age-assistance recipients by a half dozen States. With 273,000 aged on their benefit rolls, the February 1960 vendor medical care expenditures of these six States were at the annual rate of $119 million per year—an average of nearly $440 per OAA benefit recipient—including all those who received no vendor medical care. If it is assumed that the new program would provide an equal level of medical care protection for 10 million aged, utilized by them at the same level as recipients on public assistance rolls, the annual cost would be $4.4 billion. Costs would rapidly increase as the number of aged increase. A $4.4 billion expenditure would obviously require an added tax of 2 percent of taxable payroll, above the tax rates presently scheduled.

Additional expenditures of the magnitude above indicated must be most carefully assessed within the framework of overall welfare costs. It is clear that these overall costs will increase very rapidly even under present social security commitments and without any additional liberalizations. OASDI alone, according to the OASDI trustees' report filed in March of this year, estimates that in less than 10 years expenditures will be at the annual rate of nearly $17 billion—more than double the 1958 expenditures.

Nor can we ignore the fact that even present expenditures are not being currently financed, 1957, 1958, and 1959 were deficit years for OASDI. Its taxes and interest failed to meet its expenditures by more than $2½ billion—and further deficits are in prospect. The public interest requires that OASDI be soundly financed on a pay-as-you-go basis, and that no additional burdens be added without contemporaneously adding to the taxes.

A primary problem we already face is the size of the taxes scheduled to be paid in the future. OASDI protection is dependent on the willingness of future taxpayers to assume this progressively heavy burden. They will decide the portion of the Nation's income which will be transferred by Government from them to the aged. Only by prudent present planning can we assure that future taxpayers will not repudiate the system or reduce the presently promised protection, through inflation, amendment, or otherwise.

OVERALL PROBLEM OF THE AGED

Present health programs—and it may be mentioned that much care in addition to public program care is provided through private means—negates any allegation that an emergency exists which must be immediately handled. Our aged are not lacking adequate medical care. Aged persons are not refused medical care because of lack of ability to pay.

Therefore, the medical problem does not require emergency action. In fact, medical care is only one of the several areas which are to be discussed at length in January of next year at the White House Conference on the Problems of the Aged. The agenda and background papers of this White House Conference, as well as the regional conferences in the States which have been held, indicate that the overall problem of the aged is not a simple nor single one—it is a complex of economic, social, family, and psychological problems and community relations all intimately related. To attempt to solve the medical aspects of this complex without thorough consideration of all the interrelated and vital considerations, would be most unwise.

HASTY ACTION

Among considerations that must be borne in mind is that immediate expenditures of large amounts, in an attempt to provide adequate medical care for this particular group, must be viewed within the overall picture of presently available medical facilities and medical personnel. There is no escaping the fact that any large scale immediate increase in the utilization of medical facilities and personnel by this particular age group would of necessity result in an inadequacy of medical facilities and personnel for the remainder of the population. Accordingly, any shift in the use of medical facilities and personnel prior to most careful study might well create more serious problems and inequities than it could possibly remedy.

Some of the pending proposals would add medical care for the aged as a benefit under OASDI, to be financed by additional OASDI taxes. No justification has been advanced as to why this added benefit would be made available to the aged beneficiaries but denied the disabled, children and other beneficiaries.

Furthermore, no basis has been advanced for providing the same protection to everyone regardless of his contributions. This is not consistent with the variable benefit and contribution principles of OASDI. To give flat benefits under OASDI is, in effect, to create a dole financed by its taxes.

Furthermore, the proposal is but an opening wedge for a complete compulsory medical care system—in short, the English system. This would mean scrapping existing plans which have been developed over the course of the years and the substitution of a Federal monopoly in this area of personal services.

Unlike cash benefits, Government medical care and the provision of medical care under voluntary plans, is mutually exclusive.

Government provided medical care means a concentration of authority and expensive Government administration. Under the proposal that OASDI be the procurer of medical care for over 10 million potential eligibles throughout the Nation, this Government monopoly and control would be most serious. The power and authority and purse-string control in the hands of the bureaucrats administering the program would be inconsistent with the proper solution of the many local problems which are involved.

PRESERVATION OF VOLUNTARY HEALTH INSURANCE

A few years ago proponents of Government provision of compulsory medical care argued that this was the only feasible approach to satisfactory health protection of the general public. This false premise has been exploded by the extension of voluntary private protection to over 130 million persons. The now modified argument is that in the case of the aged, Government must establish a compulsory plan—despite the giant strides made recently in this area of coverage which now includes nearly half of the older population.

Projections of present growth indicate that in a relatively few short years the coverage of aged will be as satisfactorily accomplished as has already been achieved for the general population. The insurance industry estimates that by the end of the current year nearly two-thirds of the aged wanting and needing such protection will have it, that 5 years from now, four-fifths will have this protection available, and that in another 5 years 9 out of 10 will have it.

This bright prospect is jeopardized by the threat of Government intervention.

CONCLUSION

In view of the fiscal considerations, the level of existing benefits, the complexity of the problems, and the current public exploration of problems of the aged which will culminate in next year's White House conferences, and in view of the advances under private auspices of medical protection, and the disaster of hasty and ill considered governmental action, it is the recommendation of the National Association of Manufacturers that no action should be taken at this time on any of the proposed social security benefit liberalizations.

We favor the provisions in H.R. 12580 which strengthen the operation of the unemployment compensation system.

AMERICAN PODIATRY ASSOCIATION,
Washington, D.C., July 1, 1960.

Hon. HARRY FLOOD BYRD,
Chairman, Committee on Finance,
U.S. Senate, Washington, D.C.

DEAR SENATOR BYRD: As secretary and editor of the American Podiatry Association (from 1912 until 1958 known as the National Association of Chiropodists), I regret that the time element did not permit your committee to schedule me to present testimony. However, I do appreciate the opportunity to present this statement for incorporation into the record of the hearings on H.R. 12580, especially in regard to the provisions for medical services for the aged.

More than 30 million times a year the public visits foot doctors' offices. Perhaps as many as 40 percent of these individuals are 60 years of age or more. We, therefore, are very much aware that our older people are very much concerned with their ability to provide for necessary medical care in their retirement. The members of our association offer their support to programs which will meet this need, but the association is not prepared to suggest the form such a program should take.

As a private individual, I should like to make some personal observations and comments. The proposals for medical services for the aged offered in H.R. 12580 and the so-called administration plan have been characterized as "skimpy," "doesn't cover enough people," "leads to pauperization," "no provision for revenue to cover costs." The plans, such as proposed by Congressman Forand, have been called "the first step to socialized medicine," "intrusion of the Government into the doctor-patient relationship," "not enough benefits," "will cost too much," "will be abused," "not a voluntary program."

Perhaps the following approach has been considered. I would suggest a voluntary health insurance program to which a social security retiree could subscribe. Half the premium would be deducted from the monthly allotment, the other half to come from social security funds obtained by increasing the present social security assessment of all individuals. These health insurance benefits could be service or indemnity benefits, or plans now in operation, somewhat on the order of the types now being made available under the Federal employees health benefits plan. Adequate and reasonable ceiling for annual benefits could be arrived at with "coinsurance" and "deductible" features that would approach, if not actually reach, actuarial soundness.

This would cover the needs of all but a small percentage of retired persons. For these people, and for the few who would exhaust their annual benefits and be unable to finance additional care, their needs could be supplemented through the proposal in H.R. 12580, or the administration plan. Obviously, the amount of funds needed for State plans under these circumstances would be very minimal.

It seems to the writer that the combination of voluntary health insurance and State plans would fill the obvious need in the American tradition.

As secretary and editor of the American Podiatry Association, I call your attention to the definition of the term "physicians' services" under the new title XVI proposed by H.R. 12580, section 1606(e), page 65. Podiatrists (chiropodists) are licensed in all of the 50 States and the District of Columbia to diagnose and treat the human foot by medical and surgical means. Almost all insurance companies honor claims for scheduled services performed by podiatrists. Sixty-five percent of our practitioners are participating doctors in so-called Blue Cross-Blue Shield plans. However, the definition of "physicians' services" being considered is susceptible of individual interpretation, varying from official to official and from State to State, leading to possible injustice to the patient who elects a legally qualified foot doctor to perform a scheduled service.

We would petition you that any definition of medical care or of physician service provide that any practitioner licensed by the State to treat by medical and surgical means may be elected by the patient to provide the service within his scope of license. Or the cited definition (or any similar definition in any legislation being considered) could be amended by substituting a semicolon for the period at the end of the sentence and adding "or a podiatrist (chiropodist) operating within the scope of his license."

Thank you for the opportunity to include this statement in the record of the hearing.

Sincerely,

A. RUBIN, D.S.C., *Secretary and Editor.*

THE NATIONAL ASSOCIATION OF LIFE UNDERWRITERS,
Washington D.C., July 1, 1960.

Re title VI of H.R. 12580.

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

DEAR SENATOR BYRD: As chairman of the committee on social security of the National Association of Life Underwriters, I am taking this opportunity to make a brief statement of the views of my organization with respect to the various proposals being studied by the Senate Finance Committee to provide Government health care for the aged. These proposals include that contained in title VI of H.R. 12580.

For your information, my association is a trade association having a membership of 78,000 life insurance agents, general agents and managers located in

all 50 States, the District of Columbia and Puerto Rico. The vast majority of these individuals sell health insurance as well as life insurance.

We have long opposed the Forand bill (H.R. 4700) and similar measures that would provide health care for aged individuals under the social security program irrespective of their ability to provide for their own health care needs. By and large, our reasons for taking this position are substantially the same as those which were so ably presented to your committee by Dr. Leonard W. Larson, of the American Medical Association, in his statement of June 30.

We are also in disagreement with the type of approach recommended to your committee on June 29 by Secretary Arthur S. Flemming, of the Department of Health, Education, and Welfare, on behalf of the administration.

Passing now to title VI of H.R. 12580, this proposal would add to the Social Security Act a new title XVI, which would set up a Federal-State program to provide health care for aged persons who, although not eligible to receive public assistance, do not have the means to finance their own health care. Thus, as we understand the purpose of this proposed new program, it would be designed to help only those who are actually in need.

In this connection, I wish to point out that at my association's midyear meeting held in Louisville, Ky., last March, our board of trustees adopted a recommendation made by our committee on social security that we "not oppose any proposal where by the Federal Government would undertake to help to finance the health care of the aged out of general revenues on a 'needs' test basis along the lines of—or perhaps as a part of—the existing old age assistance program." Our reasons for adopting this policy were, again, essentially the same as those set forth in Dr. Larson's above-mentioned statement of June 30.

Acting in line with our foregoing policy, I should therefore like to advise you that while we recognize that future experience may disclose the need for amendments to title VI of H.R. 12580, we do not oppose its enactment by the Congress at this time.

I respectfully request that this letter be incorporated in the record of the hearings held by your committee on June 20 and 30.

Sincerely yours,

ALBERT C. ADAMS,
Chairman, Committee on Social Security.

STATEMENT ON SOCIAL SECURITY LEGISLATION BY RUDOLPH T. DANSTEDT, DIRECTOR OF THE WASHINGTON BRANCH OFFICE, NATIONAL ASSOCIATION OF SOCIAL WORKERS JUNE 30, 1960

Mr. Chairman and members of the committee, the National Association of Social Workers as an organization and through its individual members has long been a supporter of the Social Security Act.

The association's policy position on social insurance says in part: "All workers, including civilian and military personnel, governmental and railroad employers, and self-employed persons, should be protected by a single system against loss of income due to retirement, premature death, and permanent disability. Included in this system should be provision for medical services to covered persons and their dependents."

We are pleased that H.R. 12580 now before this committee would provide, as recommended in our policy statement, "Federal protection against permanent and total disability to all insured workers without age limitation including dependents' benefits." In 1956 when the disability insurance amendment was enacted it was the subject of some controversy. Now, 4 years later, the elimination of age 50 is seen as not only desirable but necessary.

The bill passed by the House, however, is in our judgment greatly inadequate in its failure to provide health care benefits for the aged—one of the large remaining single problems for which no national program has been established.

SCOPE OF THE PROBLEM OF THE HEALTH NEEDS OF THE AGED

The problem is an easily stated one although one of substantial proportions. The aged in the United States are increasing rapidly. Today we have 16 million persons over 65. Tomorrow at this time there will be 1,000 more such persons since that is approximately the daily net increase. But it is not only a question of large numbers of persons over 65. Because of the improvements in medical

care and in our standards of living, more persons are living to a ripe old age. Of all persons 65 and over, more than one-third have passed their 75th birthday. One in seven is in the 80's, and most of them are women; the women exceeding the men by nearly 120 to 100. There are, we understand, more than 5,000 persons in the United States over 100 years of age and some of them are actually working and paying their social security taxes.

With old age have come the usual diseases of age and senility—diseases which are long in duration and chronic illnesses which frequently require expensive care in hospitals.

FINANCIAL STATUS OF THE AGED

Any casual analysis of the income position of the aged in the United States reveals the very simple truth that by and large the aged in this country cannot afford to pay for medical care. Sixteen percent of the aged receive old-age assistance which means that they meet very strict standards of need. Another million aged persons are receiving pensions because of the death or retirement of a Government employee or railroad worker and almost a million are receiving veterans' pensions because of previous military service. In 1956 and 1957, three-fifths of all people 65 and over had less than $1,000 in money income. Only one-fifth had more than $2,000. Of all couples with a husband aged 65 and over, almost half had cash incomes of less than $2,000 in 1956. Half of the aged persons living alone or with nonrelatives had incomes of less than $900. Even this small income is not reasonably certain since much of what goes into these averages comes from employment and other sources which decrease as age increases. Almost half—45 percent—of the total income of the aged comes in the United States from income-maintenance programs, primarily social security and other public programs.

THE SOLUTION TO THE PROBLEM OF THE HEALTH NEEDS OF THE AGED

We believe that it is now abundantly evident that the solution to providing health care benefits to the aged must be through a governmental program under Federal leadership. We do not consider a program of public assistance or some variation of such a program, but still using a means or income test as suggested in title XVI of the House bill, is either an adequate or a desirable answer to the problem of the health care needs of the aged.

It seems to us that the solution to this problem lies in a program of contributors social insurance through which our citizens can pay for the cost of the hospital and related services needed in their older years. We have developed in the United States a method of insuring against widespread social risks. We have insured against industrial accident through workmen's compensation; we have insured against old age through old-age, survivor, and disability insurance; we have insured against total and permanent disability through this system; and we have insured against the contingency of death of the wage earner. We have also insured against the contingency of unemployment through unemployment insurance. In four States in the Union we have insured against temporary disability or sickness. All of these have been done through the mechanism of social insurance.

The social security program has become throughly accepted by the rank and file of the people of this country as it has by the rank and file of the people of practically every Western industralized country in the world. It is a sound method on insuring against certain risks, and it is in the tradition of American values in that it provides for saving during a person's working and productive years so that when the contingency insured against arises the person will be able to take care of his problems.

Pending before this committee are a number of bills: S. 1151, introduced by Senator Humphrey; S. 2915, introduced by Senator Kennedy; S. 3503, introduced by Senator McNamara, and various proposed amendments to title II by Senators Gore, Morse, and Anderson. All would meet the health needs of older people through social insurance.

While we do not endorse these various bills in all particulars we do support strongly the principle of providing for the health care bills of the aged through use of the social insurance system contained in all these bills.

We earnestly hope, therefore, that this committee which has, through study and legislation, improved and broadened our social security program, will take still a further and urgent step forward by providing to older people within the social insurance system the one basic protection not now available to them—health care benefits.

NEED FOR A GENERAL ASSISTANCE CATEGORY

We wish to register our support for S. 3755 introduced by Senator McCarthy, which provides a new public assistance title for needy persons free of residence restrictions. The plight of the employable unemployed, who do not qualify for unemployment compensation or for whom compensation payments are inadequate or who, for various reasons, are not eligible for assistance under existing titles, demands a Federal-State grant-in-aid program.

IMPROVEMENT OF CHILD WELFARE SERVICES

Finally, we believe that the child welfare section of title V: Maternal and Child Welfare Services, should be amended to provide authorization of $25 million instead of the $20 million proposed in the House bill. When Congress, in 1958, enabled child welfare services to be provided to all children in need regardless of whether they live in urban or rural areas, an opportunity was offered the States to help neglected and dependent children significantly. The authorization should adequately reflect this broadened responsibility.

We suggest also that the definition of child welfare services included in the report of the congressionally authorized Advisory Council on Child Welfare Services be included in the child welfare section of title V so as to provide an adequate definition of the types of children to be served and services provided.

STATEMENT BY J. C. ZIMMERMAN FOR KENTUCKY CHAMBER OF COMMERCE

The Kentucky Chamber of Commerce is a nonprofit organization representing individuals and businesses throughout Kentucky and has its principal office at 670 South Third Street, Louisville, Ky.

This organization is gravely concerned with the numerous measures considered or being considered in this session of Congress which will, of necessity, through their adoption create the need of added taxation or costs to the citizenry of this Nation. In particular, the advance of the Federal Government into the field of medical and hospital insurance comes into this category.

It is apparent that continuation of this accelerated policy of spending and taxing will greatly diminish the ability of the individual citizen to manage his own affairs and will, in fact, destroy personal initiative in the management of his own economic position.

The Kentucky Chamber of Commerce has already indicated its complete opposition to Forand type legislation proposed for the purpose of providing medical and hospital benefits on a broad basis to the aged. This organization does not endorse the Mills (or Forand) proposal, for many valid reasons, namely that the Government again is extending its influence into the affairs of the citizen in matters which he should decide for himself.

It is observed that this legislation has been handled in a frenzied and hurried manner. We do not believe that a matter as important or as far reaching as this should be passed without a complete and exhaustive study of needs and cost and final effect on the economic balance of our country.

STATEMENT OF AMERICAN DENTAL ASSOCIATION, WASHINGTON, D.C., JULY 1, 1960

The American Dental Association has been given permission to file a statement for the record of the hearings scheduled by the Finance Committee for June 29-30, 1960, on H.R. 12580, Social Security Amendments of 1960, as passed by the House of Representatives June 23, 1960.

The association's primary concern at this time is not with H. R. 12580, which by and large is an extension and modification of existing social security programs, but with the various new and sweeping proposals that have been and are being advanced as substitutes for title VI of H.R. 12580 relating to health care programs for people 65 years of age and over. Accordingly, because of the limitations of time that have been established, this presentation is confined to a brief statement of the association's position that the committee should not undertake at this ime to consider aged healh care proposals that go beyond that contained in H.R. 12580.[1]

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[1] App. I, attached hereto, contains a suggestion for amending H.R. 12580.

As indicated in a telegram submitted to the chairman of the Senate Finance Committee late Tuesday afternoon, June 28, the American Dental Association does not believe that the complex subject of health care for the aged can be given adequate consideration in the 2 days of hearings that have been scheduled.

The association believes the Finance Committee will make a serious and irretrievable mistake if it departs in this instance from the traditional and sound legislative procedure of reporting important legislation only after there have been full hearings and the members of the committee have had sufficient opportunity to give careful study to such legislation and the problems sought to be corrected thereby.

To this association's knowledge, the Finance Committee has never held hearings on the health care problems of the aged or on any of the pending legislative proposals related thereto.

Hearings before other agencies on the general subject of aged and aging have demonstrated the vast areas of disagreement regarding the nature of the health problems of the aged and the many and varied approaches that have been made toward meeting these problems. The Congress recognized this in 1958 when, ostensibly with full knowledge and deliberateness, it enacted legislation establishing an elaborate program and machinery for holding a White House Conference on Aging in January 1961 at which representatives from all States and interested public and private agencies will have an opportunity to participate. It would appear to this association that to take action now on far-reaching and irreversible Federal programs dealing with the very subject to be taken up by the 1961 conference would be entirely inconsistent with the previous action. Moreover, much of the extensive work that already has gone into preparations for the conference will have been wasted and no regard will be paid by the Congress to the creature it created to "make recommendations for a course of positive action in dealing with the problem of aging."

The effect of precipitous action by Congress at this stage would be completely to ignore the active and serious preparations for the 1961 conference that have been made by 53 States and territories.

It is entirely possible that information, evidence, and recommendations will be developed at this conference which will show that many of the plans being put forward for consideration of the Finance Committee are not best suited for meeting the problems of the aged. Surely, action by the committee on new and untried programs should be deferred to permit a balancing of the conflicting proposals and a weighing of the evidence in support of each of them.

Moreover, the entire legislative situation surrounding health care of the aged appears to be in a state of confusion. According to newspaper reports, several members of the Finance Committee have within the last day or two introduced new aged health proposals that previously have not been available for evaluation and study.

Other proposals suggested for consideration of the committee have not even been drafted in legislative form so that, at best, the committee and other interested agencies and individuals have only a vague and general frame of reference.

The majority of the measures now being offered and announced in the press as substitutes for title VI of H.R. 12580 have never been subjected to public hearings before any committee of Congress. Even the controversial Forand bill, elements of which are contained in several pending proposals, received only limited consideration in the House of Representatives. The same is true of title VI of the House-passed bill H.R. 12580, although it is recognized that this proposal is in essence an extension or augmentation of existing programs that are well known to the committee.

This association is opposed to the proposals which would introduce a vast Federal health program as a part of the OASDI provision of the Social Security Act. It is believed strongly that these measures to make the Federal Government the sole purchaser of health care services for people over 65 would not be in the country's best interests.

It is reasonable to expect that once a program of this kind is adopted it will be extended until all health services are included for the entire population. This kind of system is certain to place undesirable limitations upon the availability of health personnel and facilities both for people over 65 and for those in other segments of the population. In addition, under such programs, the providers of health services unquestionably would be brought under the domination and regimentation of their sole consumer, the Federal Government, and this would result in a lowering of health care standards as it has in other countries.

The dental profession is especially fearful that adoption of a Government program concentrating care on adults will result in the neglect of children's health needs. This has occurred in England and is completely contrary to all accepted professional standards of dental health care.

There is also the real concern that manpower, facilities, and other resources will be diverted from the preventive research and other programs which hold out man's greatest hope for freedom from suffering and disease.

These are but a few of the considerations that should be taken into account by the committee.

The committee also should obtain information on the extent to which hospitals, in particular, will be able to deliver the services envisioned in the Forand bill and similar measures and the extent, if any, to which people other than aged who are in need of hospital and medical care may be displaced. There also is the basic question of whether the greatest health need of the aged is in the form of hospital care or in the form of less intensive care.

The committee should also receive evidence to determine whether the needs of the aged would best be served by a program based upon personal investigations and decisions at the local level or upon stereotyped categorical rules made at the Federal level.

Many, many other serious problems are involved in the legislation which are deserving of deep study and analysis that cannot be accomplished in the hectic atmosphere of the few remaining days of Congress and in the heat of the presidential and congressional election campaigns that are now in progress.

Programs as far-reaching and permanent in nature as those being proposed require sober, statesmanlike consideration and strict adherence to sound, deliberative legislative procedures.

Most, if not all, of the aged health proposals before Congress include provision of dental services in varying extent. The American Dental Association believes that, as the representative of approximately 100,000 dental practitioners, it has a vital and important interest in such legislation and should be accorded full opportunity to communicate its views in detail to the committee.

The American Dental Association strongly recommends therefore that the Finance Committee not act upon new aged health care programs until it has had an opportunity to hold comprehensive hearings and to review the proceedings and recommendations that will be forthcoming from the 1961 White House Conference on Aging.

APPENDIX I

The American Dental Association wishes to bring to the committee's attention a provision included in title VI of H.R. 12580 which introduces a standard for determining eligibility for "major dental treatment" that is professionally unsound and unrealistic.

The provision referred to is the language of section 1606(b)(1) which provides that only major dental treatment "to the extent determined by a physician to be medically necessary" is to be included as a benefit under the law. According to the House report on the bill (H. Rept. No. 1799, 86th Cong., 2d sess., p. 134), this language is intended to exclude "routine dental services for conditions not seriously affecting a person's general health." However, the meaning of the quoted statement from the House report is not clear since section 1606(b)(2)(J) specifically limits "major dental treatment" to conditions that have or may "seriously affect" a person's general health.

It is the opinion of the American Dental Association that the inclusion of these provisions in the bill indicates such ignorance of medical and dental science and practice that doubt is cast upon the content of the entire bill. It definitely is illustrative of what happens when health care or other technical legislation is drafted by persons having no knowledge of the subject and no attempt is made to obtain professional advice and assistance.

The association believes it should hardly be necessary to point out that by education, training, and experience dentists are acknowledged to be better trained and equipped to diagnose and determine the seriousness of dental diseases than members of any other profession including medicine. In fact, doctors of medicine receive little, if any, training relating to dental diseases and it is common and usual practice for them to refer patients to dentists when a dental disease is suspected. Moreover, certain dental diseases and conditions in aged persons may be acutely serious, whereas the same disease in young persons may be regarded as of a more or less routine nature. Professionally

speaking, however, it is difficult to conceive of a dental disease in an elderly person which would not have serious effect upon his general health. In any event, a proposed Federal statute such as H.R. 12580 need not contain such limitations. The State and local administrators, in cooperation and consultation with professional people who understand the problems, can best determine the medical, dental, and other health needs of persons eligible for care. The medical care authorizations in the existing assistance statutes make no distinctions and carry no restrictions of the type referred to in H.R. 12580, and programs operated thereunder have not encountered difficulty in this regard; under those programs eligible persons having conditions or diseases requiring treatment receive it without particular regard to the anatomical location of such disease or condition.

It is also noted that under section 1606(b)(2)(1) an aged person with a serious oral infection could not receive penicillin or other medication on the prescription of his dentist.

It is submitted that the restrictions referred to above are unnecessary and unrealistic and should be deleted from the bill.

STATEMENT OF SOUTH DAKOTA STATE MEDICAL ASSOCIATION

The South Dakota State Medical Association has considered carefully the problems surrounding provision of medical care for the elderly, some of which are covered in title XVI of H.R. 12580.

The deliberations of the house of delegates during the association's annual meeting in May resulted in what we consider a logical five-point program. Basic points in that program are as follows:

1. Implementation of a statewide medical care program for the indigent aged (categorical assistance recipients).
2. Possible implementation of the above program to provide services to the near needy who do not meet the rigid requirements for indigency under old-age assistance.
3. Improvement locally of nursing home facilities.
4. Broadening of voluntary health insurance plans to cover aged with ability to purchase coverage.
5. Removal of the $1,200 per annum ceiling of earnings of social security beneficiaries.

Title XVI, as passed by the House of Representatives, may well meet the requirements of our point No. 2. Any change that would provide medical care to all beneficiaries of social security would be most unwelcome and ill timed.

The doctors of South Dakota cannot accept the premise that all social security beneficiaries are destitute any more than we can accept social security as insurance. Such programs are not actuarily sound, have established no real need for being, and are exorbitant in cost.

It is respectfully recommended that title XVI of H.R. 12580 be accepted as passed by the House or deleted entirely pending deliberations of the White House Conference on Aging in January.

HARRISBURG, PA., *July 1, 1960.*

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

Obviously time does not permit Pennsylvania Medical Society preparing testimony on H.R. 12580 suitable for printing in record. We have reviewed statement of Dr. Leonard W. Larson supporting H.R. 12580 and endorse his position. Please inform committee to this effect.

DANIEL H. BEE, M.D.,
Chairman, Board of Trustees, Pennsylvania Medical Society.

STATEMENT OF SENATOR E. L. (BOB) BARTLETT IN SUPPORT OF S. 3503, JUNE 29, 1960

One of the great problems of our Nation, and one of the distressing facts, is that about 9½ to 10 million persons over 65 have no medical care insurance. Although the Department of Health, Education, and Welfare has estimated that as many as 6½ million persons over 65 have some coverage, a 1957 survey showed

that among hospitalized insured couples, 73 percent had zero to one-half of their medical costs met by insurance.

It is clear that private insurance plans have been unable to meet the need for health insurance in this age group. The very period of life when the need for medical care is most urgent is the period of life when vast numbers of our fellow citizens are lacking the income or the insurance to provide that care. Many of these citizens must rely upon charity for assistance. Others live with the day-to-day dread of serious illness, which, when it comes, can erase savings.

One consequence of this situation is that many Americans over 65 years of age are without the contentment and the peace of mind to which they aspire so justly. A second consequence is that preventive medicine, an area of medical science of increasing significance, is largely neglected insofar as millions of our fellow citizens are concerned.

It now appears that our country's political leadership, regardless of party, recognizes the need for Federal legislation. The question is not whether there should be legislation, but what type of legislation should be enacted.

As for me, I believe that S. 3503—the McNamara bill—is legislation America needs. By providing coverage for home health services, laboratory and X-ray services without the prerequisite of hospitalization, S. 3503 encourages preventive medicine and discourages unnecessary congestion of our limited hospital facilities.

Primarily, the costs of insurance under the bill would be financed through the social security system. The dignity of American men and women would be enhanced not only by protection against the increasingly prohibitive cost of medical care, but also by their realization that benefits under this program are made possible only by their own contributions during the working years. A country which prides itself on self-reliance and initiative should be a country where men and women need not rely on charity or doles to meet medical needs in old age. At the same time, the concept of self-reliance does not prohibit our national community from facing the problem of medical costs for the aged in a sensible manner, apportioning the costs among the entire working population to minimize hardship and catastrophe to the individual. This principle is nothing more than the principle of all insurance programs, expressed by our people in a national decision.

One of the virtues of S. 3503 is that provision is made for coverage of those citizens among whom the need is frequently most crucial. I refer to those retired persons who do not qualify for OASI benefits.

While using the simple administrative mechanism of the social security system, the bill does not neglect those who are not qualified for social security payments. A provision is in the bill to meet their need and to give them coverage. This provision, I believe, is one of the chief advantages of S. 3503 over H.R. 4700.

There are some who object to so-called compulsory features of the bill, but I submit that it is no less compulsory to pay charitable contributions to the sick out of general tax revenues than it is to increase social security levies to pay for this program of vital social legislation.

The United States is the only major industrial Nation which has no plan for medical insurance for the aged. It is an old principle of government, and a conservative principle, that it is proper for government to help people to help themselves.. Approval of S. 3503 offers that kind of help and provides a real answer to a pressing national problem.

I am hopeful that the committee and the Senate will act favorably on S. 3503, so that the retirement years can be more truly "the golden years" and so that our senior citizens can know freedom from fear more completely.

CAMDEN, N.J., *July 6, 1960.*

SENATE FINANCE COMMITTEE,
New Senate Office Building,
Washington, D.C.:

The members of the Industrial Union of Marine and Shipbuilding Workers of America, AFL–CIO, urge the Senate Finance Committee to adopt medical care benefits for the aged within the social security system. Only through this method can we insure equitable medical coverage for all the people in this country under an administratively feasible program which can be tied in with one already in existence. We unalterably oppose any medical program which

establishes a means test as a standard of whether or not such individual shall receive such care. By the time the means test is undergone the individual may well be dead. We hold that it is a matter of right and equity that those people who have established insurance for themselves under the social security system shall be assisted in furthering such self-insurance through a program of medical care which is covered by this system. This is not socialized medicine, it is merely insurance against disaster and grief which strikes every individual during his lifetime and only on a national scale can the cost be brought down to the pocketbook of the average citizen.

JOHN J. GROGAN,
President.
ANDREW A. PETTIS,
Vice President.
RODD D. BLOOD,
Secretary-Treasurer.

MEDICAL SOCIETY OF THE STATE OF NORTH CAROLINA,
Raleigh, N.C., June 29, 1960.

Hon. HARRY F. BYRD,
Chairman, Committee on Finance,
U.S. Senate, Washington, D.C.

DEAR MR. CHAIRMAN: We regret the seeming urgency in legislative procedure which forecloses the opportunity of the Medical Society of North Carolina, through its officers, in having allocation of time in which to present in emphatic and personal testimony the sentiment expressed by this society and its members on the provisions of H.R. 12580 now before the Senate and your committee. It would seem highly desirable to us that the usual processes of government and legislation permit an adequate study of the problem of medical care and services to be required of the upcoming group of elder citizens which have so markedly excited leaders of a political concern and attitudes. To be sure, wise decisions nor workable plans are scarcely born of hasty considerations and action such as certain pressure groups are wont to devolve upon the Congress. This society conscientiously initiated a study of the question in 1955 based upon a natural and logical concern as it would with any etiology. As a result, this society adopted in its house of delegates in 1958 the principle of a general assistance program for the medical care of the aged and so recommended it to the North Carolina Advisory Budget Commission in 1958 and to the General Assembly of North Carolina in 1959. Out of this movement courses of action are in effect regarding many facets of the problem which are bringing solutions which the taxing Congress can never bring for lack of understanding and appreciation of the human equation as to gift of government on the one side and benefits to the citizen on the other.

Briefly this society takes the following categorical stand:

1. It never favors the taxing powers of government to do for people that which they can do adequately and do better for themselves than government can.

2. It finds vast inequities in the Forand principle of legislation and fears the threat of it in the form of amendments to H.R. 12580 should hearings fail to bring out needed study of the bill.

3. By policy the Government has authorized and financed a citizens conference to treat with the subject of the aging—anent the White House Conference of 1961. Therefore, the Congress should give heed to its own directed course and await the word which may emanate from this voice of citizen-leadership participating in the 1961 White House Conference on Aging.

4. In North Carolina there is in effect at this time programs of voluntary insurance wherein 55 percent of the citizens 65 years and above are covered by hospital and medical care insurance and all logical trends in the development of this movement indicates that the figure of 65 to 68 percent will be reached by 1965. Therefore, a grant-in-aid program designed solely for those in need, proven by physician and local administration investigation constitutes sound public policy and programing.

5. This society desires to assert its faith in community programs of teamwork in which the practicing physician participates and where we are demonstrating in this State that the combined approach of home nursing, physical therapy, community social and technical guidance is resulting in superior care in the home to that frequently afforded, with less efficiency, in the general hospital.

In such programs one takes note of the pride of achievement manifested in the chronically ill and aged care in the home and, indeed, pride of the family, community, and health team which has made such individualized home care possible and practicable.

6. Wherein H.R. 12580 purports to extend the eligibility of compensation benefits to the totally disabled under OASDI, there is now strong indication of laxity in medical evaluations on the present nonpatient contact basis of team evaluations, including physicians who do not practice medicine nor keep abreast of the accomplishments for the disabled through clinical medicine. This maloperation in evaluations can only be extended and exaggerated were the Congress to add yet hundreds of thousands additional disabled to the scale of eligibility. Moreover, this whole system of premium placed upon disability when related to voluntary compensation, industrial compensation, and veteran benefits, raises a point of grave concern whether the Congress does not indiscriminately create a class of malingerers and cheats for whom no self-respect or rehabilitation service serves to prise him away from the "benefit trough."

7. The previous Government policy approach to similar problems of economic need and of professional services has been efficiently devised in grant-in-aid programs participated in wisely by State and local governments and usually administered wisely and efficiently at the community and State levels without a marked abuse in bureaucracy. Such devices need to be spelled out in a proper bill drawn after adequate study.

8. Perhaps many citizens have equal or greater needs before the magic age of retirement (65) and for that reason adequate study of equivalent needs should be made before enacting half measures for those 65 and above. Investigation should be made of all who need general assistance in health services.

9. Whatever plan is authorized in current enactments should be so stable as to not warrant tampering by immediate succeeding Congresses nor subject to the whims of political pressure groups. To do otherwise will invite political wreckage of any program undertaken. Now this society favors the principles involved in H.R. 12580 or in title XVI.

10. The society has never favored inclusion of medical physicians under social security, as the tax is discriminatingly high on the concentrated period of physician earning. Moreover, physicians tend to live shorter lives and work later age levels than other groups in the working market and thus would discriminately receive fewer benefits from social security, and thereby would pay greater proportions of social security in support of other workers.

11. Physicians throughout the world resist the impact of socialiaztion of medicine because all cases prove lowered standards of services and care under such systems and socialization is noted for its sordid interference with choice of and patient relationship with physician. These facts the Forand type proposal has never taken into consideration.

For these reasons and other influences, we feel certain, the Congress will desire to take cognizance of and in so doing will yet desire to give deeper study to the overall program, thereby the present departures proposed and born of pressure tactics are being implemented in acts proposed in the Congress.

Finally we file herewith and make a part of the Committee on Finance record a document entitled "Statement of the Medical Society of the State of North Carolina, H.R. bill 4700, 86th Congress, by John Robert Kernodle, M.D., July 10, 1959, to the Committee on Ways and Means, U.S. House of Representatives."[1]

Respectfully submitted.

AMOS N. JOHNSON, M.D., *President.*

NEW YORK HOTEL TRADES COUNCIL, AFL–CIO, PENSIONERS SOCIETY,
New York, N.Y., June 28, 1960.

Senator HARRY FLOOD BYRD,
Chairman, Finance Committee,
U.S. Senate, Washington, D.C.

DEAR SENATOR BYRD: We are writing to express the views of 2,600 pensioners and 35,000 active members of the New York Hotel Trades Council.

We strongly urge that you support legislation to provide prepaid health care for our aging citizens. We favor the social security mechanism as the most efficient, economical, and practical method. Health care insurance is a logical addition to the social security system.

[1] Filed in Finance Committee files.

Our pensioners, whose income from social security and their pension combined averages about $103 monthly, can barely afford the daily necessities of life. They cannot additionally pay for health insurance.

The entire membership of our council is unalterably opposed to legislation, which requires older people, with reduced income, to pay for health insurance. They are opposed to subsidizing commercial insurance as too costly. We see no possibility that all States will raise the necessary funds to put a Federal-State subsidized insurance program into effect.

Most of our States are having difficulty meeting their budgets now. Further tax increases are anticipated without adding the heavy burden of health care.

New York State officials have publicly stated that the expense of subsidizing health care insurance would be beyond the ability of the State to meet. Governor Rockefeller has vigorously opposed the subsidizing method and has declared for the social securirty principle as most sound and practical.

Only yesterday six other Governors including Brown of California rejected all other methods of financing health care and endorsed the Forand principle, through social security.

The people do not want charity. They will not accept a means test or investigation of their private affairs. They want security with dignity. They are willing to pay for it, now, when they can afford it, so that when they are forced to retire this problem won't exist.

We urge you to actively support legislation providing health care for the aging under social security and to seek passage of it at this session of Congress.

Very truly yours,

WALTER J. SHEERIN, *Director.*

PITTSBURGH, PA., *June, 29, 1960.*

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

Would like to appear before committee to testify in support of legislation to provide health benefits to aged through contributory social security system. However do not want to delay completion of committee's work in the closing days of session, therefore would prefer to be recorded favoring adding health benefits to the OASDI system and having this telegram included in the committee's record.

MARVIN R. PLESSET, M.D.

ALAMEDA-CONTRA COSTA MEDICAL ASSOCIATION,
Oakland, Calif., June 24, 1960.

Hon. HARRY BYRD,
Senate Office Building,
Washington, D.C.

DEAR SIR: It is a pleasure to communicate with you with regard to a piece of legislation which can be honestly supported by the vast majority of medical doctors in our Nation who are the only people who have daily contact and intimate acquaintance with the health problems and needs of the aged.

This is title XVI of H.R. 12580. The diligent work of the House Ways and Means Committee has closely identified the needs of indigent old people, and has taken a long step toward solving them in a manner which is not disruptive of present mechanisms of medical practice and medical economics. This solution will permit continued improvement and evolution in the fields of health insurance and particularly in the field of providing medical services to the aged. It has the additional virtue of economy, local control, and local self-determinism to permit recognition of the variability of medical problems in the widely differing areas of our Nation.

The medical association urgently suggests that further necessary consideration by the Senate Finance Committee be accorded this legislation.

Yours very truly,

JOHN G. MORRISON, M.D., *President.*

GOLDEN AGE CLUBS,
Trenton, N.J., June 28, 1960.

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

DEAR SENATOR BYRD: We, the members of the Golden Age Club, 250 senior citizens, wish to express our firm conviction that the bill for medical care for the aged which has been approved by the House is most inadequate and will not provide the assistance so desperately needed by us.

It seems only logical and certainly more economical to use the well-established mechanism of the old-age and survivors insurance program to supply this additional care.

The basic governmental responsibility is imperative at this time if you sincerely wish to bring aid and relief of the senior citizens in this vital matter of medical care.

We urge you to use your good office to bring out a bill which will provide adequate medical care as part of the OASDI program.

Very truly yours,

BENJAMIN BERMAN, *President.*

BROOME COUNTY MEDICAL SOCIETY,
Binghamton, N.Y., June 28, 1960.

Senator HARRY F. BYRD,
U.S. Senate, Washington, D.C.

DEAR SENATOR BYRD: The Broome County Medical Society of the State of New York is in favorable accord with the action taken on social security bill H.R. 12580. This includes new medical care title XVI grant—in-aid program for the "Near Needy" aged with local determination of eligibility and administration.

We strongly urge, however, that the Senate Finance Committee hold hearings on this bill. We urge further, that no legislative action be taken on H.R. 12580 pending completion of adequate studies on the overall problem of health care for the aged.

Our reason for making these requests is obvious—the ever-increasing multiplicity of ideas regarding medical care of the aged indicates that a proper solution is still being sought. Until such time as the results of careful, thoughtful studies are known, we feel that hurried legislative action at this time would fail to achieve any real solution to the problem of medical care for the aged.

Respectfully,

JOHN A. KALB, M.D.,
Chairman, Legislative Committee.

RESOLUTION ON SOCIAL SECURITY TERMINOLGY BY THE ARKANSAS STATE ASSOCIATION OF LIFE UNDERWRITERS

Whereas the Arkansas State Association of Life Underwriters (hereinafter referred to as "ASALU"), a trade association representing 642 members, believes that the use of insurance terminology in the social security program has created a misconception by the public, since the social security program is not insurance, nor are social security taxes "premiums": Now, therefore, be it

Resolved by the board of directors of the ASALU, That it is hereby urgently requested that Congress delete all insurance terminology from the social security program, that a declaration of policy be incorporated in the act pointing out that the program is not, and is not intended to be, an insurance program and that it shall henceforth not be represented as such in any way by any official or employee of the Federal Government; and be it further

Resolved, That a copy of this resolution be sent to President Eisenhower; Hon. Arthur S. Flemming, Secretary of the Department of Health, Education, and Welfare, Hon. John L. McClellan, Hon. J. W. Fulbright, Hon. Dale Alford, Hon. Wilbur Mills, Hon. W. E. Gathings, Hon. W. F. Norrell, and Hon. Oren Harris; and be it further

Resolved, That a copy of this resolution be sent to the National Association of Life Underwriters as an indication of support in principle of its position opposing the use of insurance terminology in the Social Security Act.

CANDOR, N.Y., *June 29, 1960.*

Re medical care for the aged.

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

SIR: Social security bill H.R. 12580 is before your committee for deliberation. May I add my comment to it.

Legislation concerning revision of our social security system and the medical care for the aged is of utmost importance. The decisions reached will influence the picture of our country's retirement philosophy and tax structures to a very high degree.

There is felt a sense of urgency in congressional circles about this problem, a feeling which is accentuated by the nearness of the forthcoming elections. I like to appeal to the sense of levelheadedness of yourself and your committee members not to rush to any conclusions while exposed to undue pressures of a political nature.

Congress has set up machinery to prepare for the 1961 White House Conference on Aging, and it can rightly be expected that the country's best minds will be available at that time to help in reaching the really best possible solution. All the efforts and expenses made in connection with it would be wasted if legislation were passed now before the White House Conference had a chance to meet.

I had the opportunity to participate in a preparatory regional meeting which was held in Binghamton, N.Y., on April 20, 1960. It may interest you that it was the unanimous consensus of the group that Forand-type bills are not the answer to the medical care problem of the aged.

It was brought out that no amount of governmental subsidy will ever prove satisfactory. Rather, the best approach was felt to be an improvement of the earning power and financial situation of the aged in such a way that they themselves can be in a position to pay for their own medical care expenses.

At present a man of 65 is forced to retire from his job, and to reduce himself to the low income level for the social security benefits plus no more than $1,200 outside income a year. These stipulations were originally written into the social security legislation in order to relieve the labor situation of the thirties. That situation has basically changed since then and will probably never return. In the meantime experience has proved that that philosophy is not even as ideal as was originally assumed. Industry has frequently suffered through the loss of valuable skills. The retired worker has not always found the enforced leisure-time to be a desirable paradise.

The various panels studying this problem made the following recommendations:

(1) Retirement should be permissible on a physiologic basis not compulsory because a worker reaches his 65th birthday.

(2) The ceiling on maximum earnings should be raised considerably or preferably the restrictions on earnings should be lifted altogether.

(3) A worker's vested rights in his pension funds should be protected even when he changes jobs thus guaranteeing him the full pension income which he has earned through his lifetime accumulation of contributions.

(4) Voluntary health insurance should be made available which—

(*a*) provides coverage irrespective of age or usage;

(*b*) is guaranteed convertible from group contract to nongroup contract;

(*c*) provides the option whereby a man may elect to pay higher premiums during his working years but then has his policy fully paid up at age 60 or 65.

(5) Assistance on the Federal or State level should be made available to provide the needy with protection against catastrophic illness. The premiums payable for such subsidized major insurance and the amount of the deductible exception should be graded according to a man's need (not across the board to everybody like the provisions of the Forand bill).

After recommendations 1 to 4 are in effect the majority of retired workers will eventually have no difficulty to pay the initial deductible expense from savings, income, or through private insurance coverage of their choice before they have to call on the major medical coverage suggested in recommendation 5. I hope

that you and your committee will see fit not to vote for any immediate legislation before not all the factors involved have been carefully studied in an atmosphere of unhastened search for true wisdom.

Sincerely yours,

JOHN H. JAKES, M.D.

STATEMENT BY ILLINOIS MANUFACTURERS' ASSOCIATION IN OPPOSITION TO PROPOSED AMENDMENTS TO THE SOCIAL SECURITY ACT, H.R. 12580, JUNE 30, 1960

The Illinois Manufacturers' Association embraces in its membership approximately 5,000 manufacturing firms in Illinois, large, small, and medium sized which are engaged in a wide variety of production activities. Our members have a very direct interest in the subject of these hearings, and we are grateful for the opportunity to present our views to your committee.

We have carefully considered the changes which would be made in the Social Security Act if H.R. 12580 is enacted into law, as well as the numerous other proposals which were considered by the House Ways and Means Committee. We are especially concerned with the changes which are proposed in "Title III: Benefit Amounts," "Title IV: Disability Insurance Benefits," "Title V: Employment Security," and "Title VI: Medical Services for the Aged." We wish to express opposition to many of these proposed changes.

IMA PREDICTIONS IN 1935 WERE WELL FOUNDED

In a bulletin to members of the Illinois Manufacturers' Association dated May 6, 1935, at the time the social security bill was being considered in the Federal Congress, IMA expressed opposition to this legislation for a number of reasons and predicted that it would impose stupendous and ever-growing tax burdens upon industry and the American public. The predictions made at that time regarding the stupendous costs of this program were underestimated. In the fiscal year 1958 the taxes collected under the retirement, survivors, and disability insurance program totaled $13,099 million. This was equal to 18.3 percent of the amount of the entire Federal budget of $72 billion.

In the IMA bulletin of May 6, 1935, previously referred to, we predicted that the future course of the social security program would be dictated by political expediency. The following is a quotation from that bulletin:

"When the principles of this measure have been incorporated upon our Federal and State statute books, future consideration of social legislation would be almost entirely a matter of political expediency. Old-age pensions, unemployment insurance, etc., would become political footballs. Greater coverage and more generous allowances would be the principal issues in subsequent sessions of our legislative bodies. The 'sky would be the limit.'

"The recent almost unanimous vote of the House of Representatives of the Federal Congress on this measure illustrates how thoroughly politics dominates consideration of legislation of this type. Many of the Members of Congress voted for the bill against their best judgment, frankly saying that it would be 'political suicide' to do otherwise because of the great public sentiment for this legislation."

This prediction has certainly been borne out. The act originally provided that retirement benefits would be paid only to retired workers at age 65 or over, with the first payments to be made in 1942. But, in 1939 Congress began changing the program, moving up the first payments to 1940 and providing benefits for members of the families of retired or deceased workers. During the past 20 years group after group has been added to the eligibility rolls, benefit payments constantly raised, age limits lowered, eligibility broadened, and taxes increased.

The most sweeping changes were voted successively in 1950, 1952, 1954, 1956, and 1958—all election years for Members of the House of Representatives and one-third of the Members of the Senate. Unfortunately, our Social Security Act has become a political football.

MEDICAL CARE FOR THE AGED

In this election year of 1960 the subject of hospital and medical care for the aged has assumed great political importance. Both political parties are using medical care proposals to compete for the votes of the 16 million citizens who are 65 years of age and over. This is a voting bloc of more than ordinary potential.

The House Ways and Means Committee spent many months considering many proposals to provide medical and hospital care for aged persons. The committee finally was able to devise a bill, H.R. 12580, which on the surface is somewhat milder in its provisions than most of the other proposals. However, the manufacturing industry in Illinois as represented by the Illinois Manufacturers' Association is not in favor of this proposed legislation.

Efforts will probably be made in the Senate to amend H.R. 12580 to include many of the objectionable features which the House Ways and Means Committee has already turned down. It would be a great disservice to the American public if any such vast new permanent program, costing billions of dollars a year, were passed in haste and in an atmosphere supercharged with election year politics. Once such a measure is enacted into law, succeeding Congresses will be under pressure, as past ones have been since the first social security measure was adopted, to extend both coverage and benefits.

HEALTH INSURANCE COVERAGE IS EXPANDING

Adequate health insurance is available at reasonable premiums for aged persons as well for the general population. Voluntary health insurance is a sound and economic means for providing the aged with the medical care they need. Great strides have been made in the number of aged persons being covered by private insurance programs. The health insurance industry estimates that by the end of this year 65 percent of our older people who need and want such protection will be covered by voluntary health insurance; 80 percent will be covered by 1965, and by 1970, 90 percent of our older population will have such protection. It is obvious that the proponents of this legislation propose a permanent governmental scheme as the answer to a temporary problem.

If the Government gets into the health insurance business, voluntary insurance programs would be undermined and replaced. The Government would force a large segment of a private industry out of business. Private enterprise could not compete with a Government system of health benefits.

Under the present system of private medicine, Americans have the highest quality of health care in the world. Americans can be proud that there is no evidence that the aged fail to receive adequate health care because they cannot pay. This is a real tribute to the medical profession.

DECISION ON MEDICAL CARE SHOULD BE DEFERRED UNTIL 1961

The White House Conference on the Aged will be held early in 1961. At that time representatives from each State will discuss the whole general problem concerning our aged population. Certainly this would be an ideal time to resolve such an important issue as medical care. No Federal legislation should be enacted until the results and findings of the White House Conference are known and studied.

Medical care in any guise is a start toward socialized medicine. Even though it might temporarily be limited in scope it would provide an opening wedge for establishing a compulsory health-care program for citizens of all ages—containing certain built-in invitations for pressures to expand any initial program that might be adopted.

The quality of medical and hospital care in the country and our private medical system would be weakened. The Federal Government would set rates of compensation for hospitals, nursing homes, doctors and dentists, as well as setting standards of care. Underestimates in costs (a likely possibility) would result in pressure to reduce charges, which in turn would mean a reduction in quality of care. Overusage of facilities would be inevitable and would diminish standards of care.

It would strengthen efforts in other fields to centralize further the direction and control of our economic and social system, and weaken the efforts to attain steady, sustained progress through encouragement of individual initiative, personal freedom of choice, private enterprise achievement, and local and State responsibility. The ultimate responsibility for health treatment rests with the individual rather than through Government action.

A number of services are now available to provide medical care for persons 65 years of age or over, including—

(*a*) The individual himself and his family.

(*b*) Employers.

(c) Community and social agencies.
(d) Favorable fee treatment by doctors, hospitals, etc.
(e) Insurance companies and Blue Cross organizations.

Recommendation

The IMA submits that the Government—Federal or State—should not undertake to furnish medical care for the aged until there has been a clear and unmistakable demonstration that existing services are not adequate to supply such care. We have seen no demonstration whatsoever of such inadequacy.

We recommend, therefore, that all legislation now pending which is designed to provide medical care for aged persons should be rejected.

BENEFITS TO DISABLED PERSONS

H.R. 12580 includes a provision which would remove the age limit of 50 years to allow disabled persons to qualify for disability insurance benefits. We are not in favor of that proposal.

On February 2, 1956, a representative of the Illinois Manufacturers' Association appeared before the members of the Senate Finance Committee when it was considering proposals to include benefits to disabled persons in the Social Security Act. He said that benefits to disabled persons is a separate problem and does not belong in the old age retirement program and that it would be a big step toward socialized medicine. He continued:

"We could expect constant pressure for future liberalization provisions. The age of 50 is no magic figure as the dividing line for benefits. The disabled, regardless of age, would soon be demanding benefits. Benefits for dependents for disabled persons would doubtless be demanded in future years."

This prediction was well-founded. Dependents of disabled persons are now eligible for benefits. It is now proposed to remove the age limit and provide benefits for all disabled persons regardless of age. We object to this further liberalization of the Social Security Act.

INCREASE IN FEDERAL UNEMPLOYMENT TAX

H.R. 12580 proposes to increase the Federal unemployment tax paid by employers from 0.3 percent to 0.4 percent of their payrolls. The money which is collected from that tax is used to finance the administration of the unemployment compensation and the employment service programs of the various States.

The employers in the State of Illinois object to this tax increase. Ever since the enactment of this tax Illinois employers have been short-changed. During the fiscal years 1936 to 1953 they paid a total of $222,672,000 in Federal unemployment taxes but only $103,674,000 or 46.6 percent was returned to Illinois for employment security purposes. Illinois employers object to financing the programs of other States and resist a further increase in the tax which they must pay.

During the fiscal years 1936 to 1953 employers in all States paid $2,827,802,000 in Federal unemployment compensation taxes. Of this amount, only 67.7 percent or $1,914,058,000 was used for the purpose for which the tax was paid. The surplus of $913,744,000 which was not used for employment security administration went into the Federal Treasury.

Since 1954 the surplus has been used to build up a loan fund of $200 million to be used for loans to States which exhaust their trust funds from which benefits are paid and the balance was returned to the individual States.

One of the proposed reasons advanced for the increased Federal tax is to build up the loan fund to $550 million instead of the present $200 million. We recommend that a part of the nearly a billion dollars surplus which was paid by employers and not used for the purpose intended, be appropriated by the Congress and added to the loan fund instead of increasing the Federal tax for this purpose.

There is probably no other law that commits future generations to greater financial obligations than does our Social Security Act.

It is unwise and unnecessary for Congress to mortgage the future of Americans as a free people by enacting legislation of the type presented in H.R. 12580. In the best interests of all, we ask you to vote against these proposals.

STATEMENT OF THE CHAMBER OF COMMERCE OF THE UNITED STATES ON AMENDMENTS TO THE SOCIAL SECURITY ACT OF 1935, JULY 5, 1960

The Chamber of Commerce of the United States supports some social security proposals being considered by your committee, but is opposed to all the health care proposals for reasons outlined in this statement.

MEDICAL CARE FOR THE AGED

H.R. 12580 would create a new program (title XVI), involving Federal grants-in-aid to those State which provide medical assistance to aged persons who cannot readily afford costly illness. According to the report of the House Ways and Means Committee, this program would initially cost about $325 million annually, with the National Government supplying $165 million and States, $160 million.

This report estimated that the number of aged who might qualify for such medical assistance number from 500,000 to 1 million in a year. We have examined the committee report in detail and we believe that data now available are inadequate on which to make a reasonable, reliable estimate of the additional cost to the National Government and to the State governments. Also, we find no data indicating all States need to establish such programs.

Finally, the Ways and Means Committee held no public hearings on this proposal, and the Senate Finance Committee held only 2 days of hearings. We feel that there has not been sufficient opportunity to study this proposal. For these reasons, the national chamber is opposed to this proposal in H.R. 12580.

Several other proposals for providing medical care for aged persons within the OASDI program, including S. 881, S. 1151, S. 2015, and S. 3503, are also before this committee. The first three embody what is sometimes referred to as the Forand principle which would pay for limited hospital and other specified medical care from the OASI trust fund. This care would be provided to those drawing social security benefits, as well as to those eligible to receive benefits but who are not receiving them because they are earning a self-supporting living. In other words, there is no work test. These health care service benefits would be provided to almost 2 million people who have not retired, as well as to the 10 million who have.

The national chamber is opposed to these bills embodying the Forand approach, because, first, they would establish a "service" benefit in social security in lieu of the cash benefit; second this benefit would be provided to older persons (women 62 and over, men 65 and over) who are earning self-supporting incomes and hence may have experienced no wage loss.

We believe that the National Government should not initiate any kind of benefit in social security which denies to each individual the freedom of choice—the freedom to decide how he wishes to spend his benefit money. In the case of these proposals, additional benefit money would be raised by increasing social security taxes. However, none of this money would be paid to the beneficiaries so that each could decide how he chooses to spend it. Instead, it would be used to pay for certain health care benefits for which Congress feels he should be compelled to use that income.

The national chamber is also opposed to the Forand approach because it abolishes the work test. Age (62 for women and 65 for men) would then be the main factor determining who would receive this health care protection, and who would not. We see no more justification for mere age alone as the deciding condition of eligibility for health care benefits than we do age 50 for disability benefits.

We believe that within a relatively few years this age requirement would be eliminated and we would then have a universal compulsory health care program for all—regardless of age. Incidentally, a universal compulsory program is the admitted long-range goal of leaders of organized labor (see testimony of Mr. Nelson Cruikshank and Mr. Walter Reuther, "Hospital, Nursing Home, and Surgical Benefits for OASI Beneficiaries," hearings, House Committee on Ways and Means, 86th Cong., 1st sess. pp. 101, 403).

Adoption of any Forand-type proposal (as well as S. 3503) is the certain way to achieve this goal—piecemeal. In consequence, the national chamber is opposed to all Forand-type proposals since we believe the National Government should not intervene in any area in which it has been demonstrated that private effort, depending upon individual freedom of choice, can meet human needs and wants.

The tax costs of such a universal program would certainly equal the amount people voluntarily spend for such health care, which in 1958 totaled more than $16 billion. Experience in other countries where health care benefits are supposedly "free," strongly suggests that the tax costs would exceed this $16 billion amount—and would involve many billions of dollars additional social security taxes annually on workers and on business. This additional tax burden could threaten public acceptance of the present social security program on which so many millions now depend as a "floor of protection." In considering any changes in social security, it must always be borne in mind that the present schedule of benefits will require a 50-percent increase in taxes on workers and on employers by 1969. Assurance of benefits in the future depends wholly on workers' willingness to pay these much larger taxes.

In slight contrast to these first three bills (S. 881, S. 1151, and S. 2915) S. 3503 contains a kind of a work test but it differs radically from the one now in social security. The present work test is one which must be met each and every year until age 72. However, the work test in S. 3503 is one which must be met only once—in any calendar year after a woman's 61st birthday or a man's 64th birthday. Having met this test once, a person could receive health care benefits regardless of whether he was truly retired, or working full-time.

Here again, age would be the decisive factor separating those who would get benefits from those who would not. The inequities are obvious. For example, in the case of two men—one, aged 63 and the other 65, and both working full-time and receiving the same pay—the first one would receive no health care benefits while the second one would get such benefits. We do not believe such inequities could long persist—Congress would soon remove "age" as a condition of eligibility.

It should be noted that the work test in S. 3503 for health care benefits is $2,000 of earnings in any calendar year, or $100 a month wages in each of 3 months in any calendar year after a woman's 61st birthday, or after a man's 64th birthday. This "test" differs very materially from the present work test for cash benefits. In consequence, many older people would receive the proposed health care benefits under social security but could not receive cash benefits. Obviously, the easier work test in S. 3503 would soon be made to prevail for the social security cash benefits as well.

As under the Forand-type proposals, social security would then no longer be a system of benefits partially to replace wage-loss on retirement, but one paying benefits automatically at age 65. Tax costs would increase very substantially. Since monthly income guaranteed at age 65 can be obtained through private enterprise, we do not believe the National Government should intervene in this field.

Should a sound work test be placed in any Forand-type proposal, or in S. 3503, the national chamber would still oppose the initiation of the service type benefit in social security. In a compulsory program, there is no substitute for paying benefits in cash that is acceptable to free Americans. Benefits in cash alone preserve the individual's freedom to decide how he wants to use that income—to choose whether he wishes to save it, or to spend it—to spend it for medicine, drugs, health insurance, or for other things to meet his own needs.

OTHER SOCIAL SECURITY CHANGES

H.R. 12580 would extend social security coverage. The national chamber has long had the following policy—"The system of Federal old-age and survivors insurance benefits now covers more than 90 percent of the workers of the country. Extension should be made promptly to the few noncovered groups."

Another provision in H.R. 12580 would reduce the quarters of coverage required for benefit eligibility. The national chamber is opposed to this proposal easing quarters of coverage from one out of two to the one out of four as a condition of benefit eligibility. We know of no conditions which would justify this change.

CHANGES IN THE FEDERAL UNEMPLOYMENT TAX ACT

H.R. 12580 would increase the Federal unemployment tax rate on employers' payrolls from 3 percent to 3.1 percent. The maximum credit against this would remain at 2.7 percent. The net effect is to increase the Federal unemployment compensation tax rate from 0.3 to 0.4 percent on the employers' payrolls covered by the act.

The present Federal unemployment compensation tax rate continues to yield revenues in excess of the amounts required for administrative purposes and for the Employment Service. Consequently, the national chamber is opposed to any increase in these taxes since additional moneys to operate an effective unemployment compensation program are not now needed.

ROCHESTER, N.Y., *June 30, 1960.*

Senator HARRY F. BYRD,
Committee Chairman, Senate Committee on Finance,
U.S. Senate, Washington, D.C.:

As a doctor of medicine I should like to appear before your committee to testify in support of legislation to provide health benefits to the aged. However, I don't want to delay completion of your committee's work in these closing days of the congressional session and if my personal appearance would hold up the committee's deliberations I would prefer to be recorded favoring added health benefits to the OASDI system by having this telegram included in the committee's record.

WILLIAM A. SAWYER, M.D.,
Medical Consultant, International Association of Machinists.

PHILADELPHIA, PA., *July 1, 1960.*

Senator HARRY F. BYRD,
Chairman, Committee on Finance,
U.S. Senate, Washington, D.C.:

As medical director of the Sidney Hillman Medical Center, I would like to go on record as requesting that your committee give favorable consideration to legislation providing health benefits to aged through social security system.

JOSEPH A. LANGBORD, M.D.

WASHINGTON, D.C., *July 1, 1960.*

Hon. HARRY F. BYRD,
Chairman, U.S. Senate Office Building,
Washington, D.C.:

Textile Workers Union of America, AFL-CIO, representing over 220,000 workers in 38 States, request that it be recorded in current hearings of Senate Finance Committee as urging adoption at this session of legislation assuring health care for the aging along the lines of the McNamara and Forand bills. We insist upon the social insurance principle as absolutely essential to a sound and workable bill to aid the aging. We reject a means test as degrading, unfair, and cumbersome. Please record our opposition to title VI of H.R. 12580 and our support for a measure similar to S. 3503. Recent convention of our union voted this position after full debate in which only rank and file delegates took floor.

WILLIAM POLLOCK,
General President, Textile Workers Union of America, AFL-CIO.

ELKINS, W. VA., *June 30, 1960.*

Senator HARRY F. BYRD,
Chairman, Senate Finance Committee,
Washington, D.C.:

As a practicing surgeon and hospital medical director I feel the present proposed social security system for assisting the aged in the cost of their medical care is the best presented to date. I heartily urge its passage and shall be willing to testify on its behalf. Should time not permit I ask that this concurrent telegram be incorporated in the records.

BENJAMIN I. GOLDEN, M.D.

HAMDEN, CONN., *June 30, 1960.*

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

The Connecticut State Labor Council strongly urges your committee report favorably a bill of health care for senior citizens. Based on the well-established

social insurance principle of social security there is no adequate and equitable means of alleviating the financial burden of medical and hospital costs which retirees on reduced income face. The social security solution to this problem, based as it is on contribution of employer and employee, is the least costly of all solutions to Federal and State Governments.

JOSEPH M. ROURKE,
Secretary-Treasurer, Connecticut State Labor Council.

ITHACA, N.Y., *June 30, 1960.*

Hon. HARRY F. BYRD,
U.S. Senate, Washington, D.C.:

Regarding your current hearings on proposed legislation for health care of the aged, may I request insertion of remarks into your committee record. As a physician engaged for 20 years in administrative medicine at the level of the local community, the State, and the Federal Government, I am convinced that health services of aged persons can be maintained at proper American standards only through insurance which is fully paid up before age 65. This is most feasible through our well-established social security system. Such coverage would halt the rise in voluntary hospitalization insurance premiums now carried by wage-earning citizens while also reinforcing the financing of our voluntary hospitals at their weakest points. I therefore urge amendment of the Social Security Act to provide hospital and medical services for aged beneficiaries. For identification purposes I am an associate professor of administrative medicine at Cornell University.

MILTON I. ROENER, M.D.

PORTLAND, OREG., *July 1, 1960.*

Hon. HARRY F. BYRD,
Chairman, Senate Finance Committee,
Room 2227, New Senate Office Building, Washington, D.C.:

On behalf of the International Woodworkers of America, AFL–CIO, we urge you and your committee to adopt a program of medical care for the aged within the social security system. We urge you to oppose direct relief approach and means test requirements.

A. F. HARTUNG,
International President, International Woodworkers of America, AFL–CIO.

DETROIT, MICH., *June 30, 1960.*

Hon. HARRY F. BYRD,
Chairman, Senate Committee on Finance,
U.S. Senate, Washington, D.C.:

Urge that the Finance Committee give favorable consideration to amending House Ways and Means Committee social security bill to provide that broad health benefits for the aged be obtained through the social security system. This will afford the most sound and economical solution to a vast social and economic problem. Please include this telegram in the record of the committee.

FREDERICK D. MOTT, M.D.

MEYERSDALE, PA., *June 30, 1960.*

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

I do not feel that the present bill for medical assistance to the senior citizens is nearly adequate. Any legislation must be coupled with social security benefits in broader coverage to be satisfactory.

ROSS RAMBAUGH, M.D.

SALISBURY, PA., *June 30, 1960.*

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

In my opinion the present administration hospitalization bill for the aged is unfair to the majority of our senior citizens. I feel strongly that any adequate

bill should be part of the social security program. I just returned from a month's survey of European hospitals and found that the aged in the seven countries I visited are adequately protected against the insecurities of expensive hospitalization by national insurance programs.

ALEXANDER SOLOSKO, M.D.,
Chief of Staff, Meyersdale Community Hospital, Meyersdale, Pa.

AUSTIN, TEX., *June 30, 1960.*

HARRY BYRD,
Chairman, Senate Finance Committee,
U.S. Senate, Washington, D.C:

In behalf of the 675 members of the Texas Hospital Association who are dedicated to the better health of all Texans, we urge you to use your vote and influence to defeat the unnecessary legislation pending before the Senate regarding federally supported health care for the aged. This is a local and State responsibility and we are doing our utmost to provide the necessary care through voluntary means.

FRED R. HIGGINBOTHAM,
President, Texas Hospital Association.

CINCINNATI, OHIO, *June 30, 1960.*

HON. HARRY F. BYRD,
Room 227, New Senate Office Building,
Washington, D.C.:

I urge your committee to adopt medical care benefits for aged as part of social security system and oppose any means test legislation.

GEORGE M. HARRISON,
Brotherhood of Railway Clerks.

WINDOW CLEANERS UNION, LOCAL 16,
BUILDING SERVICE EMPLOYEES INTERNATIONAL UNION,
Pittsburgh, Pa., June 29, 1960.

Senator HARRY BYRD,
Chairman, Senate Finance Committee.

DEAR SENATOR: On behalf of 250 members of our organization and for myself, I am writing this letter to urge you to do all in your power to support the Senate bill 3503.

Your support of this bill will be greatly appreciated.

Very truly yours,

LEO KAPRUS, *Secretary-Treasurer.*

U.S. SENATE,
COMMITTEE ON BANKING AND CURRENCY,
July 1, 1960.

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

DEAR MR. CHAIRMAN: I have recently noted that he Nationwide Insurance Co. of Columbus, Ohio, has taken a strong position supporting the use of the social insurance principle to meet the health needs of older citizens.

This responsible company which has grown to list assets of $350 million, is the first such large insurance carrier to recognize the desirability of legislation to carry out this principle. At the same time, it understands that such a measure would leave a large area of opportunity for the private insurance industry.

For the information of the Members of the Senate and others who will be studying this issue, therefore, I would like to request that the policy statement of the Nationwide Insurance Co. on this issue together with a memorandum indicating the supporting reasons for their policy position, and a New York Times

editorial of June 13, 1960, commenting upon their action, be included in the official record of the hearings on H.R. 12580 when these hearings are printed. I am enclosing these items with this letter.

With kindest regards.

Faithfully yours,

PAUL H. DOUGLAS.

[From Congressional Record, Appendix, June 15, 1960]

NATIONWIDE INSURANCE COS.' POLICY POSITION ON HEALTH INSURANCE FOR AGED

On April 7, 1960, the Nationwide Insurance Board of directors adopted the following policy relative to health insurance for older persons:

"Whereas the Nationwide Insurance Cos. are deeply committed to the principle of helping people to meet their social and economic needs; and the health needs of their older citizens are among the mose urgent and pressing social problems remaining unsolved; and

"Whereas most of the health costs of older people are not being met by insurance as evidenced by certain statistics which indicate that 86 percent of couples receiving social security benefits in 1957 had none of their medical care costs met by insurance; and

"Whereas certain statistics indicate that most older people had neither the income nor the assets to meet such expenses as evidenced by the figures that nearly 4 out of 10 couples over 65 years of age had total income of less than $2,000 in 1958: Be it

"*Resolved*, That it be the policy of the Nationwide Insurance Cos.:

"(*a*) To support the use of the social insurance principle to meet the health needs of older citizens.

"(*b*) To support the application of this principle in appropriate legislation to provide basic health insurance to those eligible for old-age, survivors, and disability benefits as a feasible and desirable step in this direction.

"(*c*) To continue our efforts in our own insurance program, in conjunction with cooperative health plans, and as members of the private insurance industry to provide further health care through voluntary coverage in addition to that which may be furnished through Government programs."

The adoption of this policy was based on certain major considerations which are summarized as follows:

PROBLEM

Nationwide Insurance is deeply committed to the principle of helping pepole meet their social and economic needs. The health needs of our elder citizens are among the most urgent and pressing social problems remaining unsolved.

Understandably, on an issue of this sort many different sets of figures can be cited; in fact, there are as many figures as there are viewpoints. All of them, however, have one thing in common; they all conclude that most of the health costs of older people are not being met by insurance. In Nationwide's approach to a management decision, the figures most often referred to were those provided by the U.S. Department of Health, Education, and Welfare; 86 percent (85.6 percent) of couples receiving OASDI benefits in 1957 had none of their medical care cost met by insurance. Nine out of ten (91.8 percent) of the single beneficiaries had none of their medical care cost met by insurance. Of those who received some benefit and were hospitalized, 44 percent of them had less than 25 percent of their bills covered by insurance and 73 percent had less than half of the bill covered.

Nine percent of the aged couples receiving the social security benefits had medical expense in excess of $800 annually in 1957 and 16 percent had medical expense in excess of $500. One in five (22 percent) had expense in excess of $400.

Most older people have neither the income nor the assets to meet such expenses. Nearly 4 out of 10 (37.4 percent) couples over 65 years of age had total money income of less than $2,000 in 1958. And more than half (55.4 percent) of such couples had incomes of less than $3,000 in that year. Nearly half (45 percent) of the spending units with the head of the household more than 65 had total financial assets of less than $500 and 63 percent had assets of less than $2,000.

It is not surprising that approximately 14 percent of the couples receiving social security benefits in 1957 either increased their medical debts or received charity.

The cost of voluntary insurance policies cannot be borne by older persons alone. Realistically, the most that can be hoped for is that somewhat more than half the aged can pay premiums of about $100 per year. A $100 annual premium cannot cover more than a fraction of the aged medical care needs. The enactment of a bill providing basic hospital coverage for the aged will, in fact, open up markets for voluntary insurance among our older people. Private insurance companies can design health insurance packages to meet the important supplemental areas of medical need not met by the existing legislative proposals.

For example, 20 percent of all persons over 65 who were hospitalized in 1958 remained in the hospital for more than 60 days.

Persons over 65 use, on the average, 4.4 visits annually to the doctor's office and average 1.4 physician calls at home each year. The need for home and office care provides wide opportunities for voluntary insurance to build on the base of bills presently proposed.

DETAILS

The opponents of the social insurance approach stress the potentially high costs of the program. Some estimates place the cost as high as $2 billion. Yet when it is considered that medical care for the aged is one of our most pressing social problems, and that this amount will be less than four-tenths of 1 percent of our gross national product in 1960, this seems extremely modest.

The actuarial staff of the Department of Health, Education, and Welfare estimates the annual cost of the Forand bill (one bill now under consideration in the Congress) at somewhat less than a billion dollars ($895,400,000), or 0.428 percent of taxable payroll. The Department of Health, Education, and Welfare estimates that the cost in 1975 will be between 0.49 and 0.62 percent of taxable payroll, assuming a taxable limit of $4,800, which is the current figure.

In a democratic society people decide how much of their incomes they will devote to public services.

The consumer, as a voter, secures a desired balance between public and private services. Through this process, the Federal Government has always provided a national minimum of welfare services for its citizens.

In 1935 the need for a national pension program was fulfilled by enacting the social security system. At that time the medical associations and the life insurance companies opposed the program for most of the same reasons that today they oppose the social insurance approach to health care for the aged. Yet for three decades that program has demonstrated its effectiveness in providing a floor for retirement income. In fact, its minimum provisions have made possible the widespread development of private plans in recent years.

In our opinion, private insurance carriers would have a broader, sounder market for voluntary insurance among our older people by building on the basic provisions of social insurance legislation. With a balance of effort on the part of both industry and Government, a program can be built which will provide for every citizen's health needs in his old age. The social security system can provide the foundation for a comprehensive private-public health insurance system; it is the function and the opportunity of private, voluntary insurance to build on this for completely adequate health care at reasonable cost. On behalf of our 3 million policyholders, we want to do our part.

The need for social insurance in this area has been summarized best by Business Week magazine, February 13, 1960:

"If the Government steps in to provide insurance against catastrophic illnesses of the aged, it will not be moving in where private industry can do the job. It will be assuming responsibility in an area where industry has found it cannot offer the protection needed."

An objective and unbiased article in the Harvard Business Review, "Health Care of the Aged," January–February 1960, comes to a similar conclusion:

"Notwithstanding the considerable technical problems of providing hospitalization and surgical benefits under social security, the very difficulty of cost prediction itself, as well as the essentiality of these benefits, would seem to recommend the social insurance method."

CURRENT LEGISLATIVE PROPOSALS

Health insurance for the aged is probably the single most important domestic issue now before this country. There is a growing recognition by all groups that some form of Federal legislation must be enacted. You are undoubtedly aware of the fact that there are a number of bills now before the Congress. The

situation is changing constantly and at this time it is impossible to predict which bill or combinations of bills may progress through the Congress or whether any bill will pass. The basic point of contention is whether the social security system will be used to provide this protection, or Federal funds will be used to subsidize insurance for older persons who qualify on the basis of a means test. The company policy supports the use of social security.

All of the bills now being publicly discussed have various benefit proposals. It is unlikely that any one bill will emerge unchanged and, for this reason, the bills will not be analyzed in detail.

Under consideration in the U.S. Senate are:

1. The Javits bill (sponsored by seven Members of the Senate) would appropriate Federal funds for grants to the States. Federal funds supplemented by State funds would then be used to subsidize health insurance for older persons who qualified on the basis of a means test.

2. Bills introduced by Senators Kennedy, Humphrey, and Morse would increase the social security tax to finance health care for the aged. All three of the bills are different in terms of benefits but all would cost about an additional one-quarter of 1 percent for both employer and employee.

Under consideration in the House of Representatives are:

1. The Forand bill would also use the social security system to finance the health care of older persons. Benefits are somewhat different than the other bills. The cost would be one-quarter of 1 percent for both employer and employee.

2. A proposal is being considered by the House Ways and Means Committee to increase the old-age assistance program so that larger Federal grants will be made to the States for medical care for indigent older persons.

(Later legislative developments include (1) submission to the House Ways and Means Committee by the Eisenhower administration of a "medicare program for the aged," and (2) introduction in the Senate of a bill sponsored by Senator Pat McNamara of Michigan and 16 Democratic colleagues. Under the administration program the States, with the aid of Federal matching grants, would administer a plan to be offered to those 65 and over who either did not pay an income tax in the preceding year or had gross income not exceeding $2,500 ($3,800 for a couple). Those eligible and accepting the plan would pay a $24 a year enrollment fee. The McNamara bill, like the Forand bill, is based on the social security plan but would provide more comprehensive coverage than the Forand bill. It also makes provision for coverage of people ineligible for OASDI benefits.)

All of the bills in the area of health insurance for the aged have been evaluated on the basis of whether the program will be financed by the social insurance approach or the charity approach with a means test to determine eligibility.

[From New York Times, June 13, 1960]

WIDER USE FOR SOCIAL SECURITY

A convincing case for using the Federal social security system to finance health insurance for older people has been made by Nationwide Insurance. It is persuasive not only because of the arguments used but also because of its source.

Nationwide has had a unique experience in giving the public protection. Founded by a small group of Ohio farmers in 1926 as a cooperative automobile insurance concern with a capital of $10,000, it has become one of the largest insurance operations in the country. With assets of more than $350 million it gives many kinds of coverage in 20 States through more than 3 million outstanding policies.

The directors of Nationwide have stated in a formal resolution that the health costs of older people are not being met by insurance, that those over 65 haven't either the income or the assets to cover those expenses, that Nationwide favors the use of the social security principle to help meet their needs and, more specifically, that it will support "appropriate legislation" to provide basic health insurance to those eligible for Federal social security benefits.

A memorandum ably summarizes the statistical and historical evidence for the stand Nationwide has taken. It emphasizes a point which seems to be generally overlooked in the current discussions. It claims that, far from damaging the interest of private insurance companies, the companies "would have a broader, sounder market for voluntary insurance among our older people by building on the basic provisions of social insurance legislation."

The Nationwide memorandum also points out that before the establishment of the social security system in 1935 the medical societies and many insurance companies opposed the program for most of the same reasons they now oppose the social insurance approach to health care for the aged. But the three decades of experience since then have shown that the minimum social security pensions "have made possible a widespread development of private plans in recent years." We hope that the interests now opposing this extension of the social security system will prove to be as wrong as they were in 1935.

WASHINGTON, D.C., *July 1, 1960.*

Hon. HARRY FLOOD BYRD,
Chairman, Committee on Finance,
U.S. Senate, Washington, D.C.

DEAR SIR: This letter is submitted in lieu of a personal appearance before the Senate Finance Committee, due to the limited notice, to express the views of the National Associated Businessmen, Inc., on H.R. 12580.

National Associated Businessmen, Inc., is an organization of some 700 businessmen in all parts of the Nation. Its charter directs that on behalf of its members and affiliated groups it will conduct research on problems common to business and distribute its findings through appropriate channels.

Its object is to encourage mutual understanding of problems of the business community and to stimulate public interest in sound laws and other measures that will preserve for our economy the benefits of the American system of free enterprise for profit.

Our association's members as social security taxpayers and potential beneficiaries, and as businessmen interested in a sound economy, are profoundly concerned with the proposals to liberalize and add to social security benefits and Federal grants to States contained in H.R. 12580 and other pending social security measures.

In the last decade we have seen the maximum annual combined social security payroll taxes imposed on an employee and his employer increase from $60 per year to a present $288, and with further scheduled increases which by 1969 will be $432. This has been the inevitable result of benefit liberalizations each election year since World War II.

We have likewise already seen, despite repeated increases of social security taxes, the OASI expenditures running well in excess of OASI income. This has occurred during each of the past 3 years in which benefit payments were respectively $7.3, $8.3, and $9.8 billion, and OASI contributions $6.8, $7.6, and $8 billion.

What will be the situation a decade from now when expenditures are estimated to be some twice as large? Will businesses and their employees actually pay in 1970 the estimated $20.2 billion OASI taxes and $1.2 disability taxes which Congress has scheduled to finance OASDI benefits under present law?

The Ways and Means Committee report, table 4, estimates for the 3-year period 1960–62, inclusive, total taxes and interest of $34.8 billion, assuming that coverage is expanded and interest provisions liberalized as provided in H.R. 12580. But the OASDI trustees' report, filed last March, estimates that the expenditures in this same period will be some 800 million more.

Despite the background of the large deficits of the last 3 years—some $1.7 billion last year alone—and prospective deficits in ensuing years, H.R. 12580 would place some 625,000 people immediately on the OASI rolls, and would increase benefits of 400,000 children and otherwise liberalize benefits. It would likewise immediately add an estimated 250,000 to the disability rolls.

The Ways and Means Committee report on H.R. 12580 acknowledges in its estimates, that these liberalizations would add to the existing OASI level premium deficit and create a deficit for the disability system. Our organization believes it would be a grave disservice to the millions relying on the integrity of the OASDI system to vote election year liberalizations on the basis proposed by H.R. 12580. The OASDI system is committed, according to the trustees' report estimates, to expend over $63 billion in benefits and $2 billion in administrative expenses and railroad retirement transfers in this and the ensuing 4 years. These benefit payments will exceed all benefits which have been paid from the beginning of the system to January 1 of this year by over $11 billion. Until there has been some actual experience with financing expenditures of this magnitude, it would seem most unwise to increase the benefits.

All OASDI estimates in the House report on H.R. 12580 are made on the assumption of high employment levels. Prudence requires that consideration be given of the situation OASI will face in the event there is some letup in employment. The OASI trustees' report filed in March of this year recognizes this by inclusion of a table illustrating the results.

It is headed "Table 19.—Illustration Showing the Operations and Status of the Old-Age and Survivors Insurance Trust Fund Assuming the Unlikely Event of a Sharply Reduced Level of Economic Activity, Calendar Years 1960–64."

This table does not reflect a very "unlikely event." The OASI tax collections for this "unlikely" 5-year period are assumed to aggregate $52.3 billion—as compared to $34.3 billion actually collected for the 5-year period ending last January. As a matter of fact, this $52.3 billion is less than 11 percent below the revenue estimated under the "high employment" assumptions used in the report.

But even so, this table shows the trust fund, which was $20,141 million last January 1, at the beginning of the 5-year period, dropping to $10,972 by its end. This, of course, may happen. We have already seen the trust fund in the 3-year period 1957, 1958, and 1959 drop nearly $2½ billion, from $22,519 million to $20,141 million. In 1959 alone the drop was $1,723 million. The table shows an estimated drop of $469 million in 1960, $1,643 in 1961, and $2,823 in 1962.

This illustrates an economic uncertainty no actuary can solve.

It is most discouraging to our membership to see these election year liberalizations passed by the House of Representatives with no provision for meeting their additional costs. It is our hope that the Senate will reject these deficit increasing liberalizations.

H.R. 12580 likewise contains provisions for Federal grants for partial financing of medical care programs established by States for persons age 65 and older. Present law already does this for persons whose needs qualify them for public assistance, and the purpose of the pending proposal seems to be more to meet politically the recent drive for providing the aged with free medical care, rather than to meet any real emergency.

What additional funds or services are needed by the aged and how these should be provided are subjects of a White House conference to held early next year at the conclusion of regional and local conferences currently being held. Common prudence would dictate awaiting the work of these conferences before undertaking to hastily frame any kind of additional public medical care programs for this group.

The association is particularly concerned with the radical proposal which some Senators are sponsoring of providing medical care to the aged as an OASI benefit supported by OASI payroll taxes. This proposal would involve presently unascertainable but obviously huge and increasing costs. What additional tax rates would have to be imposed to those presently scheduled is uncertain. But it is certain that the number of eligibles would rapidly increase over the years. That it would tremendously add to the prospective deficits is the only certainty.

In view of the foregoing, our association most earnestly requests that no action be taken in liberalizing OASDI or providing medical benefits in this election year. Instead, it is recommended that hearings be held next year and careful analysis made of the solvency of the system.

Respectfully submitted.

ELTON B. KILE,
President, National Associated Businessmen, Inc.

OREGON STATE MEDICAL SOCIETY,
Portland, Oreg., June 29, 1960.

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

DEAR SENATOR BYRD: The privilege you afforded us to express the Oregon State Medical Society's support of title VI of H.R. 12580 recently passed by the House of Representatives was greatly appreciated.

Title VI of the bill will adequately assist the "near-needy" aged in meeting their health care costs. It is this segment of our aged citizens about which the medical profession has long had a deep concern. Especially, physicians have been concerned about the ability of that group to meet the costs of necessary hospital and nursing home care. The local determination of eligibility and local

administration provided in title VI of the bill should make possible the most effective utilization of the funds appropriated.

The society, however, strongly urges that your committee reject any amendments to title VI of the bill which would bring these benefits under the old-age survivors and disability insurance program. The society is unqualifiedly opposed to such amendments or any legislation which would bring health care benefits under that program.

Providing health care benefits for the aged through the OASDI program would transfer to the Federal Government the major responsibility for furnishing those services and remove most of the local administrative features of title VI of H.R. 12580. The vast majority of our citizens 65 and over are capable of and prefer to finance the cost of their health care by their own resources. Yet, under an OASDI program, the nonneedy as well as the near-needy and needy would become wards of the Federal Government. Moreover, through such legislation, an avenue would be opened for the extension of such a program to include all our citizens under a national compulsory health insurance system with all its demonstrated disadvantages and astronomical costs.

You and the members of your committee are, most certainly, fully aware of the tremendous growth in voluntary health insurance during the past decade. This growth has been not only in the number of our citizens who have taken advantage of this protection but in the broadening of benefits as well. The broadening of benefits offered by the many voluntary health insurance plans has been a result of the experiences gained during the not much more than a quarter century that this relatively new form of insurance protection has been so generally available.

As a result of this experience and success, voluntary health insurance plans have learned that their benefits can be extended to retired and aged persons. Here, the growth has been most astonishing. More plans are constantly being developed and offered and nearly 60 percent of our over-65 citizens have taken advantage of them. Their popularity is evidenced by the 135 percent increase in the number covered since 1952.

Just as voluntary health insurance plans have demonstrated their ability to protect the employed worker and his family against health care costs, just so can it be unquestionably anticipated that these plans will be able to provide this protection to all our aged citizens. The record of voluntary health insurance in the United States is clear and it should be given full recognition and every opportunity to fulfill the obligation it is assuming.

Therefore, we express again our support of title VI of H.R. 12580 and reemphasize our unqualified opposition to any OASDI amendments which might be proposed.

Thank you again for affording this opportunity to give the view of the Oregon State Medical Society regarding title VI of H.R. 12580.

Respectfully,

LOUIS J. FEVES, M.D., *President.*

AETNA LIFE INSURANCE CO.,
Indianapolis, Ind., June 27, 1960.

Re hospitalization insurance for senior citizens.

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

DEAR SENATOR BYRD: It has come to my attention that following a statement made by the president of the Nationwide Insurance Co. to the effect that in his opinion use of the social security system as a vehicle for providing hospitalization insurance for senior citizens is the proper means to provide an answer to any such problem which may exist, certain Senators and Congressmen have concluded that this is the considered opinion of the insurance industry. I wish to go on record firmly and emphatically that, it is my belief, quite the reverse is true, and that the great majority of those engaged in serving the public in accident and health underwriting feel that: (1) Those in need of coverage will be served more efficiently and more completely through the insured approach in private industry; (2) that it has not been demonstrated that those who actually need and want coverage cannot obtain it through private means; (3) that in the semihysteria of an election year this matter should not be decided; (4) that this subject might be more properly and more accurately discussed

the first of next year when the conference for aging convenes; and (5) at least 65 percent of people who need and want this type of coverage will be able to obtain it through private means and that this percentage will increase rather rapidly in years to come to about 90 percent.

Over and beyond the points which have been raised in the preceding paragraph is my urgent request that items of prime importance to our national morale and welfare be given prompt consideration. The tendency to shift the responsibility of care for senior citizens from the individual, the family, and the community to our Federal Government is another step in weakening our national stamina.

I urge respectively that these points be considered carefully and thoroughly when this matter is brought up for discussion.

Very truly yours,

HOWARD BULL, C.L.U.

THE RHODE ISLAND MEDICAL SOCIETY,
Providence, R.I., June 28, 1960.

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

DEAR SENATOR BYRD: Naturally the Rhode Island Medical Society is very much concerned with the legislation as adopted by the House of Representatives in H.R. 12580, and particularly as regards the new medical care title 16 which provides medical benefits for the "near-needy" aged.

We are sure that you know of the outstanding medical aid program that has been developed by the division of public assistance of the State department of social welfare with the full cooperation of the Rhode Island Medical Society.

What you may not know is the outstanding record of enrollment in our voluntary Blue Cross and Physicians Service programs by persons over the age of 65. We question that there is a State in the Nation that has such a fine record. I am enclosing a study that has just been completed by the Blue Cross and Physicians Service, and I call to your attention the conclusion on the first page which shows that the self-supporting persons in Rhode Island over the age of 65 have willingly secured our hospital and surgical-medical program.

The percentage of over age 65 persons purchasing this coverage is greater than the percentage of those under that age. Thus it is apparent that the older citizens in Rhode Island recognize the liberal benefits of our program and the outstanding service that is rendered by the physicians who accept the indemnities as full payment for all persons whose annual family income is below $6,000.

We feel strongly that the success of the voluntary effort in Rhode Island could be equally duplicated in the other States with encouragement and advice from legislative as well as other sources. We certainly hope that you will see that adequate hearings are held on H.R. 12580 before any amendments are added to it that would tend to destroy the voluntary effort that we have proved workable and successful in our Rhode Island.

Sincerely yours,

EARL J. MARA, M.D., *President.*

PHYSICIANS & SURGEONS CLINIC,
Corsicana, Tex., July 1, 1960.

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

DEAR SENATOR BYRD: My friends, my patients, my fellow physicians, and I are becoming increasingly alarmed about the ever-growing tendency of our Nation toward more and more centralized government. We know that every nation in the history of man in which the central government has become all powerful has fallen into ruin. We fear for the sacred heritage that our forefathers left to us. We believe, as did our forefathers, that eternal vigilance is the price of freedom.

We have never yet been convinced that there is a need for any kind of Federal medical care bill. In our area, we take care of our aged, needy, and indigent on a local and State basis, the way our forefathers did. We know of no one who lacks for medical care due to age or inability to pay.

According to extensive surveys, the only problem that has even hinted at being prevalent has been a temporary one which is rapidly being solved by private enterprise in the field of private health insurance and by medical society committees on aging, local and State projects.

Are we expected to sit idly by while pressure groups, especially AFL–CIO, through COPE, continue to sell our freedom down the river to oblivion?

We consider the individual primarily responsible for his care, either through his own financing or private health insurance, the family secondarily responsible, and the local and State communities finally responsible. Is this not the American way?

The bill which has already been passed, allowing income tax relief for family expenditures on medical care, should stimulate the second group. The individuals I know are proud and want to care for themselves when they possibly can.

As you and I both know and as proven by reliable surveys, not everyone over 65 is indigent or needy. Seventy percent own their own homes, and of those 80 percent are mortgage free. In 1957 their median net worth was $10,000. Most of them no longer have children at home to support and educate. Actually, their children are now able to help them in most cases.

Sixty-five percent of the aged needing and wanting protection will be insured by the end of this year, 80 percent by the end of 1965, and 90 percent by 1970.

Based on the above facts, Senator Byrd, we urge and implore you to use whatever influence you may have with your committee to defeat House-passed H.R. 12580 and any other proposed Federal medical care bills.

We cannot afford to compromise with socialism.

Yours truly,

R. L. CAMPBELL, M.D.
J. H. BARNEBEE, M.D.
WM. B. MAYFIELD, M.D.
A. L. GRIZZAFFI, M.D.
C. D. CAMPBELL, M.D.

BRIEF ANALYSES OF, DEPARTMENTAL VIEWS ON, AND TEXT OF SENATE AMENDMENTS TO H.R. 12580, AS INTRODUCED THROUGH JULY 2, 1960

1. AMENDMENT 6-24-60-C—INTRODUCED BY SENATOR McNAMARA

Staff Analysis

Eligibility.—Individuals who have reached retirement age and are (A) eligible to receive, but not necessarily receiving, social security old-age and survivors insurance benefits, and who meet an income (retirement) test provided in the bill; or (B) not eligible for social security benefits who meet the income (retirement) test provided in the bill (except persons eligible for civil service and railroad retirement benefits).

Benefits.—1. Hospital services—90 days per year (effective between July 1, 1960 and January 1, 1962).

2. Nursing home care—180 days per year (effective between January 1, 1963 and July 1, 1963).

3. Home health services—240 days per year (effective between January 1, 1962 and July 1, 1962). (The first 3 benefits may be combined for a total of 90 "units" per year—1 unit comprising 1 hospital day, or 2 nursing home days or 2⅔ home health service days.)

4. Diagnostic outpatient services as prescribed by regulation.

5. Very expensive drugs as prescribed by regulation.

Cost.—For individuals eligible for social security ((A) above): $2.79 billion per year, or 0.86 percent of payroll on a level premium basis; $1.01 billion per year or 0.48 percent of payroll on an early year basis. For individuals not eligible for social security ((B) above): Over $430 million a year out of general revenue when the program is fully operating. Offsetting this cost would be an estimated saving of about $100 million in the old-age assistance and veterans' medical programs.

Financing.—For individuals eligible for social security ((A) above), benefits would be payable out of a Federal medical insurance trust fund, established for this purpose, to be financed by an increase in the contribution rate on both employer and employee of one-fourth of 1 percent, and for the self-employed an increase of three-eights of 1 percent, beginning in 1961, and, beginning in 1972, an additional one-eighth of 1 percent each for employer and employee and three-sixteenths of 1 percent for the self-employed. For individuals not eligible for social security ((B) above) benefits would be financed out of the general revenue of the Federal Government.

Note.—The revenues derived from the tax increases provided in the amendment for individuals eligible for social security ((A) above) would amount to only 0.70 percent of payroll on a level premium basis; thus, this feature of the amendment is somewhat underfinanced.

Views of Department of Health, Education, and Welfare on Amendment 2-24-60-C Included in Following Joint Report

The Department of Health, Education, and Welfare would recommend against adoption of each of the following four amendments: Amendment No. 1, 6-24-60-C (Mr. McNamara); Amendment No. 11, 6-27-60-F (Mr. Morse); amendment No. 20 6-28-60-G (Mr. Humphrey); and amendment No. 27, 6-30-60-B (Mr. Anderson). Each of these bills proposes to amend title VI of H.R. 12580 to add health insurance benefits to the existing Federal old-age, survivors, and disability insurance system. The reasons for this recommendation are as follows:

1. The proposed extension of the existing old-age, survivors, and disability insurance system to encompass health insurance would make such insurance compulsory and would not be pinpointed to the need for aid in meeting the cost

of medical services. Under this approach, the individual would have no opportunity to determine for himself the particular pattern for meeting the threat of large medical expenses that best suits his own needs and desires. In addition, by compulsorily extending health benefits to aged persons eligible for old-age, survivors, and disability insurance, many persons would be included who have the resources and the opportunity to obtain protection against long-term or other expensive illnesses without Government help.

2. These amendments would establish an exclusively Federal program. This administration has consistently endeavored, however, to strengthen our system of government by encouraging State and local governments to assume responsibility for the many public needs which can be met through Federal-State partnership and by supporting programs to stimulate greater State and local effort in areas of critical national concern. Health care for the aged is an area of activity admirably suited to such a sharing of responsibility. In addition to bolstering the underlying cooperative foundation of our Federal system, with governmental powers divided between State and Nation, Federal-State partnership places the control over daily program operations at the level of government closest to the persons affected by the program. Thus, an individual's needs may be more immediately and effectively reflected in the current operations and the development of the program.

3. The approach proposed in the amendments would constitute a serious threat to the orderly development of present retirement, survivorship, and disability benefit features of the social security system.

The payroll tax for old-age, survivors, and disability insurance is already scheduled ultimately to be 4½ percent each on employees and employers and 6¾ percent on the self-employed. Further liberalization in retirement, survivorship, and disability benefits may call for additional revenues, which can only come from increases in the payroll tax or increases in the earnings base, or both. If health insurance as envisaged in these amendments were to be added to the system, the payroll tax would need to be increased by a total of one-half to 1 percent. As in the case of cash benefits, there would undoubtedly be insistent demands for improving the medical benefits beyond those which can be financed by the tax increase for medical benefit purposes. Increases in both health and cash benefits would place the retirement, survivorship, and disability portions of the system in competition with the health benefits for available funds, since the revenue possibilities from a payroll tax are not limitless.

It is therefore far better to reserve the payroll tax for the retirement, survivorship, and disability features of the social security system so that the revenue source is not overburdened. Whatever the Government needs to do in the area of health care for the aged should be done by the appropriation of general revenues. Such appropriation would provide for a more equitable distribution of the fiscal load than would a payroll tax on earnings of $4,800 or less.

TEXT OF AMENDMENT 6-24-60-C

Intended to be proposed by Mr. MCNAMARA (for himself, Mr. KENNEDY, Mr. CLARK, Mr. RANDOLPH, Mr. SYMINGTON, Mr. HUMPHREY, Mr. WILLIAMS of New Jersey, Mr. MAGNUSON, Mr. MCGEE, Mr. YOUNG of Ohio, Mr. DOUGLAS, Mr. GRUENING, Mr. LONG of Hawaii, Mr. MURRAY, Mr. HART, Mr. MORSE, Mr. HENNINGS, Mr. JACKSON, Mr. PASTORE, Mr. MCCARTHY, Mr. BARTLETT, Mr. ENGLE, Mr. GREEN, and Mr. MANSFIELD) to the bill (H.R. 12580), viz: On page 154, beginning with line 1, strike all through line 18 on page 172, and insert in lieu thereof the following:

TITLE VI—AMENDMENTS TO TITLE II OF THE SOCIAL SECURITY ACT

SEC. 601. (a) Title II of the Social Security Act is amended by adding after section 225 the following new section:

"MEDICAL INSURANCE BENEFITS

"SEC. 226. (a) (1) Every individual who—

"(A) has attained retirement age (as defined in section 216(a)),

"(B) is retired (as defined in paragraph (3)),

"(C) is, or would upon filing application be, entitled to monthly benefits under section 202,

shall be eligible to receive medical insurance benefits. Payment of such benefits shall be made in accordance with the provisions of this section, but only if application is filed for such payment in such form and in such manner and by such person as the Secretary may by regulation prescribe. The provisions of clauses (B) and (C) shall not apply to any person (i) who is the husband or wife of an individual eligible to receive medical insurance benefits and (ii) who was receiving more than one-half of his or her support from such individual for one year provided such year began no earlier than the calendar year preceding the year such person attained retirement age.

"(2) Payment of medical insurance benefits shall be made for hospital services, nursing home services, home health services, diagnostic outpatient services, and very expensive drugs (as defined in subsection (c)).

"(3) For purposes of paragraph (1)—

"(A) Except as may be provided in subparagraph (B), an individual shall be retired with respect to the period for which he files for payment of medical insurance benefits if—

"(i) he had total earnings (as defined in section 203(e) of less than $2,000 in any calendar year preceding the year in which the first day of such period occurs, provided such calendar year is no earlier than the year preceding the year in which he attained retirement age, or

"(ii) he did not render services for wages of more than $100, and did not engage in self-employment in each of at least three months in any calendar year, provided such third month preceded the first day of such period and such calendar year is no earlier than the year preceding the year in which he attained retirement age, or

"(iii) he attained the age of seventy-two in a month prior to such period.

"(B) For the purposes of benefits for very expensive drugs, an individual shall be retired if on the first day of the month in which he incurs the cost of such drugs he meets the provisions of clause (i), (ii), or (iii) of subparagraph (A). Such first day shall be deemed the first day of the period for which he files for the payment of medical insurance benefits. For purposes of subparagraph (A)(ii), an individual shall be presumed not to have engaged in self-employment with respect to any month if, by applying the provisions of section 203(e) and the regulations issued thereunder, the Secretary determines that such individual did not engage in self-employment in such month, except that for such purposes the term 'substantial services', as used in paragraph (3)(B)(i) of such section 203(e), shall mean services rendered by such individual with respect to his trade or business in seven or more days in such month.

"(4) Payment of medical insurance benefits which an individual is eligible to receive may be made for—

"(A) hospital services furnished to such individual for a total of not more than ninety days in any calendar year;

"(B) nursing home services furnished to such individual for a total of not more than one hundred and eighty days in any calendar year;

"(C) home health services furnished to such individual for a total of not more than two hundred and forty days;

"(D) diagnostic outpatient services but only to the extent the Secretary, after consultation with the advisory council established pursuant to subsection (f), may by regulation specify;

"(E) very expensive drugs furnished such individual, but only to the extent the Secretary, after consultation with such advisory council, may by regulation specify.

The maximum of any combination of hospital services, nursing home services, and home health services for which payment may be made for such services furnished, during any calendar year, to any individual eligible to receive medical insurance benefits shall not exceed ninety units of services. For the purpose of the preceding sentence, one 'unit of services' equals (i) one day of hospital services, (ii) two days of nursing home services, or (iii) two and two-thirds days of home health services.

"(5) Notwithstanding the previous provisions of this subsection, no individual shall be eligible to receive medical insurance benefits insofar as they relate to hospital services, nursing home services, or home health services, unless such services are rendered after referral by a physician licensed to practice surgery

or medicine in a State and such physician certifies in writing that such hospital services, nursing home services, or home health services are or were required for his medical treatment; except that such referral shall not be required for hospital services in case of an emergency which makes such referral impracticable. Periodic recertification that medical treatment which extends over a period of time is required shall, in accordance with regulations established by the Secretary, be a condition of continuing eligibility to receive such benefits during the period such services are furnished.

"(6)(A) An application for the payment of medical insurance benefits shall be valid, with respect to a period during which one or more of the services described in subsection (c) are furnished, if such application is filed no earlier than the first day of the third month preceding the month in which the first day of such period occurs or no later than the last day of the twelfth month succeeding the month in which the first day of such period occurs. An application for the payment of medical insurance benefits shall be valid with respect to the cost incurred for a very expensive drug if such application is filed within such time as the Secretary may by regulation prescribe.

"(B) For purposes of this section, a period during which—

"(i) hospital or nursing home services (or both) are furnished means a consecutive number of days (including only one day) in which services are furnished;

"(ii) home health services are furnished means one or more days (but not exceeding two hundred and forty days in any calendar year) in which such services are furnished, but only if the number of days elapsing between any two days in which said services are furnished does not exceed thirty;

"(iii) diagnostic outpatient services are furnished means one or more days (but not exceeding in any calendar year the number of days specified by the Secretary pursuant to paragraph (4)(D) of this subsection) in which such services are furnished, but only if the number of days elapsing between any two days in which such services are furnished does not exceed fourteen.

"EVIDENCE AND DETERMINATIONS OF ELIGIBILITY

"(b)(1) Proof that an individual is entitled to monthly insurance benefits under section 202 by reason of having attained retirement age shall be conclusive evidence that such individual has attained retirement age.

"(2) The provisions of section 205 relating to the making and review of determinations shall be applicable to determinations as to (i) whether an individual is eligible to receive medical insurance benefits, and (ii) the number of days, in any calendar year, for which an individual is eligible to receve such benefits.

"DESCRIPTION OF MEDICAL INSURANCE BENEFITS

"(c)(1) 'Hospital services' means, subject to further definition and limitation by regulations, the following services provided an individual as an inpatient: bed and board in a hospital, in semiprivate accommodations unless they are unavailable, or unless other accommodations are occupied at the request of the patient or, are required for medical reasons; and such medical, nursing, ambulance, and other services, and such drugs, supplies, and appliances, as the hospital customarily provides bed patients either through its own employees or through arrangements with others, except that this term shall not include services provided in connection with cosmetic or plastic surgery performed for beautification.

"(2) 'Nursing home services' means, subject to further definition by regulations, skilled nursing care, related medical and personal services required for the treatment of the patient, and accompanying bed and board furnished to an individual as an inpatient in any skilled nursing facility (including a home for the aged).

"(3) 'Home health services' means, subject to further definition by regulations, professional nursing care (including part-time homemaker services, physical and occupational therapy, medical social services, dietary counseling, ambulance service, and similar allied services) in a place of residence maintained as an individual's home, furnished by a public or other nonprofit home health service agency

"(4) 'Diagnostic outpatient services' means, subject to further definition by regulations, such services furnished by a hospital and prescribed by a physician licensed to practice surgery or medicine to any individual as an outpatient for purposes of diagnostic study.

"(5) 'Very expensive drugs' means, subject to further definition by regulations, any drug which has been prescribed by a physician licensed to practice surgery or medicine in a State for use of an individual, if such drug is prescribed by its official title as included in United States Pharmacopoeia, National Formulary, Homeopathic Pharmacopoeia, or New and Non-Official Remedies, or in any other compendium recognized by law as an official compendium and the cost of which is in excess of an amount fixed by the Secretary. Nothing in this definition shall be construed to prevent any physician from prescribing by brand or trade name if the prescription bears a notation by the prescribing physician to the effect that for medical reasons no substitution may be made.

"(6) Notwithstanding the description of services in the preceding paragraphs of this subsection, such services shall also include that part of similar but of more expensive services as is equivalent in cost to the services specified in such preceding paragraphs.

"AGREEMENTS WITH PROVIDERS OF HEALTH SERVICES

"(d)(1)(A) The Secretary shall publish, at such time or times as he designates, a list of (i) hospitals, (ii) hospitals furnishing outpatient diagnostic services, (iii) facilities furnishing nursing home services, and (iv) public or other nonprofit home health services agencies in the United States, which meet the standards prescribed by him for providing hospital services, diagnostic outpatient services, nursing home services, and home health services, and which have filed with him agreements under subparagraph (B) of this paragraph. No institution or agency required by or pursuant to State law to be licensed shall be included in any such list unless it is duly licensed. In setting eligibility standards for any class of institutions or agencies, the Secretary may take account of standards set by any recognized national listing or accrediting body. The Secretary may utilize the service of appropriate State agencies in determining whether providers of services meet such standards as he shall prescribe.

"(B) No hospital, nursing home, or home health service agency shall be included in a list under subparagraph (A) unless it has filed with the Secretary an agreement to make no charge to or on account of individuals for services furnished to such individuals who are eligible to receive medical insurance benefits under this section (and abide by regulations of the Secretary with respect to making charges in cases of uncertainty or delay in determining eligibility), but such agreements shall not preclude the making of charges to such individuals or persons for accommodations or services, furnished at their request, which are in addition to, or more expensive than, those for which patients are eligible to receive as individuals eligible for medical insurance benefits by reason of this section. An agreement under this paragraph may be terminated by the provider of health services at such time and upon such notice to the Secretary and to the public as he may specify by regulations.

"(C) No mental or tuberculosis hospital shall be included in a list under this paragraph.

"(2)(A) Any hospital, nursing home, or home health services agency, listed by the Secretary under paragraph (1) for providing a class of services, which provides services of that class to an individual eligible to receive medical insurance benefits under this section shall be entitled to receive payment for such services under this title. Under conditions specified in regulations, and in amounts determined in accordance therewith, payments shall be made to hospitals not listed by the Secretary for emergency hospital services rendered to individuals eligible to receive medical insurance benefits under this section.

"(3) Payments for hospital services and outpatient diagnostic services, to hospitals listed by the Secretary, shall be equal to the cost of rendering the services. The method or methods of determining such cost shall be prescribed by regulations, issued after consultation with the advisory council.

"(4) No payment shall be made under this section for any hospital services which the hospital is obligated by law or by contract with the United States or a State or political subdivision thereof, to render at public expense and without regard to the income or resources of the patient. No such payment shall be made for any hospital services for any injury, disease, or disability for which the patient is entitled to hospitalization (or to the cost thereof) under any workmen's compensation law; except that payment may be made if (A) an appropriate application for hospitalization (or for the cost thereof) has been made under the workmen's compensation law, (B) entitlement thereto has not

been finally determined, and (C) an arrangement satisfactory to the Secretary has been made for reimbursement of the Federal Medical Insurance Trust Fund if the claim under the workmen's compensation law is finally sustained.

"(5) The amount of payments for nursing home services and for home health services shall be determined after consultation with the advisory council and shall be based on the reasonable cost of rendering the services.

"(6)(A) Any pharmacy which employs one or more pharmacists who are licensed under the laws of the State in which it is located to dispense drugs at retail shall be eligible to enter into an agreement with the Secretary whereby such pharmacy will be paid for furnishing drugs to individuals eligible to receive medical insurance benefits under this section.

"(B) Such agreement shall apply only to the furnishing of 'very expensive drugs' as defined in subsection (c)(5), and shall relate only to the part of the cost of such drugs which exceeds such amount as may be fixed by the Secretary. The method of determining the amount of the payments to a pharmacy shall be based on the reasonable cost of such drugs to such pharmacy plus such percentage of such costs as may be determined to provide adequate compensation to such pharmacy for its services in furnishing such drugs.

"(7) No supervision or control over the administration or operation, or over the selection, tenure, or compensation of personnel, shall be exercised under the authority of this section over any hospital, nursing home facility, home health services agency, or pharmacy which has entered into an agreement under this section.

"(8) Agreements under this section shall be made by the hospital, nursing home, home health services agency, or pharmacy providing the services described in subsection (c), but this paragraph shall not preclude representation of such institution or pharmacy by any individual, association, or organization authorized by the institution or agency to act on its behalf.

"(9) Nothing in such agreements or in this section shall be constructed to give the Secretary supervision or control over the practice of medicine or the manner in which medical services are provided.

"(10) Except to the extent the Secretary has made provision pursuant to subsection (g) (relating to utilization of private nonprofit organizations) for the making of payments to providers of health services, he shall from time to time determine the amount to be paid to each provider of health services under an agreement with respect to the services furnished and shall pay such amount, except that such amount may be reduced or increased, as the case may be, by any sum by which the Secretary finds that the amount paid to such provider of health services for any prior period was greater or less than the amount which should have been paid to it for such period. The Secretary of the Treasury, prior to audit or settlement by the General Accounting Office, shall make payment from the Federal Medical Insurance Trust Fund, at the time or times fixed by the Secretary, in accordance with such certification.

"FREE CHOICE BY PATIENT

"(e) Any individual eligible to receive medical insurance benefits under this section may obtain hospital services, nursing home services, home health services, or diagnostic outpatient services from any provider of health services which is listed by the Secretary under subsection (d)(1) as eligible to provide the class of health services in question and which admits such individual or undertakes to provide him services; and may obtain very expensive drugs, upon such payment as may be required, from any pharmacy with which the Secretary has in effect an agreement under subsection (c)(6).

"NATIONAL MEDICAL INSURANCE BENEFITS ADVISORY COUNCIL

"(f)(1) For the purpose of advising and assisting the Secretary in the formulation of policy and the promulgation of regulations in connection with the administration of this section, there is hereby created a National Medical Insurance Benefits Advisory Council which shall consist of the Commissioner of Social Security and the Surgeon General of the Public Health Service, who shall serve as co-chairman ex officio, and twelve members to be appointed by the Secretary. Not less than four of the appointed members shall be representatives of the general public, and the remainder of the appointed members shall be persons who are outstanding in the fields pertaining to hospitals and health activities. Each appointed member shall hold office for a term of four years,

except that any member appointed to fill a vacancy occurring prior to the expiration of the term for which his predecessor was appointed shall be appointed for the remainder of such term, and the terms of office of the member first taking office shall expire, as described by the Secretary at the time of appointment, three at the end of the first year, three at the end of the fourth year after the date of appointment. An appointed member shall not be eligible to serve continuously for more than two terms but shall be eligible for reappointment if he has not served immediately preceding his reappointment. The advisory council is authorized to appoint such special advisory and technical committees as may be useful in carrying out its functions. Appointed members of the advisory council and members of its advisory or technical committees, while serving on business of the advisory council, shall receive compensation at rates fixed by the Secretary, but not exceeding $50 per day, and shall also be entitled to receive an allowance for actual and necessary travel and for subsistence expenses while so serving away from their places of residence. The advisory council shall meet as frequently as the Secretary deems necessary, but not less than once each year. Upon request of four or more members it shall be the duty of the Secretary to call a meeting of the advisory council.

"(2) The advisory council, or a technical committee appointed by the council with the approval of the Secretary, shall have the duty of study and evaluation of the operation of this section. Any recommendations by the council for amendment of this section shall be transmitted to the Congress by the Secretary.

"UTILIZATION OF NONPROFIT ORGANIZATIONS

"(g)(1) The Secretary may utilize, to the extent he finds economical and otherwise advantageous, the services of private nonprofit organizations exempt from Federal taxation under section 501 of the Internal Revenue Code of 1954, or public agencies which are skilled in dealing with hospitals in matters pertaining to hospitalization of individual patients and payment therefor. The Secretary is authorized to enter into an agreement with any such organization or agency under which, in the whole or any part of the United States, the organization or agency undertakes to determine (subject to such review as may be provided for in the agreement) the payments to hospitals required by this section and by regulations prescribed thereunder, and to make such payments, and to perform such other functions as may be deemed appropriate by the Secretary. The Secretary is authorized to utilize in similar manner the services of such organizations or agencies to determine and make payments, and to perform such other functions as he deems appropriate, in the provision of services (other than hospital services) described in subsection (c).

"(2) An agreement under paragraph (1) shall provide for payment from the Federal Medical Insurance Trust Fund to the organization or agency of the amounts paid out by such organization to providers of health services under this section and of the cost of administration determined by the Secretary with the advice of the advisory council to be necessary and proper for carrying out such organization's or agency's functions under its agreement pursuant to this section. Such payments to any organization or agency shall be made either in advance on the basis of estimates by the Secretary or as reimbursement, as may be agreed upon by the organization and the Secretary, and adjustments may be made in subsequent payments on account of overpayments or underpayments previously made to the organization under this section. Such payments shall be made by the Secretary of the Treasury from the Federal Medical Insurance Trust Fund at such time or times as the Secretary may specify and shall be made prior to audit or settlement by the General Accounting Office.

"(3) An agreement under subsection (a) with any organization may require any of its officers or employees certifying payments or disbursing funds pursuant to the agreement, or otherwise participating in its performance, to give surety bond to the United States in such amount as the Secretary may deem necessary, and may provide for the payment of the cost of such bond from the Federal Medical Insurance Trust Fund.

"RULEMAKING POWERS OF THE SECRETARY

"(h) The Secretary, after consulting with the advisory council, shall have full power and authority to make rules and regulations and to establish procedures, not inconsistent with the provision of this section, which are necessary or

appropriate to carry out such provisions, and shall adopt reasonable and proper rules and regulations to regulate and provide for the nature and extent of the proofs and evidence and the method of taking and furnishing the same in order to establish the right of individuals to medical insurance benefits hereunder, and the right of providers of services to payment.

"CERTIFYING AND DISBURSING OFFICERS

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

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

FEDERAL MEDICAL INSURANCE TRUST FUND

(b) (1) The heading to section 201 of the Social Security Act is amended to read: "FEDERAL OLD-AGE AND SURVIVORS INSURANCE TRUST FUND, FEDERAL DISABILITY INSURANCE TRUST FUND, AND FEDERAL MEDICAL INSURANCE TRUST FUND".

(2) Subsection (a) of section 201 of such Act is amended by inserting before the semicolon in paragraph (3) thereof the following: "and in clause (1) of subsection (c) of this section"; by inserting before the period in paragraph (4) thereof the following: "and in clause (2) of subsection (c) of this section"; by amending the last sentence thereof to read as follows: "The amounts appropriated by clauses (3) and (4) shall be transferred from time to time from the general fund in the Treasury to the Federal Old-Age and Survivors Insurance Trust Fund, the amounts appropriated by clauses (1) and (2) of subsection (b) shall be transferred from time to time from the general fund in the Treasury to the Federal Disability Insurance Trust Fund, and the amounts appropriated by clauses (1) and (2) of subsection (c) shall be transferred from time to time from the general fund in the Treasury to the Federal Medical Insurance Trust Fund, such amounts to be determined on the basis of estimates by the Secretary of the Treasury of the taxes, specified in clauses (3) and (4) of this subsection, paid to or deposited into the Treasury; and proper adjustments shall be made in amounts subsequently transferred to the extent prior estimates were in excess of or were less than the taxes specified in such clauses (3) and (4) of this subsection.

(3) Section 201 of such Act is further amended by redesignating subsections (c), (d), (e), (f), (g), and (h) as (d), (e), (f), (g), (h), and (i), respectively.

(4) Section 201 of such Act is further amended by adding after subsection (b) the following new paragraph:

"(c) There is hereby created on the books of the Treasury of the United States a trust fund to be known as the 'Federal Medical Insurance Trust Fund'. The Federal Medical Insurance Trust Fund shall consist of such amounts as may be appropriated to, or deposited in, such fund as provided in this section. There is hereby appropriated to the Federal Medical Insurance Trust Fund for the fiscal year ending June 30, 1961, and for each fiscal year thereafter, out of any moneys in the Treasury not otherwise appropriated, amounts equivalent to 100 per centum of—

"(1) (A) one-half of 1 per centum of the wages (as defined in section 3121 of the Internal Revenue Code of 1954) paid after December 31, 1960, and before January 1, 1972, and reported to the Secretary of the Treasury or his delegate pursuant to subtitle F of the Internal Revenue Code of 1954, which wages shall be certified by the Secretary of Health, Education, and Welfare on the basis of the records of wages established and maintained by such Secretary in accordance with such reports; and

"(B) three-fourths of 1 per centum of the wages (as defined in section 3121 of the Internal Revenue Code of 1954) paid after December 31, 1971, and reported to the Secretary of the Treasury or his delegate pursuant to subtitle F of the Internal Revenue Code of 1954, which wages shall be certified by the Secretary of Health, Education, and Welfare on the basis of the records of wages established and maintained by such Secretary in accordance with such reports; and

"(2)(A) three-eighths of 1 per centum of the amount of self-employment income (as defined in section 1402 of the Internal Revenue Code of 1954) reported to the Secretary of the Treasury or his delegate on tax returns under subtitle F of the Internal Revenue Code of 1954 for any taxable year beginning after December 31, 1960, and before January 1, 1972, which self-employment income shall be certified by the Secretary of Health, Education, and Welfare on the basis of the records of self-employment income established and maintained by the Secretary of Health, Education, and Welfare in accordance with such returns; and

"(B) nine-sixteenths of 1 per centum of the amount of self-employment income (as defined in section 1402 of the Internal Revenue Code of 1954) reported to the Secretary of the Treasury or his delegate on tax returns under subtitle F of the Internal Revenue Code of 1954 for any taxable year beginning after December 31, 1971, which self-employment income shall be certified by the Secretary of Health, Education, and Welfare on the basis of the records of self-employment income established and maintained by the Secretary of Health, Education, and Welfare in accordance with such returns."

(5) Subsection (d) of section 201 of such Act, as redesignated by paragraph (3) of this subsection, is amended by striking out "and the Federal Disability Insurance Trust Fund" and inserting in lieu thereof ", the Federal Disability Insurance Trust Fund, and the Federal Medical Insurance Trust Fund".

(6) Subsection (g) of section 201 of such Act, as redesignated by paragraph (3) of this subsection, is amended to read as follows:

"(g) The interest on, and the proceeds from the sale or redemption of, any obligations held in the Federal Old-Age and Survivors Insurance Trust Fund, the Federal Disability Insurance Trust Fund, and the Federal Medical Insurance Trust Fund shall be credited to and form a part of the Federal Old-Age and Survivors Insurance Trust Fund, the Federal Disability Insurance Trust Fund, and the Federal Medical Insurance Trust Fund, respectively."

(7) Subsection (h) of section 201 of such Act, as redesignated by paragraph (3) of this subsection, is amended by striking out in the third sentence of paragraph (1) thereof "either or both" and inserting in lieu thereof "any or all"; by striking out in the fourth sentence of such paragraph "from one to the other of" and inserting in lieu thereof "among"; by striking out in the fifth sentence of such paragraph "from one to the other of" and inserting in lieu thereof "among".

(8) The last sentence of paragraph (2) of subsection (h), as redesignated by paragraph (3) of this subsection, is amended to read as follows: "Payments pursuant to the first sentence of this paragraph shall be made from the Federal Old-Age and Survivors Insurance Trust Fund, the Federal Disability Insurance Trust Fund, and the Federal Medical Insurance Trust Fund in the ratio in which amounts were appropriated to such trust funds under clause (3) of subsection (a) of this section, clause (1) of subsection (b) of this section, and clause (1) of subsection (c) of this section."

(9) Subsection (i) of section 201 of the Social Security Act, as redesignated by paragraph (3) of this subsection, is amended by inserting after the first sentence the following sentence: "Payments required to be made under section 226 shall be made only from the Federal Medical Insurance Trust Fund."

(10) Subsection (h)(1) of section 218 of such Act is amended by striking out "and (b)(1)" and inserting in lieu thereof ", (b)(1), and (c)(1)".

(11) Subsection (b) of section 1106 of such Act is amended by striking out "and the Federal Disability Insurance Trust Fund" and inserting in lieu thereof ", the Federal Disability Insurance Trust Fund, and the Federal Medical Insurance Trust Fund".

EFFECTIVE DATE

(c) Payments pursuant to section 226 of the Social Security Act, as added to such Act by subsection (a) of this section, shall be made only with respect to hospital services, nursing home services, home health services, diagnostic outpatient services furnished or very expensive drugs purchased after dates to be fixed by the Secretary, but such dates shall be, in the case of (1) hospital services, not earlier than July 1, 1961, or later than January 1, 1962, (2) nursing home services, not earlier than January 1, 1963, or later than July 1, 1963, (3) home health services, not earlier than January 1, 1962, or later than July 1, 1962, (4) diagnostic outpatient services, not earlier than July 1, 1961, or

later than January 1, 1962, and (5) the purchase of very expensive drugs, not earlier than July 1, 1962, or later than January 1, 1963. The terms used in this section shall have the meaning assigned to them in title II of the Social Security Act.

MEDICAL BENEFITS FOR RETIRED AGED NOT ELIGIBLE FOR BENEFITS UNDER TITLE II

SEC. 602. (a) The Social Security Act is further amended by adding after title XV thereof the following new title:

"TITLE XVI—MEDICAL BENEFITS FOR THE RETIRED AGED NOT ELIGIBLE FOR BENEFITS UNDER TITLE II

"SEC. 1601. (a) (1) Every individual who—

"(A) has attained retirement age (as defined in section 216(a)),

"(B) is retired (as defined in paragraph (3)),

"(C) is a resident of the United States, and

"(D) is not eligible to receive medical insurance benefits under section 226,

shall be eligible to receive medical benefits. Payment of medical benefits shall be made in accordance with the provisions of this section, but only if application is filed for such payment in such form and in such manner and by such person as the Secretary may by regulation prescribe. The provisions of clause (B) shall not apply to any person (i) who is the husband or wife of an individual eligible to receive medical benefits and (ii) who was receiving more than one-half of his or her support from such individual for one year provided such year began no earlier than the calendar year preceding the year such person attained retirement age.

"(2) Payment of medical benefits shall be made for hospital services, nursing home services, home health services, diagnostic outpatient services, and very expensive drugs (as defined in section 226(c)).

"(3) For purposes of paragraph (1)—

"(A) Except as may be provided in subparagraph (B), an individual shall be retired with respect to the period for which he files for payment of medical benefits if—

"(i) he had total earnings (as defined in section 203(e)) of less than $2,000 in any calendar year preceding the year in which the first day of such period occurs, provided such calendar year is no earlier than the year preceding the year in which he attained retirement age, or

"(ii) he did not render services for wages of more than $100, and did not engage in self-employment in each of at least three months in any calendar year, provided such third month preceded the first day of such period and such calendar year is no earlier than the year preceding the year in which he attained retirement age, or

"(iii) he attained the age of seventy-two in a month prior to such period.

"(B) For the purposes of benefits for very expensive drugs, an individual shall be retired if on the first day of the month in which he incurs the cost of such drugs he meets the provisions of clause (i), (ii), or (iii) of subparagraph (A). Such first day shall be deemed the first day of the period for which he files for the payment of medical benefits.

For purposes of subparagraph (A)(ii), an individual shall be presumed not to have engaged in self-employment with respect to any month if, by applying the provisions of section 203(e) and the regulations issued thereunder, the Secretary determines that such individual did not engage in self-employment in such month, except that for such purposes the term, 'substantial services', as used in paragraph (3)(B)(i) of such section 203(e), shall mean services rendered by such individual with respect to his trade or business in seven or more days in such month.

"(4) Payment of medical benefits which an individual is eligible to receive may be made for—

"(A) hospital services furnished to such individual for a total of not more than ninety days in any calendar year;

"(B) nursing home services furnished to such individual for a total of not more than one hundred and eighty days in any calendar year;

"(C) home health services furnished to such individual for a total of not more than two hundred and forty days;

"(D) diagnostic outpatient services but only to the extent as the Secretary, after consultation with the advisory council, established pursuant to subsection 226(f), may by regulation specify;

"(E) very expensive drugs furnished such individual, but only to the extent the Secretary, after consultation with such advisory council, may by regulation specify.

The maximum of any combination of hospital services, nursing home services, and home health services for which payment may be made for such services furnished, during any calendar year, to any individual eligible to receive medical benefits shall not exceed ninety units of services. For the purpose of the preceding sentence, one "unit of services" equals (i) one day of hospital services, (ii) two days of nursing home services, or (iii) two and two-thirds days of home health services.

"(5) Notwithstanding the previous provisions of this subsection, no individual shall be eligible to receive medical benefits insofar as they relate to hospital services, nursing home services, or home health services, unless such services are rendered after referral by a physician, and such physician certifies in writing that such hospital services, nursing home services, or home health services are or were required for his medical treatment except that such referral shall not be required for hospital services in case of an emergency which makes such referral impracticable. Periodic recertification that medical treatment which extends over a period of time is required shall be a condition of continuing eligibility to receive such benefits during the period such services are furnished.

"(6)(A) An application for the payment of medical benefits shall be valid, with respect to a period during which one or more of the services described in section 226(c) are furnished, if such application is filed no earlier than the first day of the third month preceding the month in which the first day of such period occurs or no later than the last day of the twelfth month succeeding the month in which the first day of such period occurs. An application for the payment of medical benefits shall be valid with respect to the cost incurred for a very expensive drug if such application is filed within such time as the Secretary may by regulations prescribe.

"(B) For purposes of this section, a period during which—

"(i) hospital or nursing home services (or both) are furnished means a consecutive number of days (including only one day) in which such services are furnished;

"(ii) home health services are furnished means one or more days (but not exceeding two hundred and forty days in any calendar year) in which such services are furnished, but only if the number of days elapsing between any two days in which such services are furnished does not exceed thirty;

"(iii) diagnostic outpatient services are furnished means one or more days (but not exceeding in any calendar year the number of days specified by the Secretary pursuant to paragraph (4)(D) of this subsection) in which such services are furnished, but only if the number of days elapsing between any two days in which such services are furnished does not exceed fourteen.

"DETERMINATIONS OF ELIGIBILITY

"(b) The provisions of section 205 relating to the making and review of determinations shall be applicable to determinations as to (i) whether an individual is eligible to receive medical benefits, and (ii) the number of days, in any calendar year, for which an individual is eligible to receive such benefits.

"INCORPORATION OF CERTAIN PROVISIONS OF SECTION 226

"(c) For the purposes of administering this title, the provisions of section 226(d), (e), (f), (g), and (h) shall be applicable to this title, and for such purposes references in such subsections of section 226 to title II, medical insurance benefits, and section 226 (or any subsection, paragraph, or subparagraph thereunder) shall be deemed to refer to this title, medical benefits for which payment may be made under this section, and this section, respectively.

"CERTIFYING AND DISBURSING OFFICERS

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

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

"APPROPRIATION

"SEC. 1602. There are hereby authorized to be appropriated to the Federal Medical Insurance Trust Fund for each fiscal year, beginning with the fiscal year ending June 30, 1962, out of any moneys in the Treasury not otherwise appropriated, such sums as the Secretary determines to be necessary to meet the payments made from such Trust Fund pursuant to this title with respect to individuals who are eligible to receive medical benefits under this title, plus interest accruing on such sums at the rate for each such fiscal year equal to the average rate of interest (as determined by the managing trustee) earned on the invested assets of such Trust Fund during the preceding fiscal year.

"PAYMENTS

"SEC. 1603. Payments required to be made under this title, as provided in section 1601, shall be made from the Federal Medical Insurance Trust Fund.

"NONAPPLICABILITY OF THIS TITLE

"SEC. 1604. The provisions of this title shall not apply to any individual (i) who is, or upon filing application would be, entitled to an annuity or a pension undr the Railroad Retirement Act or (ii) who is receiving, or is eligible to receive, an annuity under the Civil Service Retirement Act, or (iii) who is the wife or dependent husband of an individual described in clauses (i) or (ii)."

EFFECTIVE DATE

(b) Payments pursuant to subsection (a) of this section shall be made only with respect to hospital services, nursing home services, home health services, diagnostic outpatient services furnished, or very expensive drugs purchased after dates to be fixed by the Secretary, but such dates shall be, in the case of (1) hospital services, not earlier than July 1, 1961, or later than January 1, 1962, (2) nursing home services, not earlier than January 1, 1963, or later than July 1, 1963, (3) home health services, not earlier than January 1, 1962, or later than July 1, 1962, (4) diagnostic outpatient services, not earlier than July 1, 1961, or later than January 1, 1962, and (5) the purchase of very expensive drugs, not earlier than July 1, 1962, or later than January 1, 1963. The terms used in this section shall have the meaning assigned to them in title II of the Social Security Act.

AMENDMENTS TO THE INTERNAL REVENUE CODE OF 1954

CHANGES IN TAX SCHEDULES

SELF-EMPLOYMENT INCOME TAX

SEC. 603. (a) Section 1401 of the Internal Revenue Code of 1954 (relating to rate of tax on self-employment income) is amended to read as follows:

"SEC. 1401. RATE OF TAX.

"In addition to other taxes, there shall be imposed for each taxable year, on the self-employment income of every individual, a tax as follows:

"(1) in the case of any taxable year beginning after December 31, 1959, and before January 1, 1961, the tax shall be equal to 4½ percent of the amount of the self-employment income for such taxable year;

"(2) in the case of any taxable year beginning after December 31, 1960, and before January 1, 1963, the tax shall be equal to 4⅞ percent of the amount of the self-employment income for such taxable year;

"(3) in the case of any taxable year beginning after December 31, 1962, and before January 1, 1966, the tax shall be equal to 5⅝ percent of the amount of the self-employment income for such taxable year;

"(4) in the case of any taxable year beginning after December 31, 1965, and before January 1, 1969, the tax shall be equal to 6⅜ percent of the amount of the self-employment income for such taxable year;

"(5) in the case of any taxable year beginning after December 31, 1968, and before January 1, 1972, the tax shall be equal to 7⅛ percent of the amount of the self-employment income for such taxable year; and

"(6) in the case of any taxable year beginning after December 31, 1971, the tax shall be equal to 7⅝ percent of the amount of the self-employment income for such taxable year."

TAX ON EMPLOYEES

(b) Section 3101 of such Code (relating to rate of tax on employees under the Federal Insurance Contributions Act) is amended to read as follows:

"SEC. 3101. RATE OF TAX.

"In addition to other taxes, there is hereby imposed on the income of every individual a tax equal to the following percentages of the wages (as defined in section 3121(a)) received by him with respect to employment (as defined in section 3121(b))—

"(1) with respect to wages received during the calendar year 1960, the rate shall be 3 percent;

"(2) with respect to wages received during the calendar years 1961 and 1962, the rate shall be 3¼ percent;

"(3) with respect to wages received during the calendar years 1963 to 1965, both inclusive, the rate shall be 3¾ percent;

"(4) with respect to wages received during the calendar years 1966 to 1968, both inclusive, the rate shall be 4¼ percent;

"(5) with respect to wages received during the calendar years 1969 to 1971, both inclusive, the rate shall be 4¾ percent; and

"(6) with respect to wages received after December 31, 1971, the rate shall be 4⅞ percent."

TAX ON EMPLOYERS

(c) Section 3111 of such Code (relating to rate of tax on employers under the Federal Insurance Contributions Act) is amended to read as follows:

"SEC. 3111. RATE OF TAX.

"In addition to other taxes, there is hereby imposed on every employer an excise tax, with respect to having individuals in his employ, equal to the following percentages of the wages (as defined in section 3121(a)) paid by him with respect to employment (as defined in section 3121(b))—

"(1) with respect to wages paid during the calendar year 1960, the rate shall be 3 percent;

"(2) with respect to wages paid during the calendar years 1961 and 1962, the rate shall be 3¼ percent;

"(3) with respect to wages paid during the calendar years 1963 to 1965, both inclusive, the rate shall be 3¾ percent;

"(4) with respect to wages paid during the calendar years 1966 to 1968, both inclusive, the rate shall be 4¼ percent;

"(5) with respect to wages paid during the calendar years 1969 to 1971, both inclusive, the rate shall be 4¾ percent; and

"(6) with respect to wages paid after December 31, 1971, the rate shall be 4⅞ percent."

DECLARATION OF POLICY ON RAILROAD RETIREMENT AND CIVIL SERVICE ANNUITANTS

SEC. 604. It is hereby declared to be the policy of the Congress in enacting this Act to include as many retired people as possible under the type of program established by this Act and to provide that their benefits should, to the extent possible, be financed by contributions made by them (and their employers) during their working years. To further this policy, the Congress should take action as soon as possible to make available to persons receiving annuities under the Railroad Retirement Act and the Civil Service Retirement Act a program under which such individuals can obtain the same type of services made available by this Act to those who are receiving old-age and survivors insurance benefits.

STUDY OF HEALTH NEEDS OF INDIVIDUALS

SEC. 605. Section 702 of the Social Security Act is amended by inserting "(a)" after "702"; by adding at the end thereof the following new subsection:

"(b) The Secretary shall conduct a continuing study and investigation of the health needs of individuals who have reached retirement age, and the means by which such needs may most effectively and efficiently be met. In connection with such study and investigation, the Secretary shall institute and conduct appropriate demonstration programs relating to the health needs of such individuals and the manner and means by which such needs may be fulfilled. The Secretary is authorized to provide for the carrying on of such research studies pertaining to health care and the administration of such care as may be recommended by the advisory council designated pursuant to section 226(f). Such research studies may be carried on directly by the Department of Health, Education, and Welfare, by others under contracts negotiated for, or grants made by the Secretary for, such purpose."

SEC. 606. As used in the provisions of the Social Security Act, amended by this Act, the term "Secretary" means the Secretary of Health, Education, and Welfare.

SEC. 607. This title may be cited as the "Retired Persons Medical Insurance Act."

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2. AMENDMENT 6-25-60-D—INTRODUCED BY SENATOR WILLIAMS OF NEW JERSEY

STAFF ANALYSIS

Makes liberalization of the insured status requirement (sec. 204 of House-passed bill) inapplicable as to any individual who is or will become entitled to retirement benefits under the teachers pension and annuity fund of the State of New Jersey or to retirement benefits under the public employees retirement system of the State of New Jersey.

Cost.—Negligible savings.

VIEWS OF THE DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE ON AMENDMENT 6-24-60-D

While the present law does contain modifications to the general provisions governing coverage under the old-age, survivors, and disability insurance program, the Department believes, in general, that special provisions are undesirable in that they tend to nullify the effect of the general provisions of the law, and may introduce inequities and anomalies into the program. The proposed special amendment, applying only to persons receiving retirement benefits under two named New Jersey retirement systems, is subsequent to the additional objection that it would be the first special amendment (i.e., an amendment applying to specifically named groups) to the basic provisions of the program for determining eligibility to benefits and benefit amounts.

The Department believes that it is of fundamental importance in a broad social insurance system such as old-age, survivors, and disability insurance that the benefit rights of all persons covered under the program be determined on the same basis. The proposed amendment would not provide favorable treatment under the program for the group affected; it would nevertheless be a departure from the principle that all covered persons should be subject to the same requirements as to insured status. If enacted, it would undoubtedly be considered as a precedent by persons or groups seeking advantages through additional special amendments to the insured status or benefit computation provisions of the act.

The proposed amendment is designed to be of help to a relatively small number of persons entitled to benefits under the two New Jersey systems, and would no doubt be of overall assistance to them (subject, of course, to the interpretation of the amendment by the State of New Jersey). Nonetheless, it would make inapplicable to these persons an insured status provision of the Social Security Act and might inadvertently be of disadvantage to some members of the systems by reducing the amount of benefits they would obtain under the Federal program.

Since the objective of the proposed amendment is to affect favorably the benefit rights of certain individuals under the two named New Jersey retirement systems, its achievement would seem to be a matter for State, rather than Fed-

eral, legislation. An amendment to the Federal law which has as its objective modifying benefit rights under State law does not seem desirable.

For these reasons the Department recommends that the proposed amendment not be enacted.

TEXT OF AMENDMENT 6-24-60-D

Intended to be proposed by Mr. WILLIAMS of New Jersey to the bill (H.R. 12580), viz: On page 67, between lines 14 and 15, insert the following new subsection:

(e) The amendment made by subsection (a) shall not apply in the case of any individual who, on, before, or after the date of enactment of this Act, becomes entitled to retirement benefits under the Teachers Pension and Annuity Fund of the State of New Jersey or to retirement benefits under the Public Employees Retirement System of the State of New Jersey.

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3. AMENDMENT 6-24-60-E—INTRODUCED BY SENATOR JAVITS FOR HIMSELF AND SENATOR KEATING

STAFF ANALYSIS

Permits the States to extend their unemployment insurance laws to provide coverage with respect to those nonprofit organizations which are not subject to the Federal unemployment tax without regard to the conditions specified in section 3303 of the Internal Revenue Code of 1954 (the Federal Unemployment Tax Act). It would thus permit States to allow to these organizations reduced rates of contributions to pooled unemployment funds on a reimbursable or other basis having no relation to unemployment experience or other factors having a direct relation to unemployment risk.

VIEWS OF DEPARTMENT OF LABOR ON AMENDMENTS 6-24-60-E (IDENTICAL WITH S. 3594)

It is our understanding that Amendment 6-24-60-E (which is identical to S. 3594) is intended primarily to allow State coverage of nonprofit organizations on a reimbursable basis, according to which these organizations would be billed periodically for the benefit costs charged to them and required to pay only these amounts into the State fund. Under a number of State laws, State and local governments are presently permitted to effect coverage of their employees on such a basis.

While the Department of Labor believes that employees of nonprofit organizations are entitled to unemployment insurance protection, we question the desirability of permitting treatment of one class of private employers on a basis inconsistent with the insurance approach to unemployment compensation. Such treatment would also appear to involve practical problems which might minimize its effectiveness in expanding unemployment insurance protection, while possibly hindering future extension of Federal coverage to employees of nonprofit organizations in all States instead of merely those which could avail themselves of the proposed coverage.

State unemployment insurance laws, all of which now provide for pooled funds, represent an insurance approach to the financing of unemployment costs. Such an approach offers the advantages of a wide pooling of risks among industries and employers, while also insuring annual employer costs that are predictable and limited by minimum and maximum rates. Some employers might not otherwise be capable of absorbing the benefit costs chargeable to them. Individual employer or industry financing through payments reimbursing the State fund for benefit costs provides neither the advantages of pooling nor the predictability of an annual tax.

The nature of nonprofit organizations does not appear necessarily to justify such a departure from the established pattern of unemployment insurance financing. Many receive the bulk of their funds from sources other than voluntary contributions, engage in commercial operations, and sell goods and services in competition with profitmaking organizations that are presently subject to unemployment insurance laws on a regular basis. Amendment 6-24-60-E might be considered by other employers as unduly preferential and thus lead to efforts for further extension.

In practice, the costs of coverage on a reimbursable basis may, under certain circumstances, exceed those on a tax basis, thus presenting problems to the organizations themselves and imperiling the extension of unemployment insurance which this amendment is intended to foster. For example, should an organization be required to reduce operations for budgetary reasons, thus laying off employees, benefit costs would ordinarily rise at the very time that the organization would least be able to absorb these additional costs.

Nonprofit organizations should not necessarily be classed with States or municipal corporations which, as previously noted, are covered under some State laws on a reimbursable basis. These entities are not "persons" within the meaning of section 3303 of the Federal act, and unlike private employers they are necessarily exempt from the Federal tax for constitutional reasons. Their activities do not ordinarily present competitive problems in relation to other employers. Such governmental entities are permanent, or nearly so, and even when dissolution occurs it ordinarily takes the form of merger or consolidation insuring payment or assumption of prior debts. They have resources of taxation and credit which assure a high measure of continuity in operations and financial capacity. These considerations are not generally applicable to nonprofit organizations, which often do operate in competition with other employers subject to unemployment insurance laws, have no assured level of operations or financial capacity, and can and do go out of existence with consequent risk of default.

There is the possibility also that this amendment might hinder extension of the Federal act to nonprofit organizations since State coverage pursuant to amendment 6–24–60–E would be in conflict with the conditions of section 3303 which would become applicable upon Federal coverage.

TEXT OF AMENDMENT 6–24–60–E

Intended to be proposed by Mr. JAVITS (for himself and Mr. KEATING) to the bill (H.R. 12580), viz: On page 142, between lines 13 and 14, insert the following:

CONDITIONS FOR REDUCED RATE OF CONTRIBUTIONS

(d) Section 3303(c) of such Code (relating to conditions of additional credit allowance) is amended by adding at the end thereof the following new paragraph:

"(9) PERSON.—The term 'person' shall not include any organization, service for which is excepted from employment under paragraph (8) of section 3306(c)."

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4. AMENDMENT 6–24–60–F—INTRODUCED BY SENATOR JAVITS FOR HIMSELF AND SENATOR KEATING

STAFF ANALYSIS

Permits child to receive survivor benefits on record of individual who stood in loco parentis (in the place of the parent) for not less than 5 years immediately preceding the day on which the individual died; also requires that child must have been living with the worker at time of death and have been receiving at least three-fourths of his support from such worker.

Cost.—Unknown. Cost of amendment if amended as suggested by Department of Health, Education, and Welfare in the following report is estimated as negligible.

VIEWS OF THE DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE ON PROPOSED AMENDMENT 6–24–60–F

The Department of Health, Education, and Welfare is in favor of this amendment in principle and recommends its enactment. The Department believes, however, that the amendment needs to be modified as described below.

The amendment provides for the payment of child's insurance benefits only if the insured worker has died. A child who is living with and being supported by a retired or disabled worker also needs the protection of the program. The Department recommends that the amendment be modified to provide for paying benefits also in cases where the worker is disabled or retired.

The Department recommends a further modification to provide for paying benefits to a child who is receiving one-half of his support from the worker, rather than three-fourths as proposed in the amendment. The present law uses a one-half support requirement as a test of dependency, and we have no reason to believe that the present requirement is not an adequate one.

The Department believes that a requirement that the child have been living in the worker's household for 1 year, rather than 5 years as required by the proposed amendment, is sufficient to assure that benefits would be paid only where the worker had in fact assumed responsibility for the child's support, and recommends that the amendment be modified accordingly. If H.R. 12580 is enacted, the duration-of-relationship requirements for eligibility for the dependents' benefits, now 3 years in certain cases and 1 year in other cases, would all be made 1 year, so that the provision of the law would be consistent in this respect.

H.R. 12580 contains a provision relating to the payment of benefits in cases where a child is adopted by a disabled person that is intended to limit the payment of benefits to cases where it is generally reasonable to assume that the disabled worker, before the disability benefits were payable, had intended to adopt the child. In keeping with the intent of that provision the Department recommends that the proposed amendment be modified so that benefits would be paid under it only in cases where the child had been living with the worker before the worker became entitled to retirement or disability benefits.

The Department recommends also that the amendment not permit the payment of benefits to a child on the earnings record of a foster parent who is being regularly paid by a child-placement agency or the child's parent to care for the child.

Finally, it should be noted that the determination of whether an individual stands in loco parentis to another is somewhat subjective in nature and not easily administered in a program as large as OASDI. The amendment, both in its present form and as it would be modified in accordance with the Department's suggestions, would contain objective criteria for determining the existence of the kind of relationship justifying payment of benefits to the "child" on the basis of the individual's earnings record and it would appear undesirable to add this further administratively difficult test.

TEXT OF AMENDMENT 6-24-60-F

Intended to be proposed by Mr. JAVITS (for himself and Mr. KEATING) to the bill (H.R. 12580), viz:

On page 72, line 14, insert "(1)" immediately after "(b)".

On page 72, line 16, strike out "and".

On page 72, line 20, strike out "died", and insert in lieu thereof "died, and (3) in the case of a deceased individual, a child with respect to whom an individual has stood in loco parentis for not less than five years immediately preceding the day on which such individual died".

On page 72, between lines 20 and 21, insert the following new paragraph:

"(2) Subsection (d) of section 2002 of such Act is amended by adding at the end thereof the following new paragraph:

"'(7) A child shall be deemed dependent upon the individual who stands in loco parentis with respect to such child at the time specified in paragraph (1) (C) if, at such time, the child was living with and was receiving at least three-fourths of his support from such individual.'"

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5. AMENDMENT 6-24-60-G—INTRODUCED BY SENATOR JAVITS FOR HIMSELF AND SENATOR KEATING

STAFF ANALYSIS

Provides for the continuation of a child's benefit up until age 21 (presently terminated at age 18) if he has been regularly and continuously attending school since age 18. School is defined as a high school, trade school, junior college,

college, or university. Would continue the payment of mother's benefit on the basis of the continued benefit for the child.

Cost.—0.08 percent of payroll on a level-premium basis.

Financing.—No tax increase provided to cover added cost to program.

VIEWS OF THE DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE ON AMENDMENT 6-24-60-G TO H.R. 12580

The Department of Health, Education, and Welfare does not favor enactment of amendment 6-24-60-G.

Enactment of the amendment would increase the cost of the old-age, survivors, and disability insurance program by 0.08 percent of payroll on a level-premium basis. The amendment does not provide for any increase in income to the system to meet the increased cost. In the opinion of the Department the need for paying benefits to children over age 18 is not well enough established at this time to justify an increase in contributions to meet the additional cost.

TEXT OF AMENDMENT 6-24-60-G

Intended to be proposed by Mr. Javits (for himself and Mr. Keating) to the bill H.R. 12580), viz:

On page 80, between lines 3 and 4, insert the following:

"CONTINUATION OF CHILD'S BENEFITS OF CHILDREN ATTENDING SCHOOL

"SEC. 211. (a) Clause (B) of section 202(d)(1) of such Act is amended to read as follows:

"'(B) at the time such application was filed was unmarried and (i) had not attained the age of eighteen, or (ii) had not attained the age of twenty-one and was and had been continuously since attainment of age eighteen regularly attending school, or (iii) was under a disability (as defined in section 223(c)) which began before he attained the age of eighteen, and'.

"(b) So much of the first sentence of such section 202(d)(1) as follows clause equities, improve the financing of the trust funds, and provide disability benfit for each month, beginning with the first month after August 1950 in which such child becomes so entitled to such insurance benefits and ending (except as otherwise provided by the following sentence) with the month preceding the first month in which any of the following occurs: Such child (i) dies, (ii) marries, (iii) is adopted (except for adoption by a stepparent, grandparent, aunt, or uncle subsequent to the death of such fully or currently insured individual), (iv) in the case of a child (other than a child referred to in clauses (v), (vi), or (vii)), attains the age of eighteen, (v) in the case of a child (other than a child referred to in clauses (vi) or (vii)) who for any period of time commencing on the date he attained age eighteen has regularly and continuously attended school, ceases regularly and continuously to attend school or attains the age of twenty-one, whichever first occurs, (vi) in the case of a child (other than a child referred to in clause (vi)) who upon attainment of age eighteen was under a disability (as defined in section 223(c)) which began before he attained such age, ceases to be under such a disability, or (vii) in the case of a child who upon attainment of age eighteen was under a disability (as defined in section 223(c)) which began before he attained such age and who for any period of time commencing on the date he attained such age has regularly and continuously attended school, ceases to be under such a disability and ceases regularly and continuously to attend school or ceases to be under such a disability and attains the age of twenty-one, whichever first occurs.'

"(c) Such section 202(d)(1) (as amended by this Act) is further amended by adding at the end thereof the following new sentence: 'For purposes of this paragraph, the term "school" means a high school, trade school, junior college, college, or university.'

"(d) The last sentence of section 203(b) of such Act is amended to read as follows: 'No deduction shall be made under this subsection from any child's insurance benefit for the month in which the child entitled to such benefit attained the age of eighteen or any subsequent month, if such child is entitled to such benefit by reason of being under a disability (as defined in section 223(c)) which began before he attained such age.'

"(e)(1) The first sentence of paragraph (1) of section 222(b) of such Act is amended by inserting 'by reason of being under a disability (as defined in section 223(c)) which began before he attained such age' immediately after 'and is entitled to child's insurance benefits'.

"(2) The first sentence of paragraph (2) of such section 222(b) is amended by inserting '(if such child is entitled to such benefit by reason of being under a disability, as defined in section 223(c), which began before he attained such age)' immediately after 'child who has attained the age of eighteen is entitled'.

"(f) The first sentence of section 225 of such Act is amended to read as follows: 'If the Secretary, on the basis of information obtained by or submitted to him, believes that an individual entitled to benefits under section 223, or that a child who has attained the age of eighteen and is entitled to benefits under section 202(d) by reason of being under a disability which began before he attained such age, may have ceased to be under a disability, the Secretary may suspend the payment of benefits under such section 223 or 202(d) until it is determined (as provided in section 221) whether or not such individual's disability has ceased or until the Secretary believes that such disability has not ceased.'

"(g) The amendments made by this section shall be effective with respect to monthly benefits payable under section 202 of the Social Security Act for months after the month in which this Act is enacted."

On page 108, beginning with line 6, strike out all through line 19, and insert in lieu thereof the following:

"(d) Section 202(d)(1) of such Act is amended by inserting after the first sentence thereof the following new sentence: 'Notwithstanding the provisions of the preceding sentence relating to the month in which the child's insurance benefits of an individual shall end, the entitlement to such benefits of an individual who is entitled thereto because he is under a disability shall not end, because he ceases to be under a disability, until the month preceding the third month following the third in which he ceases to be under a disability.'"

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6. AMENDMENT 6-24-60-N—INTRODUCED BY SENATOR BYRD OF WEST VIRGINIA FOR HIMSELF AND THE FOLLOWING SENATORS: BARTLETT, CHAVEZ, CLARK, DODD, DOUGLAS, HARTKE, HUMPHREY, JACKSON, JOHNSTON OF SOUTH CAROLINA, LONG OF HAWAII, MANSFIELD, McGEE, MOSS, MURRAY, PROXMIRE, RANDOLPH, YARBOROUGH, AND YOUNG OF OHIO

Staff Analysis

Provides option of earlier retirement for male workers and dependent husbands at age 62 (now 65) with an actuarial reduction on the same basis presently provided for women workers and wives. The actuarial reduction for workers (five-ninths of 1 percent for each month prior to age 65) would, at age 62, be 80 percent of the full benefit payable at age 65.

The actuarial reduction for dependent husbands (twenty-five thirty-sixths of 1 percent for each month prior to age 65) would, at age 62, be 75 percent of the benefit payable at age 65.

Cost.—0.05 percent of payroll on a level premium basis.

Financing.—No tax increase provided to cover added cost to program.

Views of Department of Health, Education, and Welfare on Amendment 6-24-60-N and 6-24-60-O in Joint Report Below:

The Department of Health, Education, and Welfare recommends against enactment of these amendments. The amendments in themselves would not appreciably increase the cost of the old-age, survivors, and disability insurance program. But actuarially reduced benefits for men at age 62 and for women at age 60 would be so low in many cases as to be quite inadequate, particularly for men, who generally have family responsibilities. Accordingly, it could be expected that enactment of the proposals would give rise to pressures for payment of full-rate benefits at the lower ages specified. Payment of full-rate benefits to men at 62 would increase costs by about 0.43 percent of payroll; payment of full-rate benefits to men and women at 62 would increase costs by about 0.76 per-

cent of payroll; and payment of full-rate benefits to men at 62 and women at 60 would increase costs by about 1.25 percent of payroll.

The payment of benefits at ages lower than those now specified in the law would have the additional disadvantage that it might tend to reduce job opportunities for older people by encouraging employers to retire workers at an earlier age than is now customary and by lowering the hiring age for older people, since many employers hesitate to hire workers nearing retirement age. Thus one of the effects of lowering the eligibility age could be a further loss of job opportunities for older workers who want and need work and a lessening of the attention being paid to the very real problems of helping older workers find jobs.

Securing jobs at older ages is undoubtedly difficult for many, but this is true in some circumstances as early as age 40 or 45. Early retirement for a person not too disabled to engage in gainful activity is not, in the opinion of this Department, a real solution to the problem. Rather, the solution would appear to be found in continued efforts toward the development of additional employment opportunities for older workers.

TEXT OF AMENDMENT 6-24-60-N

Intended to be proposed by Mr. Byrd of West Virginia (for himself and Mr. Bartlett, Mr. Chavez, Mr. Clark, Mr. Dodd, Mr. Douglas, Mr. Hartke, Mr. Humphrey, Mr. Jackson, Mr. Johnston of South Carolina, Mr. Long of Hawaii, Mr. Mansfield, Mr. McGee, Mr. Moss, Mr. Murray, Mr. Proxmire, Mr. Randolph, Mr. Yarborough, and Mr. Young of Ohio) to the bill (H.R. 12580), viz: On page 80, between lines 3 and 4, insert the following new section:

SEC. 211. (a) Section 216(a) of the Social Security Act is amended to read as follows:

"Retirement Age

"(a) The term 'retirement age' means age sixty-two".

(b) Subsections (q), (r), and (s) of section 202 of such Act are amended to read as follows:

"Adjustment of Old-Age, Wife's, and Husband's Insurance Benefit Amounts in Accordance With Age of Beneficiary

"(q)(1) The old-age insurance benefit of any individual for any month prior to the month in which such individual attains the age of sixty-five shall be reduced by—

"(A) five-ninths of 1 per centum, multiplied by

"(B) the number equal to the number of months in the period beginning with the first day of the first month for which such individual is entitled to an old-age insurance benefit and ending with the last day of the month before the month in which such individual would attain the age of sixty-five.

"(2) The wife's or husband's insurance benefit of any individual for any month after the month preceding the month in which such individual attains retirement age and prior to the month in which such individual attains the age of sixty-five shall be reduced by—

"(A) twenty-five thirty-sixths of 1 per centum, multiplied by

"(B) the number equal to the number of months in the period beginning with the first day of the first month for which such individual is entitled to such wife's or husband's (as the case may be) insurance benefit and ending with the last day of the month before the month in which such individual would attain the age of sixty-five, except that in no event shall such period start earlier than the first day of the month in which such individual attains retirement age.

In the case of an individual entitled to wife's insurance benefits, the preceding provisions of this paragraph shall not apply to the benefit for any month in which such individual has in her care (individually or jointly with the individual on whose wages and self-employment income her wife's insurance benefit is based) a child entitled to child's insurance benefits on the basis of such wages and self-employment income. With respect to any month in the period specified in clause (B) of the first sentence of this paragraph, if (in the case of an individual entitled to wife's insurance benefits) such individual does not have in such month such a child in her care (individually or jointly with the individual on whose wages and self-employment income her wife's insurance benefit is

based), she shall be deemed to have such a child in her care in such month for the purposes of the preceding sentence unless there is in effect for such month a certificate filed by her with the Secretary, in accordance with regulations prescribed by him, in which she elects to receive wife's insurance benefits reduced as provided in this subsection. Any certificate filed pursuant to the preceding sentence shall be effective for purposes of such sentence—

"(i) for the month in which it is filed, and for any month thereafter, if in such month she does not have such a child in her care (individually or jointly with the individual on whose wages and self-employment income her wife's insurance benefit is based), and

"(ii) for the period of one or more consecutive months (not exceeding twelve) immediately preceding the month in which such certificate is filed which is designated by her (not including as part of such period any month in which she had such a child in her care (individually or jointly with the individual on whose wages and self-employment income her wife's insurance benefit is based)).

If such a certificate is filed, the period referred to in clause (B) of the first sentence of this paragraph shall commence with the first day of the first month (i) for which such individual is entitled to a wife's insurance benefit, (ii) which occurs after the month preceding the month in which she attains retirement age, and (iii) for which such certificate is effective.

"(3) In the case of any individual who is entitled to an old-age insurance benefit to which paragraph (1) is applicable and who, for the first month for which such individual is so entitled (but not for any prior month) or for any later month occurring before the month in which such individual attains the age of sixty-five, is entitled to a wife's or husband's insurance benefit to which paragraph (2) is applicable, the amount of such wife's or husband's insurance benefit for any month prior to the month in which such individual attains the age of sixty-five shall, in lieu of the reduction provided in paragraph (2), be reduced by the sum of—

"(A) an amount equal to the amount by which such old-age insurance benefit for such month is reduced under paragraph (1), plus

"(B) an amount equal to—

"(i) the number equal to the number of months specified in clause (B) of paragraph (2), multiplied by

"(ii) twenty-five thirty-sixths of 1 per centum, and further multiplied by

"(iii) the excess of such wife's or husband's insurance benefit (as the case may be) prior to reduction under this subsection over the old-age insurance benefit prior to reduction under this subsection.

"(4) In the case of any individual who is or was entitled to a wife's or husband's insurance benefit to which paragraph (2) is applicable and who, for any month after the first month for which such individual is or was so entitled (but not for such first month or any earlier month) occurring before the month in which such individual attains the age of sixty-five, is entitled to an old-age insurance benefit, the amount of such old-age insurance benefit for any month prior to the month in which such individual attains the age of sixty-five shall, in lieu of the reduction provided in paragraph (1), be reduced by the sum of—

"(A) an amount equal to the amount by which such wife's or husband's (as the case may be) insurance benefit is reduced under paragraph (2) for such month (or, if such individual is not entitled to a wife's or husband's insurance benefit for such month, by an amount equal to the amount by which such benefit was reduced for the last month for which such individual was entitled to such a benefit), plus

"(B) if the old-age insurance benefit for such month prior to reduction under this subsection exceeds such wife's or husband's (as the case may be) insurance benefit prior to reduction under this subsection, an amount equal to—

"(i) the number equal to the number of months specified in clause (B) of paragraph (1), multiplied by

"(ii) five-ninths of 1 per centum, and further multiplied by

"(iii) the excess of such old-age insurance benefit over such wife's or husband's (as the case may be) insurance benefit.

"(5) In the case of any individual who is entitled to an old-age insurance benefit for the month in which such individual attains the age of sixty-five or any month thereafter, such benefit for such month shall, if such individual was

also entitled to such benefit for any one or more months prior to the month in which such individual attained the age of sixty-five and such benefit for any such prior month was reduced under paragraph (1) or (4), be reduced as provided in such paragraph, except that there shall be subtracted, from the number specified in clause (B) of such paragraph—

"(A) the number equal to the number of months for which such benefit was reduced under such paragraph, but for which such benefit was subject to deductions under paragraph (1) or (2) of section 203(b),

and except that, in the case of any such benefit reduced under paragraph (4), there also shall be subtracted from the number specified in clause (B) of paragraph (2), for the purpose of computing the amount referred to in clause (A) of paragraph (4)—

"(B) the number equal to the number of months for which the wife's or husband's (as the case may be) insurance benefit was reduced under such paragraph (2), but for which such benefit was subject to deductions under paragraph (1) or (2) of section 203(b), under section 203(c), or under section 222(b),

"(C) in case of a wife's insurance benefit, the number equal to the number of months occurring after the first month for which such benefit was reduced under paragraph (2) in which such individual had in her care (individually or jointly with the individual on whose wages and self-employment income such benefit is based) a child of such individual entitled to child's insurance benefits, and

"(D) the number equal to the number of months for which such wife's or husband's (as the case may be) insurance benefit was reduced under such paragraph (2), but in or after which such individual's entitlement to wife's or husband's insurance benefits was terminated because such individual's spouse ceased to be under a disability, not including in such number of months any month after such termination in which such individual was entitled to wife's or husband's insurance benefits.

Such subtraction shall be made only if the total of such months specified in clauses (A), (B), (C), and (D) of the preceding sentence is not less than three. For purposes of clauses (B) and (C) of this paragraph, the wife's or husband's insurance benefit of an individual shall not be considered terminated for any reason prior to the month in which such individual attains the age of sixty-five.

"(6) In the case of any individual who is entitled to a wife's or husband's insurance benefit for the month in which such individual attains the age of sixty-five or any month thereafter, such benefit for such month shall, if such individual was also entitled to such benefit for any one or more months prior to the month in which such individual attained the age of sixty-five and such benefit for any such prior month was reduced under paragraph (2) or (3), be reduced as provided in such paragraph, except that there shall be subtracted from the number specified in clause (B) of such paragraph—

"(A) the number equal to the number of months for which such benefit was reduced under such paragraph, but for which such benefit was subject to deductions under section 203(b) (1) or (2), under section 203(c), or under section 222(b),

"(B) in case of a wife's insurance benefit, the number equal to the number of months, occurring after the first month for which such benefit was reduced under such paragraph, in which such individual had in her care (individually or jointly with the individual on whose wages and self-employment income such benefit is based) a child of such individual entitled to child's insurance benefits, and

"(C) the number equal to the number of months for which such wife's or husband's (as the case may be) insurance benefit was reduced under such paragraph, but in or after which such individual's entitlement to wife's or husband's insurance benefits was terminated because such individual's spouse ceased to be under a disability, not including in such number of months any month after such termination in which such individual was entitled to wife's or husband's insurance benefits,

and except that, in the case of any such benefit reduced under paragraph (3), there also shall be subtracted from the number specified in clause (B) of paragraph (1), for the purpose of computing the amount referred to in clause (A) of paragraph (3)—

"(D) the number equal to the number of months for which the old-age insurance benefit was reducel under such paragraph (1) but for which such benefit was subject to deductions under paragraph (1) or (2) of section 203(b).

Such subtraction shall be made only if the total of such months specified in clauses (A), (B), (C), and (D) of the preceding sentence is not less than three.

"(7) In the case of an individual who is entitled to an old-age insurance benefit to which paragraph (5) is applicable and who, for the month in which such individual attains the age of sixty-five (but not for any prior month) or for any later month, is entitled to a wife's or husband's insurance benefit, the amount of such wife's or husband's insurance benefit for any month shall be reduced by an amount equal to the amount by which the old-age insurance benefit is reduced under paragraph (5) for such month.

"(8) In the case of an individual who is or was entitled to a wife's or husband's insurance benefit to which paragraph (2) was applicable and who, for the month in which such individual attains the age of sixty-five (but not for any prior month) or for any later month, is entitled to an old-age insurance benefit, the amount of such old-age insurance benefit for any month shall be reduced by an amount equal to the amount by which the wife's or husband's (as the case may be) insurance benefit is reduced under paragraph (6) for such month (or, if such individual is not entitled to a wife's or husband's insurance benefit for such month, by (i) an amount equal to the amount by which such benefit for the last month for which such individual was entitled thereto was reduced, or (ii) if smaller, an amount equal to the amount by which such benefit would have been reduced under paragraph (6) for the month in which such individual attained the age of sixty-five if entitlement to such benefit had not terminated before such month).

"(9) The preceding paragraphs shall be applied to old-age insurance benefits, wife's insurance benefits, and husband's insurance benefits after reduction under section 203(a) and application of section 215(g). If the amount of any reduction computed under paragraph (1), under paragraph (2), under clause (A) or clause (B) of paragraph (3), or under clause (A) or clause (B) of paragraph (4) is not a multiple of $0.10, it shall be reduced to the next lower multiple of $0.10.

"Presumed Filing of Application by Individual Eligible for Old-Age and Wife's or Husband's Insurance Benefits

"(r) Any individual who becomes entitled to an old-age insurance benefit for any month prior to the month in which such individual attains the age of sixty-five and who is eligible for a wife's or husband's insurance benefit for the same month shall be deemed to have filed an application in such month for wife's or husband's (as the case may be) insurance benefits. Any individual who becomes entitled to a wife's or husband's insurance benefit for any month prior to the month in which such individual attains the age of sixty-five and who is eligible for an old-age insurance benefit for the same month shall be deemed, unless (in the case of an individual entitled to wife's insurance benefits) such individual has in such month in her care (individually or jontly with the individual on whose wages and self-employment income her wife's insurance benefits are based) a child entitled to child's insurance benefits on the basis of such wages and self-employment income, to have filed an application in such month for old-age insurance benefits. For purposes of this subsection an individual shall be deemed eligible for a benefit for a month if, upon filing application therefor in such month, such individual would have been entitled to such benefit for such month.

"Disability Insurance Beneficiary

"(s)(1) If any individual becomes entitled to a widow's insurance benefit, widower's insurance benefit, or parent's insurance benefit for a month before the month in which such individual attains the age of sixty-five, or becomes entitled to an old-age insurance benefit, wife's insurance benefit, or husband's insurance benefit for a month before the month in which such individual attains the age of sixty-five which is reduced under the provisions of subsection (q), such individual may not thereafter become entitled to disability insurance benefits under this title.

"(2) If an individual would, but for the provisions of subsection (k)(2)(B), be entitled for any month to a disability insurance benefit and to a wife's or husband's insurance benefit, subsection (q) shall be applicable to such wife's or husband's insurance benefit (as the case may be) for such month only to the extent it exceeds such disability insurance benefit for such month.

"(3) The entitlement of any individual to disability insurance benfits shall terminate with the month before the month in which such individual becomes entitled to old-age insurance benefits."

(c) So much of such section 202(b)(1) as follows clause (C) is amended by striking out "she becomes entitled to an old-age or disability insurance benefit based on a primary insurance amount which is equal to or exceeds one-half of an old-age or disability insurance benefit of her husband,".

(d)(1) Clause (D) of subsection (c)(1) of such section 202 is amended by striking out "or he becomes entitled to an old-age or disability insurance benefit equal to or exceeding one-half of the primary insurance amount of his wife,".

(2) Subsection (c)(3) of such section 202 is amended by striking out "Such" and inserting in lieu thereof "Except as provided in subsection (q), such".

(e) Subsection 202(j)(3) of such Act is amended to read as follows:

"(3) Notwithstanding the provisions of paragraph (1), an individual may, at his option, waive entitlement to old-age insurance benefits, wife's insurance benefits, or husband's insurance benefits for any one or more consecutive months which occur—

"(A) after the month before the month in which such individual attains retirement age,

"(B) prior to the month in which such individual attains the age of sixty-five, and

"(C) prior to the month in which such individual files application for such benefits;

and, in such case, such individual shall not be considered as entitled to such benefits for any such month or months before he filed such application. An individual shall be deemed to have waived such entitlement for any such month for which such benefit would, under the second sentence of paragraph (1), be reduced to zero."

(f) Section 3121(a)(9) of the Internal Revenue Code of 1954 is amended to read as follows:

"(9) any payment (other than vacation or sick pay) made to an employee after the month in which he attains the age of 62, if such employee did not work for the employer in the period for which such payment is made; or".

(g)(1) The amendment made by subsection (a) shall apply only in the case of lump-sum death payments under section 202(i) of the Social Security Act with respect to deaths occurring after October 1960, and in the case of monthly benefits under title II of such Act for months after October 1960 on the basis of applications filed after the date of enactment of this Act.

(2) For purposes of section 215(b)(3)(B) of the Social Security Act (but subject to paragraph (1) of this subsection)—

(A) a man who attains the age of sixty-two prior to November 1960 and who was not eligible for old-age insurance benefits under section 202 of such Act (as in effect prior to the enactment of this Act) for any month prior to November 1960 shall be deemed to have attained the age of sixty-two in 1960 or, if earlier, the year in which he died;

(B) an individual shall not, by reason of the amendment made by subsection (a), be deemed to be a fully insured individual before November 1960 or the month in which he died, whichever month is the earlier; and

(C) the amendment made by subsection (a) shall not be applicable in the case of any individual who was eligible for old-age insurance benefits under such section 202 for any month prior to November 1960.

An individual shall, for purposes of this paragraph, be deemed eligible for old-age insurance benefits under section 202 of the Social Security Act for any month if he was or would have been, upon filing application therefor in such month, entitled to such benefits for such month.

(3) For purposes of section 209(i) of such Act, the amendment made by subsection (a) shall apply only with respect to remuneration paid after October 1960.

(h)(1) The amendments made by subsections (b) through (e) shall take effect November 1, 1960, and shall be applicable with respect to monthly benefits under title II of the Social Security Act for months after October 1960.

(2) The amendment made by subsection (f) shall be effective with respect to remuneration paid after October 1960.

7. AMENDMENT 6-24-60-O—INTRODUCED BY SENATOR BYRD OF WEST VIRGINIA

STAFF ANALYSIS

Provides option of earlier retirement for men at age 62 (now 65) and for women at age 60 (now 62) with an actuarial reduction for all people except widows who could qualify for full benefits at age 60 (now 62). The actuarial reduction for workers (five-ninths of 1 percent for each month prior to age 65) would be 80 percent of the full benefit payable at age 65 for men retiring at age 62, and 66⅔ percent of the full benefit for women retiring at age 60.

The actuarial reduction for a wife (twenty-five thirty-sixths of 1 percent for each month prior to age 65) would at age 60, be 58⅓ percent of the benefit payable to her at age 65. (Wives can now apply at age 62 with 75 percent their full benefit.)

Cost.—0.25 percent of payroll on a level premium basis.

Financing.—No tax increase provided to cover added cost to the program.

VIEWS OF DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE ON AMENDMENT 6-26-60-N AND AMENDMENT 6-26-60-O

See joint report on page 469.

TEXT OF AMENDMENT 6-24-60-O

Intended to be proposed by Mr. BYRD of West Virginia to the bill (H.R. 12580), viz: On page 80, between lines 3 and 4, insert the following new section:

SEC. 211. (a) Section 216(a) of the Social Security Act is amended to read as follows:

"Retirement Age

"(a) The term 'retirement age' means—

"(1) in the case of a man, age sixty-two or

"(2) in the case of a woman, age sixty."

(b) Subsections (q), (r), and (s) of section 202 of such Act are amended to read as follows:

"Adjustment of Old-Age, Wife's, and Husband's Insurance Benefit Amounts in Accordance With Age of Beneficiary

"(q)(1) The old-age insurance benefit of any individual for any month prior to the month in which such individual attains the age of sixty-five shall be reduced by—

"(A) five-ninths of 1 per centum, multiplied by

"(B) the number equal to the number of months in the period beginning with the first day of the first month for which such individual is entitled to an old-age insurance benefit and ending with the last day of the month before the month in which such individual would attain the age of sixty-five.

"(2) The wife's or husband's insurance benefit of any individual for any month after the month preceding the month in which such individual attains retirement age and prior to the month in which such individual attains the age of sixty-five shall be reduced by—

"(A) twenty-five thirty-sixths of 1 per centum, multiplied by

"(B) the number equal to the number of months in the period beginning with the first day of the first month for which such individual is entitled to such wife's or husband's (as the case may be) insurance benefit and ending with the last day of the month before the month in which such individual would attain the age of sixty-five, except that in no event shall such period start earlier than the first day of the month in which such individual attains retirement age.

In the case of an individual entitled to wife's insurance benefits, the preceding provisions of this paragraph shall not apply to the benefit for any month in which such individual has in her care (individually or jointly with the individual on whose wages and self-employment income her wife's insurance benefit is based) a child entitled to child's insurance benefits on the basis of such wages and self-employment income. With respect to any month in the period specified in clause (B) of the first sentence of this paragraph, if (in the case of an in-

dividual entitled to wife's insurance benefits) such individual does not have in such month such a child in her care (individually or jointly with the individual on whose wages and self-employment income her wife's insurance benefit is based), she shall be deemed to have such a child in her care in such month for the purposes of the preceding sentence unless there is in effect for such month a certificate filed by her with the Secretary, in accordance with regulations prescribed by him, in which she elects to receive wife's insurance benefits reduced as provided in this subsection. Any certificate filed pursuant to the preceding sentence shall be effective for purposes of such sentence—

"(I) for the month in which it is filed, and for any month thereafter, if in such month she does not have such a child in her care (individually or jointly with the individual on whose wages and self-employment income her wife's insurance benefit is based), and

"(II) for the period of one or more consecutive months (not exceeding twelve) immediately preceding the month in which such certificate is filed which is designated by her (not including as part of such period any month in which she had such a child in her care (individually or jointly with the individual on whose wages and self-employment income her wife's insurance benefit is based)).

If such a certificate is filed, the period referred to in clause (B) of the first sentence of this paragraph shall commence with the first day of the first month (I) for which such individual is entitled to a wife's insurance benefit, (II) which occurs after the month preceding the month in which she attains retirement age, and (III) for which such certificate is effective.

"(3) In the case of any individual who is entitled to an old-age insurance benefit to which paragraph (1) is applicable and who, for the first month for which such individual is so entitled (but not for any prior month) or for any later month occurring before the month in which such individual attains the age of sixty-five, is entitled to a wife's or husband's insurance benefit to which paragraph (2) is applicable, the amount of such wife's or husband's insurance benefit for any month prior to the month in which such individual attains the age of sixty-five shall, in lieu of the reduction provided in paragraph (2), be reduced by the sum of—

"(A) an amount equal to the amount by which such old-age insurance benefit for such month is reduced under paragraph (1), plus

"(B) an amount equal to—

"(i) the number equal to the number of months specified in clause (B) of paragraph (2), multiplied by

"(ii) twenty-five thirty-sixths of 1 per centum, and further multiplied by

"(iii) the excess of such wife's or husband's insurance benefit (as the case may be) prior to reduction under this subsection over the old-age insurance benefit prior to reduction under this subsection.

"(4) In the case of any individual who is or was entitled to a wife's or husband's insurance benefit to which paragraph (2) is applicable and who, for any month after the first month for which such individual is or was so entitled (but not for such first month or any earlier month) occurring before the month in which such individual attains the age of sixty-five, is entitled to an old-age insurance benefit, the amount of such old-age insurance benefit for any month prior to the month in which such individual attains the age of sixty-five shall, in lieu of the reduction provided in paragraph (1), be reduced by the sum of—

"(A) an amount equal to the amount by which such wife's or husband's (as the case may be) insurance benefit is reduced under paragraph (2) for such month (or, if such individual is not entitled to a wife's or husband's insurance benefit for such month, by an amount equal to the amount by which such benefit was reduced for the last month for which such individual was entitled to such a benefit), plus

"(B) if the old-age insurance benefit for such month prior to reduction under this subsection exceeds such wife's or husband's (as the case may be) insurance benefit prior to reduction under this subsection, an amount equal to—

"(i) the number equal to the number of months specified in clause (B) of paragraph (1), multiplied by

"(ii) five-ninths of 1 per centum, and further multiplied by

"(iii) the excess of such old-age insurance benefit over such wife's or husband's (as the case may be) insurance benefit.

"(5) In the case of any individual who is entitled to an old-age insurance benefit for the month in which such individual attains the age of sixty-five or any month thereafter, such benefit for such month shall, if such individual was also entitled to such benefit for any one or more months prior to the month in which such individual attained the age of sixty-five and such benefit for any such prior month was reduced under paragraph (1) or (4), be reduced as provided in such paragraph, except that there shall be subtracted, from the number specified in clause (B) of such paragraph—

"(A) the number equal to the number of months for which such benefit was reduced under such paragraph, but for which such benefit was subject to deductions under paragraph (1) or (2) of section 203(b),

and except that, in the case of any such benefit reduced under paragraph (4), there also shall be subtracted from the number specified in clause (B) of paragraph (2), for the purpose of computing the amount referred to in clause (A) of paragraph (4)—

"(B) the number equal to the number of months for which the wife's or husband's (as the case may be) insurance benefit was reduced under such paragraph (2), but for which such benefit was subject to deductions under paragraph (1) or (2) of section 203(b), under section 203(c), or under section 222(b),

"(C) in case of a wife's insurance benefit, the number equal to the number of months occurring after the first month for which such benefit was reduced under paragraph (2) in which such individual had in her care (individually or jointly with the individual on whose wages and self-employment income such benefit is based) a child of such individual entitled to child's insurance benefits, and

"(D) the number equal to the number of months for which such wife's or husband's (as the case may be) insurance benefit was reduced under such paragraph (2); but in or after which such individual's entitlement to wife's or husband's insurance benefits was terminated because such individual's spouse ceased to be under a disability, not including in such number of months any month after such termination in which such individual was entitled to wife's or husband's insurance benefits.

Such subtraction shall be made only if the total of such months specified in clauses (A), (B), (C), and (D) of the preceding sentence is not less than three. For purposes of clauses (B) and (C) of this paragraph, the wife's or husband's insurance benefit of an individual shall not be considered terminated for any reason prior to the month in which such individual attains the age of sixty-five.

"(6) In the case of any individual who is entitled to a wife's or husband's insurance benefit for the month in which such individual attains the age of sixty-five or any month thereafter, such benefits for such month shall, if such individual was also entitled to such benefit for any one or more months prior to the month in which such individual attained the age of sixty-five and such benefit for any such prior month was reduced under paragraph (2) or (3), be reduced as provided in such paragraph, except that there shall be subtracted from the number specified in clause (B) of such paragraph—

"(A) the number equal to the number of months for which such benefit was reduced under such paragraph, but for which such benefit was subject to deductions under section 203(b) (1) or (2), under section 203 (c), or under section 222 (b),

"(B) in the case of a wife's insurance benefit, the number equal to the number of months, occurring after the first month for which such benefit was reduced under such paragraph, in which such individual had in her care (individually or jointly with the individual on whose wages and self-employment income such benefit is based) a child of such individual entitled to child's insurance benefits, and

"(C) the number equal to the number of months for which such wife's or husband's (as the case may be) insurance benefit was reduced under such paragraph, but in or after which such individual's entitlement to wife's or husband's insurance benefits was terminated because such individual's spouse ceased to be under a disability, not including in such number of months any month after such termination in which such individual was entitled to wife's or husband's insurance benefits,

and except that, in the case of any such benefit reduced under paragraph (3), there also shall be subtracted from the number specified in clause (B) of paragraph (1), for the purpose of computing the amount referred to in clause (A) of paragraph (3)—

"(D) the number equal to the number of months for which the old-age insurance benefit was reduced under such paragraph (1) but for which such benefit was subject to deductions under paragraph (1) or (2) of section 203(b).

Such subtraction shall be made only if the total of such months specified in clauses (A), (B), (C), and (D) of the preceding sentence is not less than three.

"(7) In the case of an individual who is entitled to an old-age insurance benefit to which paragraph (5) is applicable and who, for the month in which such individual attains the age of sixty-five (but not for any prior month) or for any later month, is entitled to a wife's or husband's insurance benefit the amount of such wife's or husband's insurance benefit for any month shall be reduced by any amount equal to the amount by which the old-age insurance benefit is reduced under paragraph (5) for such month.

"(8) In the case of an individual who is or was entitled to a wife's or husband's insurance benefit to which paragraph (2) was applicable and who, for the month in which such individual attains the age of sixty-five (but not for any prior month) or for any later month, is entitled to an old-age insurance benefit, the amount of such old-age insurance benefit for any month shall be reduced by an amount equal to the amount by which the wife's or husband's (as the case may be) insurance benefit is reduced under paragraph (6) for such month (or, if such individual is not entitled to a wife's or husband's insurance benefit for such month, by (i) an amount equal to the amount by which such benefit for the last month for which such individual was entitled thereto was reduced, or (ii) if smaller, an amount equal to the amount by which such benefit would have been reduced under paragraph (6) for the month in which such individual attained the age of sixty-five if entitlement to such benefit had not terminated before such month).

"(9) The preceding paragraphs shall be applied to old-age insurance benefits, wife's insurance benefits, and husband's insurance benefits after reduction under section 203(a) and application of section 215(g). If the amount of any reduction computed under paragraph (1), under paragraph (2), under clause (A) or clause (B) of paragraph (3), or under clause (A) or clause (B) of paragraph (4) is not a multiple of $0.10, it shall be reduced to the next lower multiple of $0.10.

"Presumed Filing of Application by Individual Eligible for Old-Age and Wife's or Husband's Insurance Benefits

"(r) Any individual who becomes entitled to an old-age insurance benefit for any month prior to the month in which such individual attains the age of sixty-five and who is eligible for a wife's or husband's insurance benefit for the same month shall be deemed to have filed an application in such month for wife's or husband's (as the case may be) insurance benefits. Any individual who becomes entitled to a wife's or husband's insurance benefit for any month prior to the month in which such individual attains the age of sixty-five and who is eligible for an old-age insurance benefit for the same month shall be deemed, unless (in the case of an individual entitled to wife's insurance benefits) such individual has in such month in her care (individually or jointly with the individual on whose wages and self-employment income her wife's insurance benefits are based) a child entitled to child's insurance benefits on the basis of such wages and self-employment income, to have filed an application in such month for old-age insurance benefits. For purposes of this subsection an individual shall be deemed eligible for a benefit for a month if, upon filing application therefor in such month, such individual would have been entitled to such benefit for such month.

"Disability Insurance Beneficiary

"(s)(1) If any individual becomes entitled to a widow's insurance benefit, widower's insurance benefit, or parent's insurance benefit for a month before the month in which such individual attains the age of sixty-five, of becomes entitled to an old-age insurance benefit wife's insurance benefit, or husband's insurance benefit for a month before the month in which such individual attains the age of

sixty-five which is reduced under the provisions of subsection (q), such individual may not thereafter become entitled to disability insurance benefits under this title.

"(2) If an individual would, but for the provisions of subsection (k)(2)(B), be entitled for any month to a disability insurance benefit and to a wife's or husband's insurance benefit, subsection (q) shall be applicable to such wife's or husband's insurance benefit (as the case may be) for such month only to the extent it exceeds such disability insurance benefit for such month.

"(3) The entitlement of any individual to disability insurance benefits shall terminate with the month before the month in which such individual becomes entitled to old-age insurance benefits."

(c) So much of such section 202(b)(1) as follows clause (C) is amended by striking out "she becomes entitled to an old-age or disability insurance benefit based on a primary insurance amount which is equal to or exceeds one-half of an old-age or disability insurance benefit of her husband,".

(d)(1) Clause (D) of subsection (c)(1) of such section 202 is amended by striking out "or he becomes entitled to an old-age or disability insurance benefit equal to or exceeding one-half of the primary insurance amount of his wife,".

(2) Subsection (c)(3) of such section 202 is amended by striking out "Such" and inserting in lieu thereof "Except as provided in subsection (q), such".

(e) Subsection 202(j)(3) of such Act is amended to read as follows:

"(3) Notwithstanding the provisions of paragraph (1), an individual may, at his option, waive entitlement to old-age insurance benefits, wife's insurance benefits, or husband's insurance benefits for any one or more consecutive months which occur—

"(A) after the month before the month in which such individual attains retirement age,

"(B) prior to the month in which such individual attains the age of sixty-five, and

"(C) prior to the month in which such individual files application for such benefits;

and, in such case, such individual shall not be considered as entitled to such benefits for any such month or months before he filed such application. An individual shall be deemed to have waived such entitlement for any such month for which such benefit would, under the second sentence of paragraph (1), be reduced to zero."

(f) Section 3121(a)(9) of the Internal Revenue Code of 1954, is amended by striking out "65" and inserting in lieu thereof "62", and by striking out "62" and inserting in lieu thereof "60".

(g)(1) The amendment made by subsection (a) shall apply only in the case of lump-sum death payments under section 202(i) of the Social Security Act with respect to deaths occurring after October 1960, and in the case of monthly benefits under title II of such Act for months after October 1960 on the basis of applications filed after the date of enactment of this Act.

(2) For purposes of section 215(b)(3)(B) of the Social Security Act (but subject to paragraph (1) of this subsection)—

(A)(i) a woman who attains the age of sixty prior to November 1960 and who was not eligible for old-age insurance benefits under section 202 of such Act (as in effect prior to the enactment of this Act) for any month prior to November 1960 shall be deemed to have attained the age of sixty in 1960 or, if earlier, the year in which she died; and

(ii) a man who attains the age of sixty-two prior to November 1960 and who was not eligible for old-age insurance benefits under section 202 of such Act (as in effect prior to the enactment of this Act) for any month prior to November 1960 shall be deemed to have attained the age of sixty-two in 1960, or, if earlier, the year in which he died;

(B) an individual shall not, by reason of the amendment made by subsection (a), be deemed to be a fully insured individual before November 1960 or the month in which he died, whichever month is the earlier; and

(C) the amendment made by subsection (a) shall not be applicable in the case of any individual who was eligible for old-age insurance benefits under such section 202 for any month prior to November 1960.

An individual shall, for purposes of this paragraph, be deemed eligible for old-age insurance benefits under section 202 of the Social Security Act for any month if he was or would have been, upon filing application therefor in such month, entitled to such benefits for such month.

(3) For purposes of section 209(i) of such Act, the amendment made by subsection (a) shall apply only with respect to remuneration paid after October 1960.

(h)(1) The amendments made by subsections (b) through (e) shall take effect November 1, 1960, and shall be applicable with respect to monthly benefits under title II of the Social Security Act for months after October 1960.

(2) The amendment made by subsection (f) shall be effective with respect to remuneration paid after October 1960.

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8. AMENDMENT 6-27-60-A—INTRODUCED BY SENATOR KEATING (IDENTICAL TO THE FOLLOWING AMENDMENTS: NO. 13, 6-27-60-I, INTRODUCED BY SENATOR SCHOEPPEL; No. 16, 6-28-60-C, INTRODUCED BY SENATOR HUMPHREY; AND NO. 24, 6-29-60-X, INTRODUCED BY SENATOR HARTKE)

STAFF ANALYSIS

Increases the social security earnings limitation from $1,200 to $1,800 per year.

Cost.—$616 million per year, or 0.19 percent of payroll, on a level premium basis.

Financing.—No tax increase provided to cover added cost to program.

VIEWS OF DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE ON FOLLOWING AMENDMENTS: No. 8, 6-27-60-A; No. 9, 6-27-60-B; No. 10, 6-27-60-E; No. 13, 6-27-60-I; No. 16, 6-28-60-C; No. 21, 6-29-60-AA; No. 22, 6-29-60-BB; No. 24, 6-29-60-X; No. 25, 629-60-Y; No. 26, 6-29-60-Z

The Department of Health, Education, and Welfare believes that the retirement test in the old-age and survivors insurance program is necessary in order to assure that the funds of the program will be employed for socially useful purposes. As indicated in our report of February 11, 1960, on S. 343, S. 453, and S. 1168, elimination of the test would substantially increase the cost of the program and the additional cost would be incurred chiefly as a result of paying full benefits to people who are fully employed at relatively high earnings. If the retirement test were abolished, the cost of the old-age and survivors insurance program would be increased (on an intermediate-cost basis) by about 1 percent of payroll. The Department is therefore strongly in favor of retaining the retirement test in the old-age and survivors insurance program. Moreover, as stated in our report of July 29, 1959, on S. 108, S. 248, S. 432, S. 565, S. 638, S. 679, and S. 1288, we believe that the present exemption of $1,200 is preferable to the higher exemption proposed by the various amendments to H.R. 12580 here reported on.

An increase in the amount of earnings exempt under the earnings test would not help the great majority of old-age and survivors insurance beneficiaries, who are either unable to work or cannot find jobs. Moreover, it would not contribute at all to a solution to the basic problems involved in the retirement test. Yet, if the exempt amount were raised, the cost of the old-age and survivors insurance program would be significantly increased. For example, the estimated level-premium cost of increasing the exempt amount to $1,800, without other change in the present law, would be 0.19 percent of payroll on an intermediate-cost basis. The increase in cost would of course be even higher if the exempt amount were raised to a higher amount than $1,800, as proposed in some of the amendments here commented on.

The Department of Health, Education, and Welfare recommends against enactment of the proposed amendments.

TEXT OF AMENDMENT 6-27-60-A

Intended to be proposed by Mr. KEATING to the bill (H.R. 12580), viz: On page 80, between lines 3 and 4, insert the following new section:

SEC. 211. (a) (1) Paragraphs (1) and (2) of subsection (e) of section 203 of the Social Security Act are amended by striking out "$1,200" wherever it appears therein and inserting in lieu thereof "$1,800", and (2) such paragraphs

and paragraph (1) of subsection (g) of such section are amended by striking out "$100 times" wherever it appears therein and inserting in lieu thereof "$150 times".

(b) The amendments made by subsection (a) shall be effective, in the case of any individual, with respect to taxable years of such individual ending after 1960.

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9. AMENDMENT 6-27-60-B—INTRODUCED BY SENATOR KEATING (IDENTICAL TO NO. 22, 6-29-60-BB. INTRODUCED BY SENATOR HARTKE)

STAFF ANALYSIS

Eliminates the social security earnings limitation (now $1,200 per year). *Cost.*—$3.241 billion per year or 1.0 percent of payroll or a level premium basis. *Financing.*—No tax increase provided for additional cost of the program.

VIEWS OF DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE ON AMENDMENT 6-27-60-B

See joint report on page 480.

TEXT OF AMENDMENT 6-27-60-B

Intended to be proposed by Mr. KEATING to the bill (H.R. 12580), viz:

On page 27, line 17, strike out "(A)".

On page 27, line 22, strike out "(B)" and insert in lieu thereof "(2)".

On page 28, line 1, strike out "(2)", and insert in lieu thereof "(b)".

On page 28, beginning with line 7, strike out all through line 14.

On page 42, line 13, strike out "subsection (a)" and insert in lieu thereof "subsections (a) and (b)".

On page 80, between lines 3 and 4, insert the following new section:

"ELIMINATION OF DEDUCTIONS FROM BENEFITS ON ACCOUNT OF WORK

"SEC. 211. (a) Subsections (c), (e), (g), (j), and (k) of section 203 of the Social Security Act are repealed.

"(b) Subsection (b) of such section 203 is amended by (1) striking out 'Work or' in the heading, and (2) striking out paragraphs (1) and (2) thereof.

"(c)(1) The first sentence of subsection (d) of such section 203 is amended by striking out 'subsections (b) and (e)' and inserting in lieu thereof 'subsection (b)'.

"(2) The second sentence of such subsection (d) is repealed.

"(d) Subsection (f) of such section 203 (as amended by section 209(a) of this Act) is amended by striking out '(other than an event specified in subsection (b)(1))'.

"(e) Paragraph (1) of subsection (h) of such section 203 is amended by striking out ', (f), or (g)' and inserting in lieu thereof ', or (f)'.

"(f) Subsection (l) of such section 203 is amended by striking out 'or (g)'.

"(g) Paragraph (1) of subsection (n) of section 202 of the Social Security Act is amended by striking out 'section 203 (b) and (c)' and inserting in lieu thereof 'section 203(b)'.

"(h) Paragraph (7) of subsection (t) of section 202 of the Social Security Act is amended by striking out 'subsections (b) and (c)' and inserting in lieu thereof 'subsection (b)'.

"(i) The amendments made by this section shall apply only with respect to monthly benefits payable under title II of the Social Security Act for months beginning after the month in which this Act is enacted."

10. AMENDMENT 6-27-60-E—INTRODUCED BY SENATOR JAVITS (IDENTICAL WITH AMENDMENT 25, 6-29-60-Y, INTRODUCED BY SENATOR HARTKE)

STAFF ANALYSIS

Increases the social security earnings limitation from $1,200 to $2,400 per year.

Cost.—$1.33 billion per year, or 0.41 percent of payroll, on a level premium basis.

Financing.—No tax increase provided for additional cost of the program.

VIEWS OF DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE ON AMENDMENT 6-27-60-E

See joint report on page 480.

TEXT OF AMENDMENT 6-27-60-E

Intended to be proposed by Mr. JAVITS to the bill (H.R. 12580), viz: On page 80, between lines 3 and 4, insert the following new section:

SEC. 211. (a) (1) Paragraphs (1) and (2) of subsection (e) of section 203 of the Social Security Act are amended by striking out "$1,200" wherever it appears therein and inserting in lieu thereof "$2,400", and (2) such paragraphs and paragraph (1) of subsection (g) of such section are amended by striking out "$100 times" wherever it appears therein and inserting in lieu thereof "$200 times".

(b) The amendments made by subsection (a) shall be effective, in the case of any individual, with respect to taxable years of such individual ending after 1960.

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11. AMENDMENT 6-27-60-F—INTRODUCED BY SENATOR MORSE (IN NATURE OF SUBSTITUTE FOR TITLE VI OF H.R. 12580)—IDENTICAL TO SENATOR MORSE'S BILL S. 881, AND CONGRESSMAN FORAND'S BILL H.R. 4700

STAFF ANALYSIS

Eligibility.—Individuals who are eligible to receive, but not necessarily receiving social security old-age and survivors benefits (including dependents) would be entitled to health benefits.

Benefits.—

1. Hospital services—60 days per year.
2. Nursing home services—120 days per year (less days of hospitalization).
3. Surgical services—no limit.

Cost.—$2.56 billion per year, or 0.79 percent of payroll on a level premium basis; $1.11 billion per year, or 0.53 percent of payroll on an early year basis.

Financing.—Benefits would be payable out of the old-age and survivors insurance trust fund and would be financed by an increase in the contribution rate on both employer and employee of one-fourth of 1 percent and on the self-employed of three-eighths of 1 percent, beginning in 1961.

NOTE.—The revenues derived from the tax increases provided in amendment would amount to only 0.50 percent of payroll on a level premium basis; thus the amendment is underfinanced.

VIEWS OF DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE ON AMENDMENT 6-27-60-F INCLUDED IN FOLLOWING JOINT REPORT

The Department of Health, Education, and Welfare would recommend against adoption of each of the following four amendments: Amendment No. 1, 6-24-60-C (Mr. McNamara), Amendment No. 11, 6-27-60-F (Mr. Morse), Amendment No. 20, 6-28-60-G (Mr. Humphrey), and Amendment No. 27, 6-30-60-E (Mr. Anderson). Each of these bills proposes to amend title VI of H.R. 12580 to add health insurance benefits to the existing Federal old-age, survivors, and disability insurance system. The reasons for this recommendation are as follows:

1. The proposed extension of the existing old-age, survivors, and disability insurance system to encompass health insurance would make such insurance compulsory and would not be pinpointed to the need for aid in meeting the cost of medical services. Under this approach, the individual would have no opportunity to determine for himself the particular pattern for meeting the threat of large medical expenses that best suit his own needs and desires. In addition, by compulsorily extending health benefits to aged persons eligible for old-age, survivors, and disability insurance, many persons would be included who have the resources and the opportunity to obtain protection against long-term or other expensive illnesses without Government help.

2. These amendments would establish an exclusively Federal program. This administration has consistently endeavored, however, to strengthen our system of government by encouraging State and local governments to assume responsibility for the many public needs which can be met through Federal-State partnership and by supporting programs to stimulate greater State and local effort in areas of critical national concern. Health care for the aged is an area of activity admirably suited to such a sharing of responsibility. In addition to bolstering the underlying cooperative foundation of our Federal system, with governmental powers divided between State and Nation, Federal-State partnership places the control over daily program operations at the level of Government closest to the persons affected by the program. Thus, an individual's needs may be more immediately and effectively reflected in the current operations and the development of the program.

3. The approach proposed in the amendments would constitute a serious threat to the orderly development of present retirement, survivorship, and disability benefit features of the social security system.

The payroll tax for old-age, survivors, and disability insurance is already scheduled ultimately to be 4½ percent each on employees and employers and 6¾ percent on the self-employed. Further liberalization in retirement, survivorship, and disability benefits may call for additional revenues, which can only come from increases in the payroll tax or increases in the earnings base, or both. If health insurance as envisaged in these amendments were to be added to the system, the payroll tax would need to be increased by a total of one-half to 1 percent. As in the case of cash benefits, there would undoubtedly be insistent demands for improving the medical benefits beyond those which can be financed by the tax increase for medical benefit purposes. Increases in both health and cash benefits would place the retirement, survivorship, and disability portions of the system in competition with the health benefits for available funds, since the revenue possibilities from a payroll tax are not limitless.

It is therefore far better to reserve the payroll tax for the retirement, survivorship, and disability features of the social security system so that the revenue source is not overburdened. Whatever the Government needs to do in the area of health care for the aged should be done by the appropriation of general revenues. Such appropriation would provide for a more equitable distribution of the fiscal load than would a payroll tax on earnings of $4,800 or less.

TEXT OF AMENDMENT 6-27-60-F

Intended to be proposed by Mr. MORSE to the bill (H.R. 12580), viz: Beginning on page 154, line 1, strike out all through line 18 on page 172, and insert in lieu thereof the following:

TITLE VI—HOSPITAL AND SURGICAL INSURANCE

AMENDMENTS TO TITLE II OF THE SOCIAL SECURITY ACT

SEC. 601. (a) Title II of the Social Security Act is amended by adding after section 225 the following new section:

"HOSPITALIZATION AND SURGICAL INSURANCE

"Eligibility for Insurance

"SEC. 226. (a) (1) The cost of hospital or nursing home services furnished to any individual during any month for which he is entitled to monthly benefits under section 202 (whether or not such benefits are actually paid to him) or is deemed entitled to such benefits under the provisions of paragraph 2, or the cost of such services furnished to him during the month of his death where he ceases

to be entitled by reason of his death, and the cost of surgical services which are not of an elective nature, shall, subject to the provisions of this section, be paid from the Federal Old-Age and Survivors Insurance Trust Fund to the hospital, physician, and nursing home which furnished him the services. Services to be paid for in accordance with the provisions of this section include only services provided in the United States.

"(2) For purposes of this section, (A) any individual who would upon filing application therefor, be entitled to monthly benefits for any month under section 202 shall, if he files application under this section within the time limits prescribed in section 202(j) be deemed, for purposes of this section only, to be entitled to benefits for such month, (B) such individual shall, whether or not he files application under this section, be deemed to be entitled to benefits under section 202 for such month for purposes of determining whether the wife, husband, or child of such individual comes within the provision of clause (A) hereof, and (C) any individual shall, for purposes of this section, be deemed entitled to benefits under section 202 if such individual could have been deemed under clauses (A) or (B) of this paragraph to have been so entitled had he not died during such month.

"(3) For purposes of paragraph (2), an individual's application under this section may, subject to regulations, be filed (whether such individual is legally competent or incompetent) by any relative or other person, including the hospital, physician, or nursing home furnishing him hospital, surgical, and nursing home services and, after such individual's death, his estate.

"(4) Payments may be made for hospital services furnished under this section to an individual during his first sixty days of hospitalization in a twelve-month period that begins with the first day of the first month in which the individual received hospital services for which a payment is made under this section, and during his first sixty days of hospitalization in each succeeding twelve-month period; and for nursing home services furnished under this section to an individual if the individual is transferred to the nursing home from the hospital, and if the services are for an illness or condition associated with that for which he received hospital services: *Provided*, That the number of days of nursing home services for which payments may be made shall, in any twelve-month period as described above, not exceed one hundred and twenty less the number of days of hospital services (in the same twelve-month period) for which payments are made under this section.

"(5) The provisions of section 205 relating to the making and review of determinations shall be applicable to determinations as to whether the costs of hospital, nursing home, and surgical services furnished an individual may be paid for out of the Federal Old-Age and Survivors Insurance Trust Fund under this subsection, and the amount of such payment.

"Description of Hospital, Nursing Home, and Surgical Services

"(b) (1) For purposes of this section, the term 'hospital services' means the following services, drugs, and appliances furnished by a hospital to any individual as a bed patient: bed and board and such nursing services, laboratory services, ambulance services, use of operating room, staff services, and other services, drugs, and appliances as are customarily furnished by such hospital to its bed patients either through its own employees or through persons with whom it has made arrangements for such services, drugs, or appliances; the term 'hospital services' includes such medical care as is generally furnished by hospitals as an essential part of hospital care for bed patients; such term shall include care in hospitals described in paragraph (1) of subsection (d); such term shall not include care in any tuberculosis or mental hospital.

"(2) The term 'nursing home services' means skilled nursing care, related medical and personal services and accompanying bed and board furnished by a facility which is equipped to provide such services, and (A) which is operated in connection with a hospital, or (B) in which such skilled nursing care and medical services are prescribed by, or are performed under the general direction of, persons licensed to practice medicine or surgery in the State.

"(3) The term 'surgical services' means surgical procedures (other than elective surgery) provided in a hospital, or in case of an emergency or for minor surgery, provided in the outpatient department of a hospital or in a doctor's office. Surgical services may include oral surgery when provided in a hospital. The term 'elective surgery' means surgery that is requested by the patient, but which in the opinion of cognizant medical authority is not medically required.

"Free Choice by Patient

"(c)(1) Any individual referred to in paragraphs (1) and (2) of subsection (a) may obtain the hospital or nursing home services for which payment to the hospital or nursing home is provided by this section from any hospital or nursing home which has entered into an agreement under this section, which admits such individual and to which such individual has been referred by a physician or (in the case of hospital or nursing home services furnished in conjunction with oral surgery) dentist licensed by the State in which such individual resides or the hospital or nursing home is located, upon a determination by the physician or dentist that hospitalization or nursing home care for such individual is medically necessary; except that such referral shall not be required in an emergency situation which makes such a requirement impractical.

"(2) Any individual referred to in paragraphs (1) and (2) of subsection (a) may, with respect to the surgical services for which payment is provided by this section, freely select the surgeon of his choice, provided that the surgeon is certified by the American Board of Surgery or is a member of the American College of Surgeons except that such certification shall not be required in cases of emergency where the life of the patient would be endangered by any delay, or in such other cases where such certification is not practicable, and except that, in the case of oral surgery, such individual may select a duly licensed dentist.

"(3) Regulations under this section shall provide for payments (in such amounts and upon such conditions as may be prescribed in such regulations) to (A) hospitals for hospitals services rendered in emergency situations to individuals referred to in paragraphs (1) and (2) of subsection (a) by hospitals which have not entered into an agreement under this section, and (B) physicians for surgical services rendered by physicians not certified by the American Board of Surgery or not members of the American College of Surgery.

"Agreements With Hospitals, Nursing Homes and Providers of Surgical Services

"(d)(1) Any institution (other than a tuberculosis or mental hospital) shall be eligible to enter into an agreement for payment from the Federal Old-Age and Survivors Insurance Trust Fund of the cost of hospital or nursing home services furnished to individuals referred to in paragraphs (1) and (2) of subsection (a) if it is licensed as a hospital or nursing home pursuant to the law of the State in which it is located.

"(2) Each agreement with a hospital under this section shall cover all hospital services included under subsection (b) (which services shall be listed in the agreement), shall provide that such services shall be furnished in semiprivate accommodations if available unless other accommodations are required for medical reasons, or are occupied at the request of the patient, shall be made upon such other terms and conditions as are consistent with the efficient and economical administration of this section, and shall continue in force for such period and be terminable upon such notice as may be agreed upon.

"(3) An agreement with a hospital or nursing home under this section shall provide for payment, under the conditions and to the extent provided in this section, of the cost of hospital and nursing home services which are furnished individuals referred to in paragraphs (1) and (2) of subsection (a): *Provided*, That no such payment shall be made for services for which the hospital or nursing home has already been paid (excluding payments by such individuals for which reimbursement to them by the hospital has been assured); but no such agreement shall provide for payment with respect to hospital or nursing home services furnished to an individual unless the hospital or nursing home obtains written certification by the physician (if any) who referred him pursuant to subsection (c) that his hospitalization or care in the nursing home was medically necessary and, with respect to any period during which such services were furnished, written certification by such individual's attending physician during that period that such services were medically necessary. The amount of the payments under any such agreement shall be determined on the basis of the reasonable cost incurred by the hospital or nursing home for all bed patients, or, when use of such a basis is impractical for the hospital or nursing home or inequitable to the institution or the Federal Old-Age and Survivors Insurance Trust Fund, on a reasonably equivalent basis which takes account of pertinent factors with repsect to services furnished to individuals referred to in paragraphs (1) and (2) of subsection (a). Any such agreement shall preclude the hospital or nursing home with which the agreement is made from requiring payments from in-

dividuals for services, payment of the cost of which is provided by this section, after it has been notified that the cost of such services is payable from the Federal Old-Age and Survivors Insurance Trust Fund, except that it may require payments from such individuals for the additional cost of accommodations occupied by them at their request which are more expensive than semiprivate accommodations.

"(4) Except as provided by regulation, no agreement may provide for payments (A) to any Federal hospital, or to any other hospital for hospital services which it is obligated by contract with the United States (other than an agreement under this section) to furnish at the expense of the United States, or (B) to any hospital for hospital services which it is required by law or obligated by contract with a State or subdivision thereof to furnish at public expense except where the eligibility of the individual for such services is determined by application of a means test.

"(5) No supervision or control over the details of administration or operation, or over the selection, tenure, or compensation of personnel, shall be exercised under the authority of this section over any hospital or nursing home which has entered into an agreement under this section.

"(6) Agreements under this subsection shall be made with the hospital or nursing home providing the services, but this paragraph shall not preclude representation of such institution by any individual, association, or organization authorized by the institution to act on its behalf.

"(7) The Secretary shall enter into agreements with qualified providers of surgical services as defined in paragraph (2) of subsection (c). Such agreements shall stipulate that the rates of payment agreed on shall constitute full payment for these services. Such agreements may be made with any qualified individual, or with any association or organization authorized by the surgeons, dentists, or physicians to act in their behalf.

"(8) Nothing in such agreements or in this Act shall be construed to give the Secretary supervision or control over the practice of medicine or the manner in which medical services are provided.

"(9) Except to the extent the Secretary has made provision pursuant to subsection (h) for the making of payments to hospitals and nursing homes by a private nonprofit organization or for the making of payments to physicians, dentists, and surgeons by their designated representatives, he shall from time to time determine the amount to be paid to such provider of service under an agreement with respect to services furnished, and shall certify such amount to the Managing Trustee of the Federal Old-Age and Survivors Insurance Trust Fund, except that such amount shall, prior to certification, be reduced or increased, as the case may be, by any sum by which the Secretary finds that the amount paid to the provider of services for any prior period was greater or less than the amount which should have been paid to it for such period. The Managing Trustee prior to audit or settlement by the General Accounting Office, shall make payment from the Federal Old-Age and Survivors Insurance Trust Fund, at the time or times fixed by the Secretary in accordance with such certification.

"Nondisclosure of information

"(e) Information concerning an individual, obtained from him or from any physician, dentist, nurse, hospital, nursing home, or other person pursuant to or as a result of the administration of this section, shall be held confidential (except for statistical purposes) and shall not be disclosed or be open to public inspection in any manner revealing the identity of the individual or other person from whom the information was obtained or to whom the information pertains, except as may be necessary for the proper administration of this section. Any person who shall violate any provision of this subsection shall be deemed guilty of a misdemeanor and, upon conviction thereof, shall be punished by a fine not exceeding $1,000 or by imprisonment not exceeding one year, or both.

"Medical and Hospital Services Under Workmen's Compensation

"(f) The provisions of subsection (a) shall not be applicable to any services which an individual required by reason of any injury, disease, or disability on account of which such services are being received or the cost thereof paid for, or upon application therefor would be received or paid for under a workmen's compensation law or plan of the United States or of any State, unless equitable reimbursement to the Federal Old-Age and Survivors Insurance Fund for the

payments hereunder with respect to such services have been made or assured pursuant to agreements or working arrangements negotiated between the Secretary and the appropriate public agency. Notwithstanding the above sentence, if (1) the individual's entitlement to receive such services (or to have the cost thereof paid for) under such a workmen's compensation law or plan is in doubt when such services are required, (2) the cost of such services is otherwise payable from the Federal Old-Age and Survivors Insurance Trust Fund pursuant to this section, and (3) the individual makes an appropriate application under such workmen's compensation law or plan and agrees, in the event that he is subsequently determined to be entitled to receive such services (or to have the cost thereof paid for) under such law, to reimburse the Federal Old-Age and Survivors Insurance Trust Fund in the amount of any loss it might suffer through its payment for such services, then the cost of such services may be paid from such Trust Fund in accordance with this section. In any case in which the cost of services is paid from the Federal Old-Age and Survivors Insurance Trust Fund pursuant to the immediately preceding sentence, or is paid from such Trust Fund with respect to any such injury, disease, or disability for which no reimbursement to such Trust Fund has been made or assured pursuant to the first sentence of this subsection, the United States shall, unless not permitted under the law of the applicable State (other than the District of Columbia) be subrogated to all rights of such individual, or of the provider of services to which payments under this section with respect to such services are made, to be paid or reimbursed pursuant to such workmen's compensation law or plan for such payments. All amounts recovered pursuant to this subsection shall be deposited in the Treasury of the United States to the credit of the Federal Old-Age and Survivors Insurance Trust Fund.

"Regulations and Functions of Advisory Council

"(g) All regulations specifically authorized by this section shall be prescribed by the Secretary. In administering this section, the Secretary shall consult with a National Advisory Health Council consisting of the Commissioner of Social Security, who shall serve as Chairman ex officio, and eight members appointed by the Secretary. Four of the eight appointed members shall be persons who are outstanding in fields pertaining to hospital and health activities, and the other four members shall be appointed to represent the consumers of hospital, nursing home, and surgical services, and shall be persons familiar with the need for such services by eligible groups. Each appointed member shall hold office for a term of four years, except that any member appointed to fill a vacancy occurring prior to the expiration of the term for which his predecessor was appointed shall be appointed for the remainder of such term, and the terms of office of the members first taking office shall expire, as described by the Secretary at the time of appointment, two at the end of the first year, two at the end of the second year, two at the end of the third year, and two at the end of the fourth year after the date of appointment. An appointed member shall not be eligible to serve continuously for more than two terms but shall be eligible for reappointment if he has not served immediately preceding his reappointment. The Council is authorized to appoint such special advisory and technical committees as may be useful in carrying out its functions. Appointed Council members and members of advisory or technical committees, while serving on business of the Council, shall receive compensation at rates fixed by the Secretary, but not exceeding $50 per day, and shall also be entitled to receive an allowance for actual and necessary travel and subsistence expenses while so serving away from their places of residence. The Council shall meet as frequently as the Secretary deems necessary, but not less than once each year. Upon request by three or more members it shall be the duty of the Secretary to call a meeting of the Council.

"Utilization of Private Nonprofit Organizations

"(h) (1) The Secretary may utilize, to the extent provided herein, the services of private nonprofit organizations exempt from Federal income taxation under section 501 of the Internal Revenue Code of 1954 which (A) represent qualified providers of hospital, nursing home, or surgical services, or (B) operate voluntary insurance plans under which agreements, similar to those provided for under subsection (d), are made with hospitals, nursing homes, and physicians for defraying the cost of services. Such organizations shall be utilized by the

Secretary to the extent that he can make satisfactory agreements with them and to the extent he determines that such utilization will contribute to the effective and economical administration of this section. Such agreements shall not delegate (A) his functions relating to determinations as to whether the costs of hospital, nursing home, and surgical services furnished an individual may be paid for out of the Federal Old-Age and Survivors Insurance Trust Fund under this section and the amount of such payment, and (B) his functions relating to the making of regulations.

"(2) An agreement under paragraph (1) shall provide for payment from the Federal Old-Age and Survivors Insurance Trust Fund to the organization of the amounts paid out by such organization to hospitals, nursing homes, physicians, and dentists, under this section and of the cost of administration determined by the Secretary to be necessary and proper for carrying out such organization's functions under its agreement pursuant to this subsection. Such payments to any organization shall be made either in advance on the basis of estimates by the Secretary or as reimbursement, as may be agreed upon by the organization and the Secretary, and adjustments may be made in subsequent payments on account of overpayments or underpayments previously made to the organization under this subsection. Such payments shall be made by the Managing Trustee of the Trust Fund on certification by the Secretary and at such time or times as the Secretary may specify and shall be made prior to audit or settlement by the General Accounting Office.

"(3) An agreement under paragraph (1) with any organization may require any of its officers or employees certifying payments or disbursing funds pursuant to the agreement, or otherwise participating in its performance, to give surety bond to the United States in such amount as the Secretary may deem necessary, and may provide for the payment of the cost of such bond from the Federal Old-Age and Survivors Insurance Trust Fund.

"Certifying and Disbursing Officers

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

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

"Adjustments in Cash Benefits

"(j) For purposes of section 204, any payment under this section to any hospital, nursing home, physician, or dentist, with respect to hospital, nursing home or surgical services furnished an individual shall be regarded as a payment to such individual."

(b) The amendments made by subsection (a) shall be effective on the first day of the twelfth calendar month after the month in which this Act is enacted.

(c) Notwithstanding the provisions of section 226(a)(2) of the Social Security Act, as amended by this title, and subsection (b) of this section, applications filed under such section 226 which would otherwise be valid shall, subject to regulations of the Secretary, be considered valid even though filed more than three months prior to the effective date of this title, but not if filed prior to the first day of the fourth calendar month after the month in which this title is enacted.

AMENDMENTS TO THE INTERNAL REVENUE CODE

SEC. 602. (a) Section 1401 of the Internal Revenue Code of 1954 (relating to rate of tax on self-employment income) is amended to read as follows:

"SEC. 1401. RATE OF TAX.

"In addition to other taxes, there shall be imposed for each taxable year, on the self-employment income of every individual, a tax as follows:

"(1) in the case of any taxable year beginning after December 31, 1960, and before January 1, 1963, the tax shall be equal to 4⅞ percent of the amount of the self-employment income for such taxable year;

"(2) in the case of any taxable year beginning after December 31, 1962, and before January 1, 1966, the tax shall be equal to 5⅝ percent of the amount of the self-employment income for such taxable year;

"(3) in the case of any taxable year beginning after December 31, 1965, and before January 1, 1969, the tax shall be equal to 6⅜ percent of the amount of the self-employment income tax for such taxable year; and

"(4) in the case of any taxable year beginning after December 31, 1968, the tax shall he equal to 7⅛ percent of the amount of the self-employment income for such taxable year."

(b) Section 3101 of such Code (relating to rate of tax on employees under the Federal Insurance Contributions Act) is amended to read as follows:

"SEC. 3101. RATE OF TAX.

"In addition to other taxes, there is hereby imposed on the income of every individual a tax equal to the following percentages of the wages (as defined in section 3121(a)) received by him with respect to employment (as defined in section 3121(b))—

"(1) with respect to wages received during the calendar years 1961 and 1962, the rate shall be 3¼ percent;

"(2) with respect to wages received during the calendar years 1963 to 1965, both inclusive, the rate shall be 3¾ percent;

"(3) with respect to wages received during the calendar years 1966 to 1968, both inclusive, the rate shall be 4¼ percent; and

"(4) with respect to wages received after December 31, 1968, the rate shall be 4¾ perecent."

(c) Section 3111 of such Code (relating to rate of tax on employers under the Federal Insurance Contributions Act) is amended to read as follows:

"SEC. 3111. RATE OF TAX.

"In addition to other taxes, there is hereby imposed on every employer an excise tax, with respect to having individuals in his employ, equal to the following percentages of the wages (as defined in section 3121(a)) paid by him with respect to employment (as defined in section 3121(b))—

"(1) with respect to wages paid during the calendar years 1961 and 1962, the rate shall be 3¼ percent;

"(2) with respect to wages paid during the calendar years 1963 to 1965, both inclusive, the rate shall be 3¾ percent;

"(3) with respect to wages paid during the calendar years 1966 to 1968 both inclusive, the rate shall be 4¼ percent; and

"(4) with respect to wages paid after December 31, 1968, the rate shall be 4¾ percent."

(d) The amendment made by subsection (a) shall apply only with respect to taxable years beginning after December 31, 1960. The amendments made by subsections (b) and (c) shall apply only with respect to remuneration paid after December 31, 1960.

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12. AMENDMENT 6-27-60-H—INTRODUCED BY SENATOR JAVITS FOR HIMSELF AND THE FOLLOWING SENATORS: COOPER, SCOTT, FONG, AIKEN, KEATING, AND PROUTY (IN THE NATURE OF A SUBSTITUTE FOR TITLE VI OF THE HOUSE BILL)—SIMILAR TO S. 3350

Staff Analysis

Eligibility.—Assuming all States participate, all persons 65 and over and their spouses would be eligible to purchase a health insurance policy provided by an insurance carrier set up by the State, or by private, commercial prepayment or nonprofit insurance carriers under appropriate contracts entered into between such carriers and the State. The subscription charges for individuals under the plan shall conform to a schedule, based upon the income of the subscriber, to be determined by the State (except that the maximum monthly subscription of no individual shall exceed the maximum premium cost in the State if it is less than $13 a month).

Benefits.—The health insurance contracts may provide any or all of the following:

(1) Services rendered by licensed physicians and dentists and certain auxiliary personnel.

(2) Services in hospitals and skilled nursing or convalescent homes.

(3) Drugs, medicines, dressings and other medical supplies.

The contracts must provide for the following:

(1) 21 days a year of hospital, or equivalent nursing home care.

(2) Physician's services for 12 home or office visits each year.

(3) The first $100 each year of costs for ambulatory, diagnostic, laboratory, and X-ray services.

(4) Visiting nurse service for not less than 24 visits a year.

The State plan must provide that outpatient hospital and home and office physicians service constitute not less than one-third of the premium cost.

Costs.—Senator Javits estimates minimum benefits program would cost $840 million (Federal share $400 million; State share $440 million; individual subscribers not participating) and maximum benefits program would cost $1.5 billion (Federal share $480 million; State share $620 million; individual subscribers $400 million). Cost estimate not yet submitted by Department. See report below.

Financing.—Federal share financed from general revenues, using a Federal-State matching formula based on State per capita income. The Federal share ranging from 75 percent for the lowest-income States to 33⅓ percent for highest income States, up to a maximum premium cost of $13 a month per subscriber, less subscription charges paid by individuals.

VIEWS OF THE DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE ON AMENDMENT 6-27-60-H

The Department of Health, Education, and Welfare is currently conferring with the sponsors of proposed amendment 6-27-60-H to H.R. 12580 and is, therefore, not prepared to make recommendations at this time on the proposed amendment. At such time as these discussions are completed, a further report will be made.

While the amendment embodies many of the principles contained in the statement of the Department's views which were presented to the Committee on June 29, 1960, there are obviously a number of points of difference.

TEXT OF AMENDMENT 6-27-60-H

Intended to be proposed by Mr. JAVITS (for himself, Mr. COOPER, Mr. SCOTT, Mr. FONG, Mr. AIKEN, Mr. KEATING, and Mr. PROUTY) to the bill (H.R. 12580), viz: Strike out everything beginning on page 154, line 2, down to and including page 172, line 18, and insert in lieu thereof the following:

SEC. 601. This title may be cited as the "Health Insurance for the Aged Act".

SEC. 602. The Public Health Service Act is hereby amended by inserting at the end thereof the following new title:

"TITLE VIII—HEALTH INSURANCE FOR THE AGED

"DECLARATION OF PURPOSE

"SEC. 801. It is the purpose of this title to assist the States in establishing State plans of health insurance designed to enable aged individuals to obtain needed personal health services.

"DEFINITIONS

"SEC. 802. As used in this title, the term—

"(a) 'Service benefits' means the actual furnishing of health services to an insured individual by and through licensed physicians, hospitals, and other health personnel and institutions which have entered into contracts with insurance carriers to provide such services to such individuals;

"(b) 'Indemnity benefits' means benefits provided to an insured individual by an insurance carrier in the form of money payments toward the cost of specified personal health services, such payments being made either to the insured individual or to the provider of such services, and not necessarily covering the full cost of such services;

"(c) 'Income of insured individual' means the adjusted gross income (as defined in section 62 of the Internal Revenue Code of 1954) of such individual, plus amounts received by such individual as monthly insurance benefits under title II of the Social Security Act or as payments under laws administered by the Veterans Administration, or as annuity payments under the Railroad Retirement Act of 1937 as amended; and

"(d) 'Secretary' means the Secretary of Health, Education, and Welfare.

"REQUIREMENTS OF STATE PLANS

"SEC. 803. A State plan under this title shall—

"(a) designate a single State agency to administer the State plan;

"(b) provide for financial participation by the State;

"(c) permit participation in the health insurance program established under such plan of every individual in the State who has attained age sixty-five or is married to an individual who has attained such age; but may not permit any individual to participate in such program who has not attained such age or is not married to an individual who has reached such age;

"(d) provide to each individual eligible for health insurance under the plan a choice of at least two types of health insurance, one of which shall provide 'service benefits' in whole or in part and the other 'indemnity benefits';

"(e) provide that (1) the coverage of home medical services and physician's office calls and other ambulatory services or hospital outpatient treatment under any health insurance program under the State plan shall constitute not less than one-third of the total premium cost of such insurance program; and (2) under any such program, care in skilled nursing homes or equivalent licensed institutions may be substituted for care of equivalent cost in general hospitals which meet such standards as are established by the Secretary;

"(f) conform to reasonable standards prescribed by the Secretary with respect to (1) the providing of benefits to subscribers of health insurance programs under the State plan during temporary absence from the State in which they reside, (2) the eligibility to participate in such programs of otherwise eligible individuals who have previously discontinued participation therein, (3) the provision of additional periods after the date subscription charges become due during which subscribers may pay such charges without forfeiting coverage under such programs, (4) eligibility of individuals to transfer coverage from one type of health insurance to another type offered under the State plan of a State, (5) the period of eligibility to participate in such programs of individuals who do not elect to participate therein at the earliest date for which they are eligible to do so, (6) the eligibility of individuals who are covered by such a health insurance program of one State to become covered by such a health insurance program of another State, and (7) meeting and improving on Federal standards for medical practice and institutional facilities;

"(g) provide that the subscription charges for individual subscribers of health insurance programs under the State plan shall conform to a schedule, based upon income of the subscriber, to be determined by the State (except that the maximum monthly subscription rate of no individual shall exceed the maximum premium cost in such State if it is less than $13 per month);

"(h) provide that the State agency administering State welfare or public assistance programs shall be permitted to secure for the recipients of such programs health insurance under the State plan as a negotiated rate basis;

"(i) make provision (1) authorizing employees' pension or welfare funds to contribute to the payment of subscription charges under the State health insurance program for or on behalf of eligible members or beneficiaries of such funds, (2) authorizing employers (including the State or any political subdivision thereof when acting as an employer) to contribute to the payment of their employees' subscription charges under the State health insurance program, and (3) permitting any employee, or member or beneficiary of an employees' pension or welfare fund, to authorize his employer (including the State or any political subdivision thereof when acting as an employer) or trustee or other governing body of such fund to deduct from his wages or from such fund, as the case may be, an amount equal to his subscription charges under the State health insurance program and to pay the same to the State agency administering the State plan;

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

"(k) provide for the collection of subscription charges for health insurance under the State plan.

"(l) provide that the health insurance coverage extended to individuals eligible therefor under the State plan shall be provided by an insurance carrier set up by the State for such purpose, or by private, commercial, pre-

payment or nonprofit insurance carriers under appropriate contracts entered into between such carriers and the State agency;

"(m) provide that such contracts extend health insurance coverage to individuals eligible therefor under the State plan of any or all of the following: (1) Services rendered by licensed physicians, licensed dentists, and, under the supervision of licensed physicians or dentists, by auxiliary personnel, (2) the use by such licensed or auxiliary personnel of any and all apparatus or machines designed to aid in the diagnosis or treatment of disease or injury, (3) the provision of bed and board in general or special hospitals, skilled nursing or convalescent homes, or other institutions licensed or designated as such institutions is prescribed by and under the supervision of licensed physicians, and (4) the provision of drugs and medicines, dressings and supplies, protheses and appliances, and ambulance service, when prescribed by licensed physicians: *Provided*, That any such contract shall insure against 100 per centum of the cost of not less than (A) 21 days each year of hospital, or equivalent nursing home care, (B) physician's services for 12 home or office visits each year, (C) the first $100 each year of costs incurred for ambulatory diagnostic, laboratory, and X-ray services, and (D) visiting nurse's services (when prescribed by a physician and rendered through a public or private agency) for not less than 24 visits each year; and

"(n) make adequate provision out of general revenues of the State for the expenses incurred by the State under such plan.

"PAYMENT TO STATES

"SEC. 804. (a) From the sums appropriated therefor, the Secretary of the Treasury shall pay to each State which has an approved plan for health insurance for the aged, for each quarter (beginning with the quarter commencing July 1, 1961) (1) an amount equal to the Federal percentage of the amount by which the amount produced by multiplying—

"(i) the per capita premium cost up to but not exceeding $13 per month, by

"(ii) the sum of the total number of subscribers of health insurance for the aged for each of the months in such quarter,

exceeds the total sum of the amounts actually paid by such subscribers as subscription charges during each of such months; plus (2) an amount equal to one-half of the sums expended during such quarter as found necessary by the Secretary of Health, Education, and Welfare for the proper and efficient administration of State plan.

"(b) The method of computing and paying such amounts to the State shall be as follows: The Secretary shall, prior to the beginning of each quarter, estimate the amounts to be paid to the State under subsection (a), such estimate to be based on (A) reports filed by the State containing its estimates of the total sums to be expended by it in such quarter in accordance with subsection (a), and (b) such other investigation as the Secretary may find necessary.

"(c) The Secretary shall then certify to the Secretary of the Treasury the amount so estimated by the Secretary, reduced or increased, as the case may be, by any sums by which he finds that his estimates for any prior quarter were greater or less than the amounts which should have been paid to the State under subsection (a).

"(d) For the purposes of this section the 'Federal percentage' for any State shall be 100 per centum less that percentage which bears the same ratio to 50 per centum as the per capital income of such State bears to the per capita income of the continental United States (including Alaska and Hawaii), except that (1) the Federal percentage shall in no case be more than 75 per centum or less than 33⅓ per centum, and (2) the Federal percentage for Guam, Puerto Rico, and the Virgin Islands shall be 75 per centum each. The Federal percentages shall be promulgated by the Secretary between July 1 and August 31 of each even-numbered year, on the basis of the average of the per capita incomes of the States and of the continental United States (including Alaska and Hawaii) for the three most recent consecutive years for which satisfactory data are available from the Department of Commerce.

"OPERATION OF STATE PLANS

"SEC. 805. (a) If the Secretary, after reasonable notice and opportunity for hearing to the State agency, finds (1) that the State agency is not complying

substantially with the provisions of the State plan, or (2) that any Federal funds have been diverted from the purposes for which they have been paid under this title, the Secretary shall forthwith withhold further payments to the State under section 804 until he is satisfied that the conditions which required him to withhold such payments no longer exist.

"(b) If any State is dissatisfied with the Secretary's action under subsection (a), such State may appeal to the United States court of appeals for the circuit in which such State is located. The summons and notice of appeal may be served at any place in the United States. The Secretary shall forthwith certify and file in the court the transcript of the proceedings and record on which he based his action.

"(c) The findings of fact by the Secretary, unless substantially contrary to the weight of evidence, shall be conclusive; but the court, for good cause shown, may remand the case to the Secretary to take further evidence, and the Secretary may thereupon make new or modified findings of fact and may modify his previous action, and shall certify to the court the transcript and record of the further proceedings. Such new or modified findings of fact shall likewise be conclusive unless substantially contrary to the weight of the evidence.

"(d) The court shall have jurisdiction to affirm the action of the Secretary or to set it aside, in whole or in part. The judgment of the court shall be subject to review by the Supreme Court of the United States upon certiorari or certification as provided in title 28 of the United States Code, section 1254.

"AUTHORIZATION OF COMPACTS BETWEEN STATES

"SEC. 806. In order that individuals who are covered by a health insurance program established under this title by the State in which they reside shall not, by reason of their temporary presence in another State at the time benefits provided by such program are needed by them, be hampered in actually receiving such benefits, the consent of Congress is hereby granted to any two or more States to enter into appropriate compacts or agreements with respect to the administration and operation of their respective health insurance programs established under this title.

"ADMINISTRATION

"SEC. 807. (a) The Secretary is authorized to make such administrative regulations and perform such other actions including the negotiation of a schedule of subscription charges under each State plan as he finds necessary to carry out the provisions of this title.

"(b) In administering the provisions of this title, the Secretary is authorized to utilize the services and facilities of any executive department of the Government in accordance with an agreement with the head thereof. Payment for such services and facilities shall be made in advance or by way of reimbursement, as may be agreed upon between the Secretary and the head of the executive department furnishing such services or facilities.

"(c) In administering this title the Secretary shall cooperate with and render advice and assistance to States and the appropriate public authorities therein formulating and operating State plans under this title.

"SAVINGS PROVISION

"SEC. 808. Nothing in this title shall modify obligations assumed by the Federal Government under other laws for the hospital and medical care of veterans or other presently authorized recipients of hospital and medical care under Federal programs."

The table of contents on page 4 is appropriately amended.

13. AMENDMENT 6-27-60-I—INTRODUCED BY SENATOR SCHOEPPEL (IDENTICAL TO THE FOLLOWING AMENDMENTS: NO. 8, 6-27-60-A, INTRODUCED BY SENATOR KEATING; NO. 16, 6-28-60-C, INTRODUCED BY SENATOR HUMPHREY; AND NO. 24, 6-29-60-X, INTRODUCED BY SENATOR HARTKE)

STAFF ANALYSIS

Increases the soocial security earnings limitation from $1,200 to $1,800 per year.

Cost.—$616 million per year, or 0.19 percent of payroll, on a level-premium basis.

Financing.—No tax increase provided to cover added cost to program.

VIEWS OF DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE ON AMENDMENT 6-27-60-I

See joint report on page 480.

TEXT OF AMENDMENT 6-27-60-I

Intended to be proposed by Mr. SCHOEPPEL to the bill (H.R. 12580), viz: On page 80, between lines 3 and 4, insert the following new section:

SEC. 211. (a)(1) Paragraphs (1) and (2) of subsection (e) of section 203 of the Social Security Act are amended by striking out "$1,200" wherever it appears therein and inserting in lieu thereof "$1,800", and (2) such paragraphs and paragraph (1) of subsection (g) of such section are amended by striking out "$100 times" wherever it appears therein and inserting in lieu thereof "$150 times".

(b) The amendments made by subsection (a) shall be effective, in the case of any individual, with respect to taxable years of such individual ending after 1960.

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14. AMENDENT 6-28-60-A—INTRODUCED BY SENATORS HUMPHREY AND JAVITS

STAFF ANALYSIS

Modifies the social security definition of disability for both benefit and "freeze" purposes so that a specified degree of blindness, more liberal than the present definition for the disability "freeze," is presumptively disabling. Provides that an individual otherwise eligible can qualify for disability benefits with one quarter of coverage (present law requires fully insured status plus coverage in 20 of the 40 quarters prior to the onset of the disability). Exempts such blind beneficiaries from the provision of present law which requires deduction from benefits because of refusal to accept rehabilitation services.

Cost.—0.03 percent of payroll on a level-premium basis.

Financing. No tax increase provided to cover added cost to program.

VIEWS OF DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE ON AMENDMENT 6-28-60-A

As we indicated in our report on S. 3067, our major objection to the proposed amendment is that it would give persons with visual impairments very great advantages over other persons with equally severe impairments of another type. Blindness is no more disabling insofar as work is concerned than many other severe types of impairment. As a matter of fact, many blind persons have demonstrated the ability to earn a living in spite of their impairment and much is being done through both public and private means to encourage and aid the blind to be self-supporting. Special legislation permitting some individuals to receive benefits under conditions identical to those under which benefits are denied to others is, in our opinion, undesirable and contrary to sound principles of equity and justice.

There are also other aspects of the proposed amendment to which we have serious objections. It would, in effect, provide disability benefits for persons who are able to work and who may be working regularly. It would also provide benefits for persons who have had no significant employment. Such pro-

visions would extend the purpose of the disability program from providing a partial replacement of earnings that are lost because of disability to providing an indemnity for certain handicaps. We believe indemnity against handicap is not a proper purpose of the old-age, survivors, and disability insurance program.

There is another reason why the Department would not favor a proposal for providing disability benefits for persons who have never been regularly employed. (One quarter of coverage for eligibility for benefits would not, of course, be evidence of regular employment.) Under the present program, the right to benefits is acquired as a result of work and benefit amounts are related to earnings. Benefits are financed in part through contributions paid by the worker while he is working. All social security taxes paid by employers, employees, and self-employed persons go into special trust funds. In order to establish that the person has earned the right to benefits the program requires that he be credited with a specific amount of covered work. Payment of benefits to people who have not met the work requirements of the program would tend to undermine the contributory character of the program, attenuate and obscure the relationship between prior work and benefits, and lead to public misunderstanding of the nature and purpose of the program.

For these reasons the Department recommends that the proposed amendment not be enacted.

TEXT OF AMENDMENT 6-28-60-A

Intended to be proposed by Mr. HUMPHREY and Mr. JAVITS to the bill (H.R. 12580), viz: On page 110, after line 22, insert the following:

(c) (1) Section 223(a)(1) of such Act (as amended by section 403(b) of this Act) is further amended by striking out "the month in which he dies, the month in which he attains the age of sixty-five, or the third month following the month in which his disability ceases" and inserting in lieu thereof "the month in which he dies, the month in which he becomes entitled to old-age insurance benefits (in the case of an individual whose disability is blindness (as defined in subsection (c)(2)) and who is not fully insured when he attains retirement age), the month in which he attains the age of sixty-five (in the case of any individual whose disability is not blindness (as so defined)), or the third month following the month in which his disability ceases".

(2) Section 223(c)(1) of such Act is amended—

(A) by inserting ", other than an individual whose disability is blindness (as defined in paragraph (2))," after "An individual"; and

(B) by adding after subparagraph (B) the following new sentence: "An individual whose disability is blindness (as defined in paragraph (2)) shall be insured for disability insurance benefits in any month if he had not less than one quarter of coverage before the quarter in which such month occurs."

(3) Section 223(c)(2) of such Act is amended by striking out the first sentence and inserting in lieu thereof the following: "The term 'disability' means (A) inability to engage in any substantial gainful activity by reason of any medically determinable physical or mental impairment which can be expected to result in death or to be of long-continued and indefinite duration, or (B) blindness. The term 'blindness' means central visual acuity of 20/200 or less in the better eye with the use of correcting lenses, or visual acuity greater than 20/200 if accompanied by a limitation in the fields of vision such that the widest diameter of the visual field subtends an angle no greater than twenty degrees."

(4) Section 216(i)(1) of such Act is amended—

(A) by striking out "blindness" and all that follows in the first sentence and inserting in lieu thereof "blindness (as defined in section 223(c)(2)),"; and

(B) by striking out the second sentence.

(5) The last sentence of section 223(c)(3) of such Act is amended by inserting ", except an individual whose disability is blindness (as defined in paragraph (2))," after "for any individual".

(6) The first sentence of section 222(b)(1) of such Act is amended by striking out "an individual entitled to disability insurance benefits" and inserting in lieu thereof "an individual (other than an individual whose disability is blindness as defined in section 223(c)(2) entitled to disability insurance benefits".

(7) The amendments made by this subsection shall apply only with respect to monthly benefits under title II of the Social Security Act for months after the

month in which this Act is enacted. In the case of an individual who satisfies section 223(a)(1)(B) of such Act on the date of the enactment of this Act solely by reason of such amendments, the waiting period (as defined in section 223(c)(3) of the Social Security Act) may not begin before the first day of the fifth month before the month in which this Act is enacted.

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15. AMENDMENT 6-28-60-B—INTRODUCED BY HUMPHREY

Staff Analysis

While not making any substantial change in services which can be provided under existing law, makes more explicit the definition of "child welfare services." The amendment follows generally the language recommended by the Advisory Council on Child Welfare Services (authorized by the 1958 amendments), on the ground that such language would provide "greater latitude for inclusion of services dealing with any social problem affecting the well-being of children and eliminates the possibility of a narrow interpretation of the scope of services." Text of present definition and new definition is contained in text of the amendment.

Costs.—Department of Health, Education, and Welfare advises that this amendment will not increase the cost of the program.

Views of the Department of Health, Education, and Welfare on Amendment 6-28-60-B

The amendment to H.R. 12580, proposed by Senator Humphrey June 28, 1960, changes the definition of child-welfare services in title V, part 3, of the Social Security Act. The new definition is substantially the one that was recommended by the Advisory Council on Child Welfare Services in its report to Congress January 1, 1960.

The present definition is that these services are for the protection and care of homeless, dependent, and neglected children, and children in danger of becoming delinquent. It has been quite adequate for the type of legislation provided in that act. Grants have been made to State public-welfare agencies to establish, extend, and strengthen these services. These grants, for the most part, have been small in comparison to child-welfare expenditures from State and local funds.

The definition proposed by the Advisory Council is related to another recommendation of the Council, namely, that the Federal Government pay part of the total cost of public child-welfare services of each State and other cooperating jurisdictions through Federal grants-in-aid on a variable basis, with provision for an open end appropriation and with continuing encouragement to establishing, extending, and strengthening of such services.

The new definition is somewhat more explicit, particularly in relation to juvenile delinquency, than the present definition, although the term "in danger of becoming delinquent," together with other parts of the present definition, is inclusive enough to enable the States to use the grants to provide services to delinquent as well as to predelinquent children.

Title V, part 3, of the Social Security Act makes clear that these grants are for the purpose of establishing, extending, and strengthening public child-welfare services. By eliminating the word "public" in the new definition under the bill, question is raised as to whether these grants could be used to establish, extend, and strengthen child-welfare services under voluntary auspices. This change was not included in the Council's recommendation.

The Department recognizes the logic of the Advisory Council's recommendation embodied in this amendment in the context of other recommendations made by the Council, but does not believe that it serves the same purpose as a separate piece of legislation. In view of the questions it raises, we would not recommend its adoption.

Text of Amendment 6-28-60-B

Intended to be proposed by Mr. Humphrey to the bill (H.R. 12580), viz: On page 183, after line 20, insert the following new paragraph:

(4) Section 521 of such Act (as amended by subsection (a)(3) of this section) is further amended—

(A) by striking out "public-welfare services (hereinafter in this title referred to as 'child-welfare services') for the protection and care of homeless, dependent, and neglected children, and children in danger of becoming delinquent", and inserting in lieu thereof the following: "child-welfare services"; and

(B) by inserting after the period the following new sentence: "For the purposes of this part 3, the term 'child-welfare services' means those social services that supplement or substitute for parental care and supervision for the purpose of (1) protecting and promoting the welfare of children and youth, (2) preventing neglect, abuse, or exploitation of children and youth, (3) helping overcome problems that result in dependency, neglect, or delinquency of children and youth and correcting these conditions when they occur, and (4) when needed, providing adequate care in foster homes, adoptive homes, child-care institutions, or other facilities for children and youth who are away from home."

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16. AMENDMENT 6-28-60-C—INTRODUCED BY SENATOR HUMPHREY (IDENTICAL TO THE FOLLOWING AMENDMENTS: NO. 8, 6-27-60-A, INTRODUCED BY SENATOR KEATING; NO. 13, 6-27-60-I, INTRODUCED BY SENATOR SCHOEPPEL; AND NO. 24, 6-29-60-X, INTRODUCED BY SENATOR HARTKE)

STAFF ANALYSIS

Increases the social security earnings limitation from $1,200 to $1,800 per year.

Cost.—$616 million per year, or 0.19 percent of payroll, on a level premium basis.

Financing.—No tax increase provided to cover added cost to program.

VIEWS OF DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE ON AMENDMENT 6-28-60-C

See joint report on page 480.

TEXT OF AMENDMENT 6-28-60-C

Intended to be proposed by Mr. HUMPHREY to the bill (H.R. 12580), viz: On page 80, between lines 3 and 4, insert the following new section:

SEC. 211. (a) (1) Paragraphs (1) and (2) of subsection (e) of section 203 of the Social Security Act are amended by striking out "$1,200" wherever it appears therein and inserting in lieu thereof "$1,800", and (2) such paragraphs and paragraph (1) of subsection (g) of such section are amended by striking out "$100 times" wherever it appears therein and inserting in lieu thereof "$150 times".

(b) The amendments made by subsection (a) shall be effective, in the case of any individual, with respect to taxable years of such individual ending after 1960.

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17. AMENDMENT 6-28-60-D—INTRODUCED BY SENATOR HUMPHREY

Allows an employer a credit against his income tax for the employment of older persons. The amount of the credit granted would be equal to the increase in the employer's cost of doing business resulting from the employment of persons who are above the age of the younger employee who could reasonably be hired to perform substantially the same duties if no factor other than age were taken into account. The amount of the credit would be limited by the amount of tax imposed reduced by other allowable credits.

Cost.—See report of Treasury Department.

VIEWS OF DEPARTMENT OF TREASURY ON AMENDMENT 6-28-60-D

JULY 12, 1960.

HON. HARRY F. BYRD,
Chairman, Committee on Finance,
U.S. Senate, Washington, D.C.

MY DEAR MR. CHAIRMAN: This is in response to your request for the views of this Department on an amendment (6-28-60-D) intended to be proposed by Mr. Humphrey to the bill H.R. 12580 to extend and improve coverage under the Federal old-age, survivors, and disability insurance system * * *

This amendment would allow to an employer as defined in section 3401(d) (relating to collection of income tax at source on wages) a credit against his income tax for the employment of older persons.

The amount of credit granted would be equal to the increase in the employer's cost of doing business resulting from the employment of persons who are above the age of the youngest employee who could reasonably be hired to perform substantially the same duties if no factor other than age were taken into account. The bill defines an increase in cost to include "any expenditure made by an employer in the conduct of his trade or business (including insurance premiums, contributions to pension funds, contributions to medical costs, contributions to workmen's compensation funds, and any other trade or business expense, including the increased cost of training an older worker and increased cost of maintaining an increased medical and nursing staff where older persons are employed * * *)." Increases in cost refer not only to those attributable to an individual employee but also to older employees generally.

The amount of the credit would be limited by the amount of tax imposed reduced by other allowable credits. The proposed credit would be in addition to existing allowable deductions.

The tax benefit granted by this proposed amendment is in the form of a tax credit. Consequently, the Government in effect would bear all of the additional costs resulting from hiring older workers, up to the point where the employer's tax liability for the taxable year is eliminated.

Since the definition of older worker includes any worker older than the youngest worker who could perform substantially the same duties, workers whose ages are 25, 35, 45, or almost any age could be classified as "older workers." The Government, thus, would bear for the employer the entire additional costs of these workers through a reduction of his tax by an amount equal to this excess cost of hiring these "older workers."

Section 162 of the code already allows employers a deduction for "all the ordinary and necessary expenses" of carrying on any trade or business. Therefore, such amounts paid to or on behalf of workers, whether younger or older, are deductible. Thus, under the amendment, an employer will always receive a larger tax reduction than the additional cost of the older worker (assuming that the older worker performs substantially the same duties as a younger worker) because he will get back the entire additional cost as a tax credit and in addition take a larger regular deduction.

The benefits realized by the employer will depend upon his tax rate. For those proprietorships, partnerships and small business corporations (electing to be taxed under subchapter S) who are subject to marginal tax rates higher than the regular corporate rates the benefits will be greater than in the case of a corporation.

The amendment would be extremely difficult, if not impossible, to administer effectively. It involves concepts which are not easily measurable. There are no adequate guides or objective tests which would be readily available to the several million employers, or to the Internal Revenue Service, for use in making the required determinations of cost differentials in relation to employees' wages. These cost differentials vary widely among industries, among firms within the same industry, and even among positions within the same firm. For example, it would be necessary to determine exactly the lowest age at which an employee could be hired to perform satisfactorily each one of thousands of jobs. While certain of the increased costs, such as higher insurance premiums for older workers, could be determined, it would be almost impossible to lay down specific, or even general, rules for determining "any other trade or business expense, including the increased cost of training an older worker and increased cost of maintaining an increased medical and nursing staff necessary where older persons are employed, * * *" The language is vague and subject to various interpretations and whether regulations called for by this amendment were made specific or general, there would doubtless be a considerable volume of litigation over the definition of terms.

The revenue cost of this amendment could be substantial, on the order of billions of dollars. Because of the broad definition of "older workers" which can cover workers of almost any age, a part of labor costs of workers at present employed could qualify for the tax credit. This would account for the greater part of the revenue loss. To the extent that this amendment encouraged the additional employment of older workers, there would be additional revenue loss. Since factors other than the tax credit will affect the hiring of older workers,

it is difficult to estimate to what extent employers will take advantage of the credit.

Aside from the impact on revenue and the administrative difficulties, special tax incentive measures such as proposed in this amendment lead to resentment on the part of taxpayers who do not receive similar favored treatment. Accordingly, while the Treasury Department is in sympathy with the objective of encouraging employers to hire older workers, it does not favor the enactment of this amendment.

The Bureau of the Budget has advised the Treausry Department that there is no objection to the presentation of this report.

Sincerely yours,

JAY W. GLASMANN,
Assistant to the Secretary.

VIEWS OF DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE ON AMENDMENT 6-28-60-D

DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE,
Washington, July 11, 1960.

Hon. HARRY F. BYRD,
Chairman, Committee on Finance, U.S. Senate, Washington, D.C.

DEAR MR. CHAIRMAN: This letter is in response to your request of June 29, 1960, for a report on amendment 6-28-60-D to H.R. 12580, "Social Security Amendments of 1960."

This amendment would provide preferential tax relief to employers who hire older workers.

The Department strongly favors the employment of older workers. We believe that many capable older people have a great contribution to make to the work force and economy of our country, no small part of which is being lost because of misconceptions which prevail regarding the older worker.

However, we do not favor amendment 6-28-60-D to H.R. 12580 because of two reasons:

(1) It assumes that a premium must be paid to induce the increased employment of older persons. There is increasing evidence that employer reluctance to hire the older worker vanishes when the true facts are known about benefits which may accrue to an employer who avails himself of the stability and additional experience of the mature worker.

(2) It infers that older people are a liability rather than an asset as employees, particularly, the reference on page 2, lines 19-22, "including the increased cost of training an older worker and increased cost of maintaining an increased medical and nursing staff necessary where older persons are employed." Psychologically, this presents a gloomy picture and statistically, we believe, an inaccurate one.

With respect to the relationship of this proposal to our national tax policy and to the administration of the internal revenue laws, we defer to the views of the Treasury Department; and with respect to the evaluation of the proposal from the point of view of labor-management relations and manpower requirements, we defer to the Labor Department.

The Bureau of the Budget advises that it perceives no objection to the submission of this report to your committee.

Sincerely yours,

ROBERT A. FORSYTHE,
Assistant Secretary.

TEXT OF AMENDMENT 6-28-60-D

Intended to be proposed by Mr. HUMPHREY to the bill (H.R. 12580), viz: On page 184, after line 14, insert the following new section:

AMENDMENTS TO INTERNAL REVENUE CODE RELATING TO TAX CREDIT FOR EMPLOYMENT OF OLDER PERSONS

SEC. 710. (a) (1) Part IV of subchapter A of chapter 1 of the Internal Revenue Code of 1954 (relating to credits against tax) is amended by redesignating section 38 as section 39 and by adding after section 37 the following new section:

"SEC. 38. CREDIT FOR EMPLOYMENT OF OLDER PERSONS.

"(a) IN GENERAL.—In the case of an employer (as defined in section 3401(d)), there shall be allowed as a credit against the tax imposed by this chapter for the taxable year an amount determined under subsection (b).

"(b) AMOUNT OF CREDIT.—The credit allowed an employer by subsection (a) for any taxable year shall be an amount equal to the increase in his cost of doing business during such year which results from the employment of older persons, as determined under regulations prescribed by the Secretary or his delegate. For purposes of this subsection, any expenditure made by an employer in the conduct of his trade or business (including insurance premiums, contributions to pension funds, contributions to medical costs, contributions to workmen's compensation funds, and any other trade or business expense, including the increased cost of training an older worker and increased cost of maintaining an increased medical and nursing staff necessary where older persons are employed, within the meaning of section 162), whether attributable to an individual employee or to the employees of such employer generally, shall be considered an increase in the cost of doing business which results from the employment of older persons to the extent that it would not have been required or made if the age of each employee involved were the lowest age at which an employee could reasonably (and consistently with the sound operation of the trade or business) be hired to perform substantially the same duties (and no factors other than age were taken into account).

"(c) CREDIT NOT TO CAUSE REFUND OF TAX.—The credit allowed by subsection (a) shall not exceed the amount of the tax imposed by this chapter for the taxable year, reduced by the sum of the credits allowable under the provisions of this part other than this section and sections 31 and 32.

"(d) CREDIT IN ADDITION TO DEDUCTIONS.—The credit allowed by subsection (a) shall be in addition to, and shall not reduce or otherwise affect, any deduction which may be allowable under this chapter."

(2) The table of sections for such part IV is amended by striking out

"Sec. 38. Overpayments of tax."

and inserting in lieu thereof

"Sec. 38. Credit for employment of older persons.
"Sec. 39. Overpayments of tax."

(b)(1) Section 36 of the Internal Revenue Code of 1954 (relating to disallowance of credits to individuals paying optional tax or taking standard deduction) is amended by striking out "and 35" and inserting in lieu thereof "35, and 38".

(2) Section 37(a) of such Code (relating to retirement income credit) is amended by striking out "and section 35 (relating to partially tax-exempt interest)" and inserting in lieu thereof "section 35 (relating to partially tax-exempt interest), and section 38 (relating to credit for employment of older persons)".

(c) The amendments made by this Act shall apply only with respect to taxable years ending after the date of the enactment of this Act.

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18. AMENDMENT 6-28-60-E—INTRODUCED BY SENATOR HUMPHREY

STAFF ANALYSIS

Transfers domestic program of surplus food distribution from the Department of Agriculture to Department of Health, Education, and Welfare. Authorizes

Secretary of Health, Education, and Welfare to give assistance to State and local governments in distributing surplus foods, including storage, and report to Congress on a formula for division of the funds requested by local governments, based on per capita revenues and the relative numbers of needy persons. Directs the Secretary of Health, Education, and Welfare to institute a food stamp plan for needy individuals in areas with a specified amount of unemployment and rural areas of low net income and standard of living. (Public Law 86-341, enacted last September, authorized (but did not direct) the Secretary of Agriculture to establish a food stamp system for the distribution of surplus commodities to needy persons during the period February 1, 1960, and January 31, 1962. The Secretary has not yet exercised his authority under this enactment.)

Cost.—This amendment gives the Secretary of Health, Education, and Welfare broad regulatory authority to determine eligibility for and amount of assistance to be provided. The administrative costs for the direct distribution would also depend on a number of factors, such as State and local expansion of the present program. Because of these variable factors it is impossible for the staff to estimate the cost at this time.

Financing.—Additional cost would be paid out of general revenue.

VIEWS OF DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE ON AMENDMENT 6-28-60-E

The Department of Health, Education, and Welfare would recommend against adoption of amendment 6-28-60-E to H.R. 12580. The reasons for this recommendation are as follows: The proposed transfer of the direct commodity distribution program from the Department of Agriculture to the Department of Health, Education, and Welfare, with distribution of food to schools and needy persons overseas being left in the Department of Agriculture, would entail substantial duplication of effort and corresponding additional expenses in the two departments. Such a transfer would also mark an undesirable change in the emphasis of the commodity distribution program from an adjunct of agricultural support operations to a program predominantly welfare-focused. The stamp plan proposed in the amendment would further increase the Federal share of public assistance expenditures, which is already disproportionately high. Finally, such a stamp plan would at best be of only limited benefit to welfare recipients; it might actually be detrimental to them if, as is possible, it led to an appreciable reduction in the cash assistance they now receive from State agencies.

TEXT OF AMENDMENT 6-28-60-E

Intended to be proposed by Mr. HUMPHREY to the bill (H.R. 12580), viz: At the end of the bill add the following new title:

TITLE VIII—DISTRIBUTION OF SURPLUS FOOD

SHORT TITLE

SEC. 801. This title may be cited as the "Food Act of 1960".

STATEMENT OF PURPOSES

SEC. 802. It is the purpose of this title to (1) transfer the domestic program of direct commodity distribution to the needy from the Department of Agriculture to the Department of Health, Education, and Welfare, (2) to provide for the extension and expansion of the direct commodity distribution program by authorizing assistance to State and local governments in administering and handling such programs, and (3) provide for a food stamp plan for the purpose of securing an adequate and proper diet of foods high in nutritional value which are ordinarily consumed in inadequate quantities by the unemployed, the needy, and persons with low income, and others in designated industrial areas of labor surplus and low-income rural areas.

DEFINITION

SEC. 803. As used in this title—

(a) The term "food commodity" means any food product raised or produced in the United States on farms, including agricultural, horticultural, and dairy products, livestock, poultry, and honey.

(b) The term "direct commodity distribution" means the program for the distribution of food commodities transferred to the Secretary of Health, Education, and Welfare under section 804 of this title.

(c) The term "food stamp" means a certificate, coupon, or other similar medium of exchange issued to eligible recipients.

(d) The term "State" includes the District of Columbia, Puerto Rico, and the Virgin Islands.

(e) The term "Secretary" means the Secretary of Health, Education, and Welfare.

(f) The term "eligible food store" means an established grocery store, or merchant engaged in the distribution of food at the retail level, located in the community, meeting such requirements of eligibility as may be prescribed by the Secretary.

(g) The term "needy person" means any person so designated by any Federal or State authority approved by the Secretary as a certifying agency: *Provided*, That such term shall include persons so designated who are served by the Bureau of Indian Affairs.

TRANSFER OF DOMESTIC FOOD PROGRAMS TO DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE

SEC. 804. Not later than ninety days after the date of enactment of this title, the administration of the direct commodity distribution programs under section 416(3) of the Agricultural Act of 1949, as amended, is, except as hereafter provided, hereby transferred to the Secretary of Health, Education, and Welfare, and all functions and activities carried out by the Secretary of Agriculture under such section shall be carried out by the Secretary within the Department of Health, Education, and Welfare. Such transfer shall not apply with respect to the donation of food commodities under such section for use in nonprofit school-lunch programs and in nonprofit summer camps for children.

TRANSFER OF AGRICULTURAL FOOD PRODUCTS

SEC. 805. To facilitate the administration and continuation of such program, upon request by the Secretary of Health, Education, and Welfare, the Secretary of Agriculture and the Commodity Credit Corporation shall make available a maximum quantity of the agricultural food products acquired by the Commodity Credit Corporation. The Secretary shall reimburse the Commodity Credit Corporation for costs incurred by the Corporation in making such commodities available to the Secretary under the provisions of this title. The Commodity Credit Corporation shall upon request of the Secretary arrange for the processing, packaging, and delivery to designated points of any agricultural food product.

ADMINISTRATIVE ASSISTANCE TO STATES

SEC. 806. The Secretary is authorized to give assistance to State and local governments in meeting the costs of food distribution, including local storage, under the direct commodity distribution program to the needy in charitable institutions and family units. Such assistance shall be made available in accordance with standards developed by the Secretary and used as the basis for securing the appropriation of funds for this purpose. To this end the Secretary shall conduct a study of the current expenditures of local governments on the direct commodity distribution program, the amount necessary to extend and expand the program as directed in this title, including the addition of other cities and counties in the program, and report to the Congress on a formula for division of the funds requested, such formula to be based on the per capita revenues of the local government from whatever source, and the extent of need as represented by needy persons eligible under such program.

STANDARDS FOR ELIGIBILITY

SEC. 807. (a) The Secretary is authorized and directed to establish minimum and maximum standards of eligibility for participation in the program of food distribution to needy persons. Such minimum and maximum standards shall establish the lower and upper limits in terms of income or other resources which an individual or family may have and be eligible for participation. The failure of a State or local subdivision thereof to adhere to such standards shall consti-

tute a bar to participation in this program: *Provided*, That the right of any State or local subdivision thereof currently participating in this program to continue to do so shall not be denied under any such standards until the appropriate legislative body of such unit of government shall have had reasonable opportunity to adjust standards to those established by the Secretary: *And provided further*, That no State or local government which denies food available under the direct commodity distribution program to needy persons who are ineligible for reasons of lack of legal residence only shall be permitted to participate in such program.

OTHER AID AS RELATED TO STANDARDS

SEC. 808. In establishing minimum standards in the direct commodity distribution program, the Secretary shall deal specifically with recipients of other types of aid under the Social Security and related Acts, as well as the assistance available from State and local governments and shall bear in mind that the receipt of other types of assistance, as such, shall not bar participation. Maximum standards for participation shall, insofar as possible, relate only to income currently available to needy persons on a per capita basis.

FOOD STAMP PLAN TO SUPPLEMENT DIRECT COMMODITY DISTRIBUTION FOR NEEDY FAMILIES IN DESIGNATED AREAS

SEC. 809. The Secretary is further authorized and directed to establish and administer a food stamp plan to supplement the direct commodity distribution program for needy individuals in family units or in charitable institutions in areas—

(1) Designated by the Secretary of Labor as industrial areas in which there has existed substantial and persistent unemployment for an extended period of time. There shall be included among the areas so designated any industrial area in which there has existed unemployment of not less than (A) 12 per centum of the labor force of such area during the twelve-month period immediately preceding the date on which an application for assistance is made under this title, (B) 9 per centum of such labor force during at least fifteen months of the eighteen-month period immediately preceding such date, or (C) 6 per centum of such labor force during at least eighteen month of the twenty-four-month period immediately preceding such date. Any industrial area in which there has existed unemployment of not less than 15 per centum of the labor force during the six-month period immediately preceding the date on which application for assistance is made under this title may be designated as an eligible area if the Secretary of Labor determines that the principal causes of such unemployment are not temporary in nature.

(2) Designated by the Secretary of Agriculture as predominantly rural areas where the net income and standard of living of farm families or rural nonfarm families are substantially below the average of other rural counties.

PROGRAM REGULATIONS

SEC. 810. The Secretary shall issue regulations with respect to the operation of the food stamp program authorized by this title. Such regulations shall include the express requirements of this title; the responsibilities to be assumed by, and the other conditions to be met by, State agencies; and such other rules as the Secretary deems necessary to accomplish the purposes of this title.

ELIGIBLE HOUSEHOLDS

SEC. 811. (a) Households eligible to participate in the food stamp program shall be those determined by the Secretary to be in economic need of food assistance.

(b) The Secretary shall include in the regulations issued pursuant to this title the broad categories of households determined to be in economic need of food assistance and the basic procedures to be followed by State agencies in the certification of eligible households.

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ISSUANCE AND USE OF FOOD STAMPS

SEC. 812. (a) The Secretary shall arrange for the issuance of food stamps to State agencies and for the payment for such stamps by such State agencies. The cost of the food stamps issued to any State agency shall be an amount equal to the price charged eligible households for such stamps.

(b) The food stamps issued to any State agency shall be distributed only to households in the designated areas which have been certified by the State agency as eligible to participate in the food stamp program.

(c) The food stamps issued to any eligible household shall be used only to purchase food in mercantile establishments selling food at retail which have been approved by the State agency to accept food stamps under the regulations issued pursuant to this title.

VALUE AND COST OF FOOD STAMPS TO BE ISSUED

SEC. 813. (a) The face value of food stamps to be issued to any eligible household shall be in such amount as is designed to provide increased food purchases and improved diets in such household. The Secretary shall take such measures as he deems practicable and feasible to encourage the purchase of foods designated by the Secretary of Agriculture as being in abundant supply by households receiving food stamps.

(b) Eligible households shall be charged by the State agency for such part of the face value of the food stamps issued to them as the Secretary determines will provide reasonable assurances that the normal food expenditures of eligible households will be continued under the food stamp program.

AGREEMENTS WITH MERCANTILE ESTABLISHMENTS

SEC. 814. Any mercantile establishment selling food at retail which desires to accept food stamps under the food stamp program shall enter into an agreement with the State agency. The minimum provisions to be included in any such agreement shall be included by the Secretary in the regulations issued pursuant to this title.

REDEMPTION OF FOOD STAMPS

SEC. 815. (a) The Secretary shall provide a procedure for the face-value redemption of food stamps accepted by approved mercantile establishments. Such procedure may include the use of, the advance of funds to, and the payment for services rendered by banking institutions. Payments for such services may be made without regard to the provisions of existing laws governing the expenditure of public funds.

ADMINISTRATION AND ENFORCEMENT

SEC. 816. (a) State agencies may utilize the services of welfare or public assistance agencies of local units of government and each State agency shall submit, for the approval of the Secretary, a plan of operation describing the methods and agencies it will use to carry out the responsibilities and functions assigned to it under the regulations issued pursuant to this title.

(b) State agencies shall keep, or cause to be kept, such accounts and records as the Secretary deems necessary to determine whether the provisions of this title, or the regulations issued pursuant thereto, are being complied with. Such accounts and records shall be available at all times for inspection and audit by the Secretary and shall be preserved for such a period of time, not in excess of three years, as the Secretary determines is necessary.

(c) The Secretary shall provide in the regulations issued pursuant to this title for the suspension from participation in the food stamp program any State or political subdivision thereof, any participating household, or any registered mercantile establishment found to have violated any provision of this title or the regulations issued pursuant thereto.

(d) The Secretary shall have the power to determine, adjust, compromise, or reduce any claim or claims arising under this title and such action shall be final and shall not be reviewable by any other officer or agency of the Government.

CRIMINAL PROVISIONS

SEC. 817. (a) Whoever shall falsely make, alter, forge, or counterfeit, or cause or procure to be falsely made, altered, forged, or counterfeited, any food stamp for the purpose of obtaining or receiving, or of enabling any other person

to obtain or receive, directly or indirectly, from the United States or any of its officers or agents, any money or other thing of value, and whoever shall transfer or utter as true, or cause to be transferred or uttered as true, any false, forged, altered, or counterfeited food stamp with intent to defraud the United States, any State agency, or any mercantile establishment or person, shall upon conviction thereof, be fined not more than $5,000 or imprisoned not more than ten years, or both.

(b) Any person not being so authorized by this title or the regulations issued pursuant thereto, who shall have food stamps in his possession or under his control, or any person who shall use, transfer, or acquire food stamps in any manner not authorized by this title, or the regulations issued pursuant thereto, or who shall buy, sell, or exchange food stamps without being authorized to do so by this title or regulations issued pursuant thereto shall be guilty of a misdemeanor and shall, upon conviction thereof, be fined not more than $5,000 or imprisoned for not more than one year, or both.

MISCELLANEOUS PROVISIONS

SEC. 818. (a) Nothing in this title shall be construed as intending or justifying the lowering of standards of public assistance.

(b) The value of food stamps provided to any participating household which are in excess of the price paid for such stamps by any participating household shall not be deemed to be income or resources for the purpose of sections 2(a)(7), 402(a)(7), 1002(a)(8), and 1402(a)(8) of the Social Security Act, as amended.

APPROPRIATIONS AND FUNDS

SEC. 819. (a) There are hereby authorized to be appropriated such sums as may be necessary to carry out the purposes of this title and any part of such appropriation may be transferred to and made a part of the special fund created in subsection (b) of this section.

(b) The sums collected pursuant to section 805 of this title for the issuance to State agencies of food stamps shall be deposited into the Treasury of the United States as a special fund without fiscal year limitation to be available for the redemption of such stamps.

EFFECT ON OTHER ASSISTANCE PROGRAMS

SEC. 820. Any benefits received under this title shall not be deemed to be income or resources for the purposes of any provisions of the Social Security Act, nor shall such benefits be used to justify any decrease of cash or other benefits paid to any individual by any State or local subdivision thereof.

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19. AMENDMENT 6-28-60-F—INTRODUCED BY SENATOR HUMPHREY

STAFF ANALYSIS

Under old-age assistance, aid to the blind, and aid to the permanently and totally disabled programs the State must take into account all income and resources (needs test). Amendment modifies this requirement so as to exempt (1) the first $50 a month of earned income, (2) ownership of a home having an assessed value of less than $5,000, (3) surplus food donated under the Commodity Credit Corporation, and (4) the first $1,200 of personal property (defined to exclude clothing, furniture, household equipment, fuel, personal jewelry and other personal effects), and also requires the State to disregard the ability of family and relatives to provide support. (Similar provisions for the aid to dependent children with slightly different earned income exemptions.) Adds a State plan requirement for all programs that there be no discrimination on account of sex in determining need. Reduces eligibility age to 62 for women (now 65) for old-age assistance and amends residence provision so that the maximum imposed for all programs cannot be longer than a year immediately preceding application. Provides for direct payments to persons who are not eligible under State plans because of residence requirements, in the amount of the Federal share of such assistance payments. Requires States to have plans approved under each of the public assistance titles before there will be any Federal payments.

Cost.—Overall cost unknown. Largest cost would come from additional persons made eligible for payments and no information is available as to the size of this group. Only cost estimates which are available are on the following two provisions.

The $50 a month income exemption for old-age assistance recipients, presently on the rolls—$15 million a year additional Federal expenditure.

Reduction of the qualifying age for old-age assistance for women—$55 million a year additional Federal expenditures.

Cost of other provisions undetermined.

Financing.—Federal share paid out of general revenue.

VIEWS OF DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE ON AMENDMENT 6-28-60-F

Hon. HARRY F. BYRD,
Chairman, Committee on Finance,
U.S. Senate, Washington, D.C.

DEAR MR. CHAIRMAN: This is in response to your request for a report on an amendment to H.R. 12580 (designated as 6-28-60-F) intended to be proposed by Senator Humphrey.

1. MODIFICATION OF INCOME-AND-RESOURCES REQUIREMENT

The major proposal is to amend the public assistance titles to require the States in making a determination of need, to disregard certain earned income and other resources. The first $50 per month of earned income would have to be disregarded under titles I and XIV (as it now is under title X). Under title IV, the first $15 and $30 per month earned by the child and his "parent or guardian," respectively, would have to be disregarded. In addition, under each title, the following resources would have to be disregarded: (*a*) ownership of a home having an assessed value (less encumbrances) of $5,000, (*b*) the ability of the individual's family and relatives to support him, (*c*) surplus foods provided from Commodity Credit Corporation stocks, and (*d*) the first $1,200 in value (above encumbrances) of personal property, as well as personal effects, and interment plots or burial trust funds or insurance or contract rights not exceeding $500 in value; except that the amendments to title IV are limited to resources mentioned under (*a*) and (*c*) above.

The implication of this proposal for the public assistance program is a serious one. Public assistance is designed to meet the individual's need after his own income and resources have been taken into consideration. It is the contributory social insurance program that is designed to provide benefits on the basis of previous earnings (weighted in favor of the lower earnings brackets) and without regard to the individual's need. It is important that this distinction between the two programs be kept clear. The exemption of income proposed in this amendment is unsound in principle in that it is inconsistent with the supplementary nature of the public assistance program and would tend to give the assistance program some of the qualities of a pension. Moreover, the underlying assumption of the proposal that it would generally help recipients achieve a higher standard of living is erroneous. For the majority of people, with no earnings or hope of earnings, enactment of this proposal could actually reduce the assistance they are receiving. This could come about by States giving aid to additional people and increased aid to some people without increasing the State funds appropriated. Thus, the few with earnings would be better off, by far, than the many without earnings.

With respect to the provisions which would require exemption of certain resources other than income, we believe that the States already have under present law all the necessary latitude. The California old-age assistance plan, for example, permits a recipient to retain a home with as much as $5,000 assessed value less encumbrances, and personal property up to $1,200. The extent to which the present amendment goes raises serious question as to whether public assistance would any longer be a genuine program of assistance based on individual need. Moreover, even if the amendment did not go beyond the now permissible limits of the income-and-resource clause, it would be objectionable in that it would require the States to establish such exemptions, thus bringing additional persons into the States' public assistance programs without regard to the capacity of many States to support adequate assistance payments to them. To establish any such exemption as a Federal requirement seems to us to impose Federal

controls in a matter which should be left to the States within the limits of the present income-and-resources requirement. What is said below as to certain other proposals to impose restrictions on the States is also applicable here.

2. OTHER RESTRICTIONS ON STATE POLICY

Other provisions of this proposal would amend the public assistance titles to (1) require States to have plans approved under each of the other public assistance titles in order to receive Federal funds under any title; (2) require that the State plans be administered by the State agency in the political subdivisions, instead of permitting the State agency to limit itself to supervision of such administration; (3) require State plans to provide against discrimination based on sex in determining need; (4) reduce the age requirement for women in old-age assistance from 65 to 62 years by prohibiting the approval of a State plan that imposes an age requirement in excess of the retirement age under title II; (5) reduce the maximum State residence requirement from 5 years to 1 year in the program for the aged, blind, disabled; (6) provide to otherwise eligible individuals, until they have satisfied a State's residence requirement, a direct Federal payment equal to the Federal share of the assistance payment the individual would have received if he had satisfied such requirement; (7) provide for the withholding of Federal funds if a lien or transfer of any interest in the home is required as a condition of eligibility; and (8) provide that assistance paid is for the needs of the recipient only and shall not be regarded as income of any other person.

In addition, the so-called Jenner amendment, relating to public access to State public assistance records (sec. 618 of the Revenue Act of 1951), would be repealed, and any marking on assistance checks, warrants, or envelopes that would indicate that the recipient is a needy person would be prohibited.

While we recognize that some of these provisions may have a desirable objective, we are seriously concerned about the approach taken in these amendments to the administration of public assistance under the Social Security Act. A major objection to a number of these provisions is the control they would impose upon the States through Federal law. Some of these provisions would remove from the States the options they now have to determine the scope and coverage of their programs. Another would impose on all States a rigid pattern of direct administration of the programs in the localities by the State agency, rather than permit the option of local administration under supervision of the State agency now available under the Federal act. Such amendments are inconsistent with the basic responsibility of the States to define the conditions that govern the administration of their programs, and with the principle that Federal conformity requirements should be limited to those provisions which are considered indispensable to a genuine public assistance program based on individual need or which are otherwise essential from the point of view of the national interest in the program.

Most of the above-mentioned provisions would not seem to meet these tests. Item 6, moreover, would introduce the undesirable innovation of direct Federal assistance payments in order to meet a problem which, we believe, should be resolved within the framework of the present system of State assistance programs. We, therefore, do not believe that the proposed amendment offers a sound approach to the definition of the Federal role in public assistance under our system of Federal-State cooperation in this field.

For the above-stated reasons we recommend against enactment of the amendment.

The Bureau of the Budget advises that it perceives no objection to the submission of this report to your committee.

Sincerely yours,

ROBERT A. FORSYTHE,
Assistant Secretary.

TEXT OF AMENDMENT 6-28-60-F

Intended to be proposed by Mr. HUMPHREY to the bill (H.R. 12580), viz: At the end of the bill add the following new title:

TITLE VIII—PUBLIC ASSISTANCE

SHORT TITLE

SEC. 801. This title may be cited as the "Humanitarian and Old-Age Rights Act".

STATEMENT OF PURPOSE AND POLICY

SEC. 802. It is the purpose of this title to provide more effectively for the protection, care, and assistance of the people of the United States who are in need thereof, and to promote the welfare and happiness of the people of the United States by providing public assistance to its needy and distressed. It is the policy of the Congress that assistance under titles I, IV, X, and XIV of the Social Security Act, as amended by this title, shall be administered promptly and humanely, with due regard for the preservation of family life and without discrimination on account of race, religion, or political affiliation, and that such assistance shall be so administered as to encourage self-respect, self-reliance, and the desire to be a good citizen, useful to society. Titles I, IV, X and XIV of the Social Security Act shall be liberally construed in order to carry out this purpose and policy.

OLD-AGE ASSISTANCE

SEC. 803. (a)(1)(A) Section 2(a)(1) of the Social Security Act is amended to read as follows: "(1) provide that it shall be in effect in all political subdivisions of the State;".

(B) Section 2(a)(3) of such Act is amended to read as follows: "(3) provide for the establishment or designation of a single State agency to administer the plan;".

(2) Section 2(a)(7) of such Act is amended to read as follows: "(7) provide that the State agency shall, in determining need, take into consideration any other income and resources of an individual claiming old-age assistance; except that, in making such determination, the State agency shall disregard (A) the first $50 per month of earned income, (B) the ownership of such individual (alone or with his or her spouse) of a home having an assessed value, less all encumbrances of record thereon, of less than $5,000 (except to the extent that he is receiving rental income therefrom), (C) the ability of such individual's family and relatives to provide for his support, (D) any donations of surplus food which have been made to such individual from stocks of the Commodity Credit Corporation, and (E) the first $1,200 in value (over and above all encumbrances of record) of personal property owned by such individual;".

(3) Section 2(a) of such Act is further amended by striking out the final period and inserting in lieu thereof a semicolon and the following: "and (12) provide that there will be no discrimination based on sex in determinng the needs of individuals receiving assistance under the plan."

(4) Section 2(a) of such Act is further amended by adding after clause (12) the following new sentence: "For purposes of clause (7)(E), no life insurance policy shall be valued at more than its present surrender value to the individual, and the term 'personal property' shall not include (I) the individual's clothing, furniture, household equipment, foodstuffs, fuel, personal jewelry, or other personal effects, or (II) interment plots, money placed in trust or insurance for funeral, interment, or similar expenses, or any contact rights connected therewith, if such money, insurance, or contract rights do not exceed $500 in value."

(5) Section 2(b)(1) of such Act is amended to read as follows:

"(1) An age requirement at any given time of more than the age which at such time constitutes retirement age for purposes of title II of this Act; or".

(6) Section 2(b)(2) of such Act is amended to read as follows:

"(2) Any residence requirement which excludes any resident of the State who has resided therein continuously for one year immediately preceding the application; or".

(b) The second sentence of section 1 of such Act is amended by inserting before the period at the end thereof a semicolon and the following: "but no payment shall be made under this title to any State which has not also submitted, and

had approved by the Secretary, State plans for assistance under titles IV, X, and XIV".

(c) Section 4 of such Act is amended by striking out "or" at the end of paragraph (1), by adding "or" at the end of paragraph (2), and by inserting after paragraph (2) the following new paragraph:

"(3) that in the administration of the plan there is imposed, as a condition of old-age assistance to any individual, a requirement that such individual subject his home to a lien of any kind or transfer to the State agency any interest in his home;".

(d) Title I of such Act is amended by adding at the end thereof the following new sections:

"Direct Payments to Individuals Not Satisfying Residence Requirements

"SEC. 7. If an individual, after making application for old-age assistance, is denied such assistance by the State agency solely because he does not satisfy the residence requirements imposed under the State plan, and if such individual is not entitled to old-age assistance by reason of prior residence in another State, the State agency shall promptly notify the Secretary of the fact that such individual has made such application and would be eligible for old-age assistance if he satisfied such requirements. The Secretary shall thereupon pay directly to such individual for each month, beginning with the first month (after the month of such individual's application) in which such individual would have been eligible for old-age assstance if he satisfied such residence requirements and ending with the month preceding the first month in which he satisfies such requirements, an amount (as determined under regulations prescribed by the Secretary) equal to the Federal Government's proportionate share of the old-age assistance which such individual would receive for such month if he then satisfied such requirements.

"Assistance for Needs of Recipient Only

"SEC. 8. Assistance paid to any individual under this title is to assist him in meeting his individual needs and is not for the benefit of any other person; and such assistance shall not be regarded as income of any person other than such individual."

AID TO DEPENDENT CHILDREN

SEC. 804. (a)(1)(A) Section 402(a)(1) of the Social Security Act is amended to read as follows: "(1) provide that it shall be in effect in all political subdivisions of the State;".

(B) Section 402(a)(3) of such Act is amended to read as follows: "(3) provide for the establishment or designation of a single State agency to administer the plan;".

(2) Section 402(a)(7) of such Act is amended to read as follows: "(7) provide that the State agency shall, in determining need, take into consideration any other income and resources of any child claiming aid to dependent children; except that in making such determination the State agency shall disregard (A) the first $15 per month of income earned by such child and the first $30 per month of income earned by his parent or guardian, (B) the ownership by such child (or by his parent or guardian) of a home having an assessed value, less all encumbrances of record thereon, of less than $5,000 (except to the extent that he is receiving rental income therefrom), and (C) any donations of surplus food which may have been made to or for such child from stocks of the Commodity Credit Corporation;".

(3) Section 402(a) of such Act is further amended by striking out the final period and inserting in lieu thereof a semicolon and the word "and", and by adding at the end of the subsection the following new clause: "(13) provide that there will be no discrimination based on sex in determining the needs of individuals receiving assistance under the plan."

(b) The second sentence of section 401 of such Act is amended by inserting before the period at the end thereof a semicolon and the following: "but no payment shall be made under this title to any State which has not also submitted and had approved by the Secretary, State plans for assistance under titles I, X, and XIV".

(c) Section 404 of such Act is amended by striking out "or" at the end of paragraph (1), by adding "or" at the end of paragraph (2), and by inserting after paragraph (2) the following new paragraph:

"(3) that in the administration of the plan there is imposed, as a condition of aid to any dependent child, a requirement that such child (or his parent or guardian) subject to his (or their) home to a lien of any kind or transfer to the State agency any interest in such home;".

(d) Title IV of such Act is amended by adding at the end thereof the following new section:

"Direct Payments to Dependent Children Not Satisfying Residence Requirements

"SEC. 407. If a dependent child, after making application for aid to dependent children, is denied such aid by the State agency solely because he does not satisfy the residence requirements imposed under the State plan, and if such child is not entitled to aid to dependent children by reason of prior residence in another State, the State agency shall promptly notify the Secretary of the fact that such child has made such application and would be eligible for such aid if he satisfied such requirements. The Secretary shall thereupon pay directly to such child for each month, beginning with the first month (after the month of such child's application) in which such child would have been eligible for aid to dependent children if he satisfied such residence requirements and ending with the month preceding the first month in which he satisfies such requirements, an amount (as determined under regulations prescribed by the Secretary) equal to the Federal Government's proportionate share of the aid to dependent children which such child would receive for such month if he then satisfied such requirements."

AID TO THE BLIND

SEC. 804. (a) (1) (A) Section 1002 (a) (1) of the Social Security Act is amended to read as follows: "(1) provide that it shall be in effect in all political subdivisions of the State;".

(B) Section 1002(a) (3) of such Act is amended to read as follows: "(3) provide for the establishment or designation of a single State agency to administer the plan;".

(2) Section 1002(a) (8) of such Act is amended to read as follows: "(8) provide that the State agency shall, in determining need, take into consideration any other income and resources of an individual claiming aid to the blind; except that, in making such determination, the State agency shall disregard (A) the first $50 per month of earned income, (B) the ownership by such individual (alone or with his or her spouse) of a home having an assessed value, less all encumbrances of record thereon, of less than $5,000 (except to the extent that he is receiving rental income therefrom), (C) the ability of such individual's family and relatives to provide for his support, (D) any donations of surplus food which may have been made to such individual from stocks of the Commodity Credit Corporation, and (E) the first $1,200 in value (over and above all encumbrances of record) of personal property owned by such individual;".

(3) Section 1002(a) of such Act is further amended by striking out the final period and inserting in lieu thereof a semicolon and the following: "and (14) provide that there will be no discrimination based on sex in determining the needs of individuals receiving assistance under the plan."

(4) Section 1002(a) of such Act is further amended by adding after clause (14) the following new sentence: "For purposes of clause (8) (E), no life insurance policy shall be valued at more than its present surrender value to the individual, and the term 'personal property' shall not include (i) the individual's clothing, furniture, household equipment, foodstuffs, fuel, personal jewelry, or other personal effects, or (ii) interment plots, money placed in trust or insurance for funeral, interment, or similar expenses, or any contract rights connected therewith, if such money, insurance, or contract rights do not exceed $500 in value."

(5) Section 1002(b) (1) of such Act is amended to read as follows:

"(1) Any residence requirements which excludes any resident of the State who has resided therein continuously for one year immediately preceding the application; or".

(b) The second sentence of section 1001 of such Act is amended by inserting before the period at the end thereof a semicolon and the following: "but no payment shall be made under this title to any State which has not also submitted, and had approved by the Secretary, State plans for assistance under titles I, IV, and XIV".

(c) Section 1004 of such Act is amended by striking out "or" at the end of paragraph (1), by adding "or" at the end of paragraph (2), and by inserting after paragraph (2) the following new paragraph:

"(3) that in the administration of the plan there is imposed, as a condition of aid to any individual, a requirement that such individual subject his home to a lien of any kind or transfer to the State agency any interest in his home;".

(d) Title X of such Act is amended by adding at the end thereof the following new sections:

"Direct Payments to Individuals Not Satisfying Residence Requirements

"SEC. 1007. If an individual, after making application for aid to the blind, is denied such aid by the State agency solely because he does not satisfy the residence requirements imposed under the State plan, and if such individual is not entitled to aid to the blind by reason of prior residence in another State, the State agency shall promptly notify the Secretary of the fact that such individual has made such application and would be eligible for such aid if he satisfied such requirements. The Secretary shall thereupon pay directly to such individual for each month, beginning with the first month (after the month of such individual's application) in which such individual would have been eligible for aid to the blind if he satisfied such residence requirements and ending with the month preceding the first month in which he satisfies such requirements, an amount (as determined under regulations prescribed by the Secretary) equal to the Federal Government's proportionate share of the aid to the blind which such individual would receive for such month if he then satisfied such requirements.

"Assistance for Needs of Recipient Only

"SEC. 1008. Assistance paid to any individual under this title is to assist him in meeting his individual needs and is not for the benefit of any other person; and such assistance shall not be regarded as income of any person other than such individual."

AID TO THE PERMANENTLY AND TOTALLY DISABLED

SEC. 806. (a)(1)(A) Section 1402(a)(1) of the Social Security Act is amended to read as follows: "(1) provide that it shall be in effect in all political subdivisions of the State;".

(B) Section 1402(a)(3) of such Act is amended to read as follows: "(3) provide for the establishment or designation of a single State agency to administer the plan;".

(2) Section 1402(a)(8) of such Act is amended to read as follows: "(8) provide that the State agency shall, in determining need, take into consideration any other income and resources of an individual claiming aid to the permanently and totally disabled; except that, in making such determination, the State agency shall disregard (A) the first $50 per month of earned income, (B) the ownership by such individual (alone or with his or her spouse) of a home having an assessed value, less all encumbrances of record thereon, of less than $5,000 (except to the extent that he is receiving rental income therefrom), (C) the ability of such individual's family and relatives to provide for his support, (D) any donations of surplus food which may have been made to such individual from stocks of the Commodity Credit Corporation, and (E) the first $1,200 in value (over and above all encumbrances of record) of personal property owned by such individual;".

(3) Section 1402(a) of such Act is further amended by striking out the final period and inserting in lieu thereof a semicolon and the following: "and (13) provide that there will be no discrimination based on sex in determining the needs of individuals receiving assistance under the plan."

(4) Section 1402(a) of such Act is further amended by adding after clause (13) the following new sentence: "For purposes of clause (8)(E), no life insurance policy shall be valued at more than its present surrender value to the individual, and the term 'personal property' shall not include (i) the individual's clothing, furniture, household equipment, foodstuffs, fuel, personal jewelry, or other personal effects, or (ii) interment plots, money placed in trust or insurance for funeral, interment, or similar expenses, or any contract rights con-

nected therewith, if such money, insurance, or contract rights do not exceed $500 in value."

(5) Section 1402(b)(1) of such Act is amended to read as follows:

"(1) Any residence requirement which excludes any resident of the State who has resided therein continuously for one year immediately preceding the application; or".

(b) The second sentence of section 1401 of such Act is amended by inserting before the period at the end thereof a semicolon and the following: "but no payment shall be made under this title to any State which has not also submitted, and had approved by the Secretary, State plans for assistance under titles I, IV, and X".

(c) Section 1403 of such Act is amended by striking out "or" at the end of paragraph (1), by adding "or" at the end of paragraph (2), and by inserting after paragraph (2) the following new paragraph:

"(3) that in the administration of the plan there is imposed, as a condition of aid to any individual, a requirement that such individual subject his home to a lien of any kind or transfer to the State agency any interest in his home;".

(d) Title XIV of such Act is amended by adding at the end thereof the following new sections:

"Direct Payments to Individuals Not Satisfying Residence Requirements

"SEC. 1406. If an individual, after making application for aid to permanently and totally disabled, is denied such aid by the State agency solely because he does not satisfy the residence requirements imposed under the State plan, and if such individual is not entitled to aid to the permanently and totally disabled by reason of prior residence in another State, the State agency shall promptly notify the Secretary of the fact that such individual has made such application and would be eligible for such aid if he satisfied such requirements. The Secretary shall thereupon pay directly to such individual for each month, beginning with the first month (after the month of such individual's application) in which such individual would have been eligible for aid to the permanently and totally disabled if he satisfied such residence requirements and ending with the month preceding the first month in which he satisfies such requirements, an amount (as determined under regulations prescribed by the Secretary) equal to the Federal Government's proportionate share of the aid to the permanently and totally disabled which such individual would receive for such month if he then satisfied such requirements.

"Assistance for Needs of Recipient Only

"SEC. 1407. Assistance paid to any individual under this title is to assist him in meeting his individual needs and is not for the benefit of any other person; and such assistance shall not be regarded as income of any person other than such individual."

MISCELLANEOUS PROVISIONS

SEC. 807. (a) As used in the provisions of the Social Security Act amended by this title, the term "Secretary", except when the context otherwise requires, means the Secretary of Health, Education, and Welfare.

(b) Section 618 of the Revenue Act of 1951 (relating to public access to State public assistance records) is repealed.

(c) No check or warrant drawn in payment of assistance to any individual under title I, IV, X, or XIV of the Social Security Act, and no envelope or other outer covering therefor, shall bear any printing or marking which indicates or implies that such individual is indigent or a pauper.

(d) The amendments made by sections 803(d), 804(d), 805(d), and 806(d) shall apply with respect to months beginning after the date of the enactment of this title. Section 807(b) shall apply with respect to payments to which the States (including the agencies and political subdivisions thereof) become entitled after the date of the enactment of this title. Section 807(a) and 807(c) shall take effect on the date of the enactment of this title. The remaining amendments made by this title shall take effect on July 1, 1960.

20. AMENDMENT 6-28-60-G—INTRODUCED BY SENATOR HUMPHREY (IDENTICAL WITH HIS BILL S. 1151)

Staff Analysis

Eligibility.—Individuals who are eligible to receive, but not necessarily receiving, social security old-age and survivors benefits (including dependents), would be entitled to health benefits.

Benefits.—

(1) Hospital service—60 days per year.

(2) Nursing home services—120 days per year (less days of hospitalization).

Cost.—$2.17 billion per year, or 0.67 percent of payroll, on a level premium basis.

$920 million per pear, or 0.44 percent of payroll, on an early year basis.

Financing.—Benefits would be payable out of the old-age and survivors insurance trust fund and would be financed by an increase in the contribution rate of both employer and employee of one-fourth of 1 percent and on the self-employed of three-eighths of 1 percent, beginning in 1961.

NOTE.—The revenues derived from the tax increases provided in the amendment would amount to only 0.50 percent of payroll on a level premium basis; thus the amendment is underfinanced.

Views of Department of Health, Education, and Welfare on Amendment 6-28-60-G Included in Following Joint Report

The Department of Health, Education, and Welfare would recommend against adoption of each of the following four amendments: amendment No. 1, 6-24-60-C (Mr. McNamara), amendment No. 11, 6-27-60-F (Mr. Morse), amendment No. 20, 6-28-60-G (Mr. Humphrey), and amendment No. 27, 6-30-60-B (Mr. Anderson). Each of these bills proposes to amend title VI of H.R. 12580 to add health insurance benefits to the existing Federal old-age, survivors, and disability insurance system. The reasons for this recommendation are as follows:

1. The proposed extension of the existing old-age, survivors, and disability insurance system to encompass health insurance would make such insurance compulsory and would not be pinpointed to the need for aid in meeting the cost of medical services. Under this approach, the individual would have no opportunity to determine for himself the particular pattern for meeting the threat of large medical expenses that best suits his own needs and desires. In addition, by compulsorily extending health benefits to aged persons eligible for old-age, survivors, and disability insurance, many persons would be included who have the resources and the opportunity to obtain protection against long-term or other expensive illnesses without Government help.

2. These amendments would establish an exclusively Federal program. This administration has consistently endeavored, however, to strengthen our system of Government by encouraging State and local governments to assume responsibility for the many public needs which can be met through Federal-State partnership and by supporting programs to stimulate greater State and local effort in areas of critical national concern. Health care for the aged is an area of activity admirably suited to such a sharing of responsibility. In addition to bolstering the underlying cooperative foundation of our Federal system, with governmental powers divided between State and Nation, Federal-State partnership places the control over daily program operations at the level of government closest to the persons affected by the program. Thus, an individual's needs may be more immediately and effectively reflected in the current operations and the development of the program.

3. The approach proposed in the amendments would constitute a serious threat to the orderly development of present retirement, survivorship, and disability benefit features of the social security system.

The payroll tax for old-age, survivors, and disability insurance is already scheduled ultimately to be 4½ percent each on employees and employers and 6¾ percent on the self-employed. Further liberalization in retirement, survivorship, and disability benefits may call for additional revenues, which can only come from increases in the payroll tax or increases in the earnings base, or both. If health insurance as envisaged in these amendments were to be added to the system, the payroll tax would need to be increased by a total of one-half to 1 percent. As in the case of cash benefits, there would undoubtedly be in-

sistent demands for improving the medical benefits beyond those which can be financed by the tax increase for medical benefit purposes. Increases in both health and cash benefits would place the retirement, survivorship, and disability portions of the system in competition with the health benefits for available funds, since the revenue possibilities from a payroll tax are not limitless.

It is therefore far better to reserve the payroll tax for the retirement, survivorship, and disability features of the social security system so that the revenue source is not overburdened. Whatever the Government needs to do in the area of health care for the aged should be done by the appropriation of general revenues. Such appropriation would provide for a more equitable distribution of the fiscal load than would a payroll tax on earnings of $4,800 or less.

TEXT OF AMENDMENT 6-28-60-G

Intended to be proposed by Mr. HUMPHREY to the bill (H.R. 12580), viz: Beginning on page 154, line 1, strike out all through line 18, on page 172, and insert in lieu thereof the following:

TITLE VI—HOSPITALIZATION AND NURSING INSURANCE

PART 1—AMENDMENTS TO TITLE II OF THE SOCIAL SECURITY ACT

SEC. 601. (a) Title II of the Social Security Act is amended by adding after section 225 the following new section:

"HOSPITALIZATION AND NURSING INSURANCE

"Eligibility for Insurance

"SEC. 226. (a) (1) The cost of hospital or nursing home services furnished to any individual during any month for which he is entitled to monthly benefits under section 202 (whether or not such benefits are actually paid to him) or is deemed entitled to such benefits under the provisions of paragraph 2, or the cost of such services furnished to him during the month of his death where he ceases to be entitled by reason of his death, shall, subject to the provisions of this section, be paid from the Federal Old-Age and Survivors Insurance Trust Fund to the hospital or nursing home which furnished him the services. Services to be paid for in accordance with the provisions of this section include only services provided in the United States.

"(2) For purposes of this section, (A) any individual who would upon filing application therefore, be entitled to monthly benefits for any month under section 202 shall, if he files application under this section within the time limits prescribed in section 202(j) be deemed, for purposes of this section only, to be entitled to benefits for such month, (B) such individual shall, whether or not he files application under this section, be deemed to be entitled to benefits under section 202 for such month for purposes of determining whether the wife, husband, or child of such individual comes within the provisions of clause (A) hereof, and (C) any individual shall, for purposes of this section, be deemed entitled to benefits under section 202 if such individual could have been deemed under clause (A) or (B) of this paragraph to have been so entitled had he not died during such month.

"(3) For purposes of paragraph (2), an individual's application under this section may, subject to regulations, be filed (whether such individual is legally competent or incompetent) by any relative or other person, including the hospital or nursing home furnishing the hospital and nursing home services, and, after such individual's death, his estate.

"(4) Payments may be made for hospital services furnished under this section to an individual during his first sixty days of hospitalization in a twelve-month period that begins with the first day of the first month in which the individual received hospital services for which a payment is made under this section, and during his first sixty days of hospitalization in each succeeding twelve-month period; and for nursing home services furnished under this section to an individual if the individual is transferred to the nursing home from the hospital, and if the services are for an illness or condition associated with that for which he received hospital services: *Provided*, That the number of days of nursing home services for which payments may be made shall, in any twelve-month period as described above, not exceed one hundred and twenty less the number of days of hospital services (in the same twelve-month period) for which payments are made under this section.

"(5) The provisions of section 205 relating to the making and review of determinations shall be applicable to determinations as to whether the costs of hospital and nursing home services furnished an individual may be paid for out of the Federal Old-Age and Survivors Insurance Trust Fund under this subsection, and the amount of such payment.

"Description of Hospital and Nursing Home Services

"(b)(1) For purposes of this section, the term 'hospital services' means the following services, drugs, and appliances furnished by a hospital to any individual as a bed patient: bed and board and such nursing services, laboratory services, ambulance services, use of operating room, staff services, and other services, drugs, and appliances as are customarily furnished by such hospital to its bed patients either through its own employees or through persons with whom it has made arrangements for such services, drugs, or appliances; the term 'hospital services' includes such medical care as is generally furnished by hospitals as an essential part of hospital care for bed patients; such term shall include care in hospitals described in paragraph (1) of subsection (d); such term shall not include care in any tuberculosis or mental hospital.

"(2) The term 'nursing home services' means skilled nursing care, related medical and personal services, and accompanying bed and board furnished by a facility which is equipped to provide such services, and (A) which is operated in connection with a hospital, or (B) in which such skilled nursing care and medical services are prescribed by, or are performed under the general direction of, persons licensed to practice medicine or surgery in the State.

"Free Choice by Patient

"(c)(1) Any individual referred to in paragraphs (1) and (2) of subsection (a) may obtain the hospital or nursing home services for which payment to the hospital or nursing home is provided by this section from any hospital or nursing home which has entered into an agreement under this section, which admits such individual and to which such individual has been referred by a physician or (in the case of hospital or nursing home services furnished in conjunction with oral surgery) dentist licensed by the State in which such individual resides or the hospital or nursing home is located, upon a determination by the physician or dentist that hospitalization or nursing home care for such individual is medically necessary; except that such referral shall not be required in an emergency situation which makes such a requirement impractical.

"(2) Regulations under this section shall provide for payments (in such amounts and upon such conditions as may be prescribed in such regulations) to (A) hospitals for hospital services rendered in emergency situations to individuals referred to in paragraphs (1) and (2) of subsection (a) by hospitals which have not entered into an agreement under this section.

"Agreements With Hospitals and Nursing Homes

"(d)(1) Any institution (other than a tuberculosis or mental hospital) shall be eligible to enter into an agreement for payment from the Federal Old-Age and Survivors Insurance Trust Fund of the cost of hospital or nursing home services furnished to individuals referred to in paragraphs (1) and (2) of subsection (a) if it is licensed as a hospital or nursing home pursuant to the law of the State in which it is located.

"(2) Each agreement with a hospital under this section shall cover all hospital services included under subsection (b) (which services shall be listed in the agreement), shall provide that such services shall be furnished in semiprivate accommodations if available unless other accommodations are required for medical reasons, or are occupied at the request of the patient, shall be made upon such other terms and conditions as are consistent with the efficient and economical administration of this section, and shall continue in force for such period and be terminable upon such notice as may be agreed upon.

"(3) An agreement with a hospital or nursing home under this section shall provide for payment, under the conditions and to the extent provided in this section, of the cost of hospital and nursing home services which are furnished individuals referred to in paragraphs (1) and (2) of subsection (a) provided that no such payment shall be made for services for which the hospital or nursing home has already been paid (excluding payments by such individuals for which

reimbursement to them by the hospital has been assured); but no such agreement shall provide for payment with respect to hospital or nursing home services furnished to an individual unless the hospital or nursing home obtains written certification by the physician (if any) who referred him pursuant to subsection (c) that his hospitalization or care in the nursing home was medically necessary and, with respect to any period during which such services were furnished, written certification by such individual's attending physician during that period that such services were medically necessary. The amount of the payments under any such agreement shall be determined on the basis of the reasonable cost incurred by the hospital or nursing home for all bed patients, or, when use of such a basis is impractical for the hospital or nursing home or inequitable to the institution or the Federal Old-Age and Survivors Insurance Trust Fund, on a reasonably equivalent basis which takes account of pertinent factors with respect to services furnished to individuals referred to in paragraphs (1) and (2) of subsection (a). Any such agreement shall preclude the hospital or nursing home with which the agreement is made from requiring payments from individuals for services, payment of the cost of which is provided by this section after it has been notified that the cost of such services is payable from the Federal Old-Age and Survivors Insurance Trust Fund, except that it may require payments from such individuals for the additional cost of accommodations occupied by them at their request which are more expensive than semiprivate accommodations.

"(4) Except as provided by regulation, no agreement may provide for payments (A) to any Federal hospital, or to any other hospital for hospital services which is obligated by contract with the United States (other than an agreement under this section) to furnish at the expense of the United States, or (B) to any hospital for hospital services which it is required by law or obligated by contract with a State or subdivision thereof to furnish at public expense except where the eligibility of the individual for such services is determined by application of a means test.

"(5) No supervision or control over the details of administration or operation, or over the selection, tenure, or compensation of personnel, shall be exercised under the authority of this section over any hospital or nursing home which has entered into an agreement under this section.

"(6) Agreements under this subsection shall be made with the hospital or nursing home providing the services, but this paragraph shall not preclude representation of such institution by any individual, association, or organization authorized by the institution to act on its behalf.

"(7) Except to the extent the Secretary has made provision pursuant to subsection (h) for the making of payments to hospitals and nursing homes by a private nonprofit organization, he shall from time to time determine the amount to be paid to such provider of service under an agreement with respect to services furnished, and shall certify such amount to the Managing Trustee of the Federal Old-Age and Survivors Insurance Trust Fund, except that such amount shall, prior to certification, be reduced or increased, as the case may be, by any sum by which the Secretary finds that the amount paid to the provider of services for any prior period was greater or less than the amount which should have been paid to it for such period. The Managing Trustee, prior to audit or settlement by the General Accounting Office, shall make payment from the Federal Old-Age and Survivors Insurance Trust Fund, at the time or times fixed by the Secretary, in accordance with such certification.

"Nondisclosure of Information

"(e) Information concerning an individual, obtained from him or from any physician, dentist, nurse, hospital, nursing home, or other person pursuant to or as a result of the administration of this section, shall be held confidential (except for statistical purposes) and shall not be disclosed or be open to public inspection in any manner revealing the identity of the individual or other person from whom the information was obtained or to whom the information pertains, except as may be necessary for the proper administration of this section. Any person who shall violate any provision of this subsection shall be deemed guilty of a misdemeanor and, upon conviction thereof, shall be punished by a fine not exceeding $1,000 or by imprisonment not exceeding one year, or both.

"Hospital Services Under Workmen's Compensation

"(f) The provisions of subsection (a) shall not be applicable to any services which an individual required by reason of any injury, disease, or disability on account of which such services are being received or the cost thereof paid for, or upon application therefor would be received or paid for, under a workmen's compensation law or plan of the United States or of any State, unless equitable reimbursement to the Federal Old-Age and Survivors Insurance Fund for the payments hereunder with respect to such services have been made or assured pursuant to agreements or working arrangements negotiated between the Secretary and the appropriate public agency. Notwithstanding the above sentence, if (1) the individual's entitlement to receive such services (or to have the cost thereof paid for) under such a workmen's compensation law or plan is in doubt when such services are required, (2) the cost of such services is otherwise payable from the Federal Old-Age and Survivors Insurance Trust Fund pursuant to this section, and (3) the individual makes an appropriate application under such workmen's compensation law or plan and agrees, in the event that he is subsequently determined to be entitled to receive such services (or to have the cost thereof paid for) under such law, to reimburse the Federal Old-Age and Survivors Insurance Trust Fund in the amount of any loss it might suffer through its payment for such services, then the cost of such services may be paid from such Trust Fund in accordance with this section. In any case in which the cost of services is paid from the Federal Old-Age and Survivors Insurance Trust Fund pursuant to the immediately preceding sentence, or is paid from such Trust Fund with respect to any such injury, disease, or disability for which no reimbursement to such Trust Fund has been made or assured pursuant to the first sentence of this subsection, the United States shall, unless not permitted under the law of the applicable State (other than the District of Columbia) be subrogated to all rights of such individual, or of the provider of services to which payments under this section with respect to such services are made, to be paid or reimbursed pursuant to such workmen's compensation law or plan for such payments. All amounts recovered pursuant to this subsection shall be deposited in the Treasury of the United States to the credit of the Federal Old-Age and Survivors Insurance Trust Fund.

"Regulations and Functions of Advisory Council

"(g) All regulations specifically authorized by this section shall be prescribed by the Secretary. In administering this section, the Secretary shall consult with a National Advisory Health Council consisting of the Commissioner of Social Security, who shall serve as Chairman ex officio, and eight members appointed by the Secretary. Four of the eight appointed members shall be persons who are outstanding in fields pertaining to hospitals and health activities, and the other four members shall be appointed to represent the consumers of hospital and nursing home services, and shall be persons familiar with the need for such services by eligible groups. Each appointed member shall hold office for a term of four years, except that any member appointed to fill a vacancy occurring prior to the expiration of the term for which his predecessor was appointed shall be appointed for the remainder of such term, and the terms of office of the members first taking office shall expire, as described by the Secretary at the time of appointment, two at the end of the first year, two at the end of the second year, two at the end of the third year, and two at the end of the fourth year after the date of appointment. An appointed member shall not be eligible to serve continuously for more than two terms but shall be eligible for reappointment if he has not served immediately preceding his reappointment. The Council is authorized to appoint such special advisory and technical committees as may be useful in carrying out its functions. Appointed Council members and members of advisory or technical committees, while serving on business of the Council, shall receive compensation at rates fixed by the Secretary, but not exceeding $50 per day, and shall also be entitled to receive an allowance for actual and necessary travel, and subsistence expenses while so serving away from their places of residence. The Council shall meet as frequently as the Secretary deems necessary, but not less than once each year. Upon request by three or more members it shall be the duty of the Secretary to call a meeting of the Council.

"Utilization of Private Nonprofit Organizations

"(h)(1) The Secretary may utilize, to the extent provided herein, the services of private nonprofit organizations exempt from Federal income taxation under section 501 of the Internal Revenue Code which (A) represent qualified providers of hospital or nursing home services, or (B) operate voluntary insurance plans under which agreements, similar to those provided for under subsection (d), are made with hospitals and nursing homes for defraying the cost of services. Such organizations shall be utilized by the Secretary to the extent that he can make satisfactory agreements with them and to the extent he determines that such utilization will contribute to the effective and economical administration of this section. Such agreements shall not delegate (A) his functions relating to determinations as to whether the costs of hospital and nursing home services furnished an individual may be paid for out of the Federal Old-Age and Survivors Insurance Trust Fund under this section and the amount of such payment, and (B) his functions relating to the making of regulations.

"(2) An agreement under paragraph (1) shall provide for payment from the Federal Old-Age and Survivors Insurance Trust Fund to the organization of the amounts paid out by such organization to hospitals and nursing homes under this section and of the cost of administration determined by the Secretary to be necessary and proper for carrying out such organization's functions under its agreement pursuant to this subsection. Such payments to any organization shall be made either in advance on the basis of estimates by the Secretary or as reimbursement, as may be agreed upon by the organization and the Secretary, and adjustments may be made in subsequent payments on account of overpayments or underpayments previously made to the organization under this subsection. Such payments shall be made by the Managing Trustee of the Trust Fund on certification by the Secretary and at such time or times as the Secretary may specify and shall be made prior to audit or settlement by the General Accounting Office.

"(3) An agreement under paragraph (1) with any organization may require any of its officers or employees certifying payments or disbursing funds pursuant to the agreement, or otherwise participating in its performance, to give surety bond to the United States in such amount as the Secretary may deem necessary, and may provide for the payment of the cost of such bond from the Federal Old-Age and Survivors Insurance Trust Fund.

"Certifying and Disbursing Officers

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

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

"Adjustments in Cash Benefits

"(j) For purposes of section 204, any payment under this section to any hospital or nursing home, with respect to hospital or nursing home services furnished an individual shall be regarded as a payment to such individual."

(b) The amendments made by subsection (a) shall be effective on the first day of the twelfth calendar month after the month in which this Act is enacted.

(c) Notwithstanding the provisions of section 226(a)(2) of the Social Security Act, as amended by this Act, and subsection (b) of this section, application filed under such section 226 which would otherwise be valid shall, subject to regulations of the Secretary, be considered valid even though filed more than three months prior to the effective date of this Act, but not if filed prior to the first day of the fourth calendar month after the month in which this Act is enacted.

PART 2—AMENDMENTS TO THE INTERNAL REVENUE CODE OF 1954

CHANGES IN TAX SCHEDULES

SELF-EMPLOYMENT INCOME TAX

SEC. 610. (a) Section 1401 of the Internal Revenue Code of 1954 (relating to rate of tax on self-employment income) is amended to read as follows:

"SEC. 1401. RATE OF TAX.

"In addition to other taxes, there shall be imposed for each taxable year, on the self-employment income of every individual, a tax as follows:

"(1) in the case of any taxable year beginning after December 31, 1958, and before January 1, 1960, the tax shall be equal to 3¾ percent of the amount of the self-employment income for such taxable year;

"(2) in the case of any taxable year beginning after December 31, 1959, and before January 1, 1963, the tax shall be equal to 4⅞ percent of the amount of the self-employment income for such taxable year;

"(3) in the case of any taxable year beginning after December 31, 1962, and before January 1, 1966, the tax shall be equal to 5⅝ percent of the amount of the self-employment income for such taxable year;

"(4) in the case of any taxable year beginning after December 31, 1965, and before January 1, 1969, the tax shall be equal to 6⅜ percent of the amount of the self-employment income for such taxable year; and

"(5) in the case of any taxable year beginning after December 31, 1968, the tax shall be equal to 7⅛ percent of the amount of the self-employment income for such taxable year."

TAX ON EMPLOYEES

(b) Section 3101 of such Code (relating to rate of tax on employees under the Federal Insurance Contributions Act) is amended to read as follows:

"SEC. 3101. RATE OF TAX.

"In addition to other taxes, there is hereby imposed on the income of every individual a tax equal to the following percentages of the wages (as defined in section 3121(a)) received by him with respect to employment (as defined in section 3121(b))—

"(1) with respect to wages received during the calendar year 1959, the rate shall be 2½ percent;

"(2) with respect to wages received during the calendar years 1960 to 1962, both inclusive, the rate shall be 3¼ percent;

"(3) with respect to wages received during the calendar years 1963 to 1965, both inclusive, the rate shall be 3¾ percent;

"(4) with respect to wages received during the calendar years 1966 to 1968, both inclusive, the rate shall be 4¼ percent; and

"(5) with respect to wages received after December 31, 1968, the rate shall be 4¾ percent."

TAX ON EMPLOYERS

(c) Section 3111 of such Code (relating to rate of tax on employers under the Federal Insurance Contributions Act) is amended to read as follows:

"SEC. 3111. RATE OF TAX.

"In addition to other taxes, there is hereby imposed on every employer an excise tax, with respect to having individuals in his employ, equal to the following percentages of the wages (as defined in section 3121(a)) paid by him with respect to employment (as defined in section 3121(b))—

"(1) with respect to wages paid during the calendar year 1959, the rate shall be 2½ percent;

"(2) with respect to wages paid during the calendar years 1960 to 1962, both inclusive, the rate shall be 3¼ percent;

"(3) with respect to wages paid during the calendar years 1963 to 1965, both inclusive, the rate shall be 3¾ percent;

"(4) with respect to wages paid during the calendar years 1966 to 1968, both inclusive, the rate shall be 4¼ percent; and

"(5) with respect to wages paid after December 31, 1968, the rate shall be 4¾ percent."

21. AMENDMENT 6-29-60-AA—INTRODUCED BY SENATOR HARTKE

STAFF ANALYSIS

Increases the social security earnings limitation from $1,200 to $3,600 per year.

Cost.—$2.56 billion per year, or 0.79 percent of payroll, on a level-premium basis.

Financing.—No tax increase provided in amendment for additional cost of the program.

VIEWS OF DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE ON AMENDMENT 6-29-60-AA

See joint report on page 480.

TEXT OF AMENDMENT 6-29-60-AA

Intended to be proposed by Mr. HARTKE to the bill (H.R. 12580), viz: On page 80, between lines 3 and 4, insert the following new section:

TO INCREASE THE EARNED INCOME LIMITATION

SEC. 211. (a)(1) Paragraphs (1) and (2) of subsection 203 of the Social Security Act are amended by striking out "$1,200" whenever it appears therein and inserting in lieu thereof "$3,600", and (2) such paragraphs and paragraph (1) of subsection (g) of such section are amended by striking out "$100 times" whenever it appears therein and inserting in lieu thereof "$300 times".

(b) The amendments made by subsection (a) shall be effective, in the case of any individual, with respect to taxable years of such individual ending after 1960.

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22. AMENDMENT 6-29-60—BB—INTRODUCED BY SENATOR HARTKE (IDENTICAL TO NO. 9, 6-27-60—B, INTRODUCED BY SENATOR KEATING)

STAFF ANALYSIS

Eliminates the social security earnings limitation (now $1,200 per year).

Cost.—$3.24 billion per year or 1 percent of payroll, on a level-premium basis.

Financing.—No tax increase provided for additional cost of the program.

VIEWS OF DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE ON AMENDMENT 6-29-60—BB

See joint report on page 480.

TEXT OF AMENDMENT 6-29-60—BB

Intended to be proposed by Mr. HARTKE to the bill (H.R. 12580), viz: On page 80, between lines 3 and 4, insert the following new section:

REMOVAL OF THE EARNED INCOME LIMITATION

SEC. 211. (a) Subsections (c), (e), (g), (j), and (k) of section 203 of the Social Security Act are repealed.

(b) Subsection (b) of such section 203 is amended by (1) striking out "Work or" in the heading, and (2) striking out paragraphs (1) and (2) thereof.

(c)(1) The first sentence of subsection (d) of such section 203 is amended by striking out "subsections (b) and (c)" and inserting in lieu thereof "subsection (b)".

(2) The second sentence of such subsection (d) is repealed.

(d) Subsection (f) of such section 203 is amended by (1) striking out "or (c)" each time it appears therein, and (2) by striking out "(other than an event specified in subsection ~~(b)~~ (1) or (c)(1))".

(e) Paragraph (1) of subsection (h) of such section 203 is amended by striking out ", (f), or (g)" and inserting in lieu thereof ", or (f)".

(f) Subsection (1) of such section 203 is amended by striking out "or (g)(1)(A)".

(g) Paragraph (1) of subsection (n) of section 202 of the Social Security Act is amended by striking out "Section 203 (b) and (c)" and inserting in lieu thereof "Section 203 (b)".

(h) Paragraph (7) of subsection (t) of section 202 of the Social Security Act is amended by striking out "Subsections (b) and (c)" and inserting in lieu thereof "Subsection (b)".

(i) Paragraph (3) of section 208(a) of the Social Security Act is hereby repealed.

(j) The amendments made by subsections (a) through (h) of this section shall apply only with respect to benefits payable for months beginning after the month in which this Act is enacted, and the amendment made by subsection (i) of this section shall become effective on the first day of the month after the month in which this Act is enacted.

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23. AMENDMENT 6-29-60-CC—INTRODUCED BY SENATOR HARTKE

STAFF ANALYSIS

Provides that a State agency, under the aid to the blind program, may disregard up to $1,000 per year of net earned income in determining need up to June 30, 1961. After this date the State agency must disregard this amount. Under present law the first $50 per month of earned income must be disregarded.

Cost.—Additional cost to Federal Government of $60,000 a year for individuals already on rolls. No estimate as to persons who would be made newly eligible.

Financing.—Federal share paid out of general revenue.

VIEWS OF DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE ON AMENDMENT 6-28-60-CC

July 11, 1960.

Hon. HARRY F. BYRD,
Chairman, Committee on Finance,
U.S. Senate, Washington, D.C.

DEAR MR. CHAIRMAN: This is in response to your request for a report on an amendment to H.R. 12580 (designated as 6-29-60-CC) intended to be proposed by Senator Hartke.

The significant effect of the additional exemption of income as provided in the amendment would be to make eligible many of the employed blind persons who do not now qualify for payments under the State programs established under title X of the Social Security Act. Also, some persons now receiving assistance whose earned income in excess of $50 has been considered under the present law would be eligible for increased payments.

The implications of this amendment for public assistance are serious. An essential characteristic of aid to the blind under title X, like the other public assistance programs, is that need be determined on an individual basis, taking income and resources into account. It is the contributory social insurance program that is designed to provide benefits based on previous earnings and without regard to the individual's need. This basic distinction between assistance and insurance is inherent to the Social Security Act. Special consideration has been given the needy blind by the Congress in requiring an exemption of $50 per month of earned income. The exemption of more income as proposed in the amendment is inconsistent with the nature of the public assistance program as supplementary to the individual's resources and income, could increase pressures for exemptions of income in the other public assistance titles, and would tend to give the program some of the qualities of a pension. The majority of blind persons have no earnings or hope of earnings. The enactment of the amendment may actually reduce the amount of assistance they are receiving. This could come about by States giving aid to additional people and increase aid to some people without increasing State funds appropriated.

We would therefore recommend that this amendment not be enacted by the Congress.

The Bureau of the Budget advises that it perceives no objection to the submission of this report to your committee.

Sincerely yours,

ROBERT A. FORSYTHE, *Assistant Secretary.*

TEXT OF AMENDMENT 6-29-60-CC

Intended to be proposed by Mr. HARTKE to the bill (H.R. 12580), viz: At the end of the bill add the following new section:

AID TO THE BLIND

SEC. 710. (a) Effective for the period beginning with the first day of the calendar quarter which begins after the date of enactment of this Act, and ending June 30, 1961, clause (8) of section 1002(a) of the Social Security Act is amended by adding before the semicolon at the end thereof the following: "and may disregard not to exceed the first $1,000 per annum of net earned income".

(b) Effective July 1, 1961, clause (8) of such section 1002(a) is amended to read as follows: "(8) provide that the State agency shall, in determining need, take into consideration any other income and resources of an individual claiming aid to the blind: except that, in making such determination, the State agency shall disregard the first $1,000 per annum of net earned income;".

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24. AMENDMENT 6-29-60-X—INTRODUCED BY SENATOR HARTKE IDENTICAL TO THE FOLLOWING AMENDMENTS: NO. 8, 6-27-60-A, INTRODUCED BY SENATOR KEATING; NO. 13, 6-27-60-I, INTRODUCED BY SENATOR SCHOEPPEL; AND NO. 16, 6-28-60-C, INTRODUCED BY SENATOR HUMPHREY)

STAFF ANALYSIS

Increases the social security earnings limitation from $1,200 to $1,800 per year.

Cost.—$616 million per year, or 0.19 percent of payroll, on a level premium basis.

Financing.—No tax increase provided to cover added cost to program.

VIEWS OF DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE ON AMENDMENT 6-29-60-X

See joint report on page 480.

TEXT OF AMENDMENT 6-29-60-X

Intended to be proposed by Mr. HARTKE to the bill (H.R. 12580), viz: On page 80, between lines 3 and 4, insert the following new section:

TO INCREASE THE EARNED INCOME LIMITATION

SEC. 211. (a)(1) Paragraphs (1) and (2) of subsection 203 of the Social Security Act are amended by striking out "$1,200" whenever it appears therein and inserting in lieu thereof "$1,800", and (2) such paragraphs and paragraph (1) of subsection (g) of such section are amended by striking out "$100 times" whenever it appears therein and inserting in lieu thereof "$150 times".

(b) The amendments made by subsection (a) shall be effective, in the case of any individual, with respect to taxable years of such individual ending after 1960.

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25. AMENDMENT 6-29-60-Y—INTRODUCED BY SENATOR HARTKE (IDENTICAL WITH AMENDMENT 10, 6-27-60-E, INTRODUCED BY SENATOR JAVITS)

STAFF ANALYSIS

Increases the social security earnings limitation from $1,2000 to $2,400 per year.

Cost.—$1.33 million per year, or 0.41 percent of payroll, on a level premium basis.

Financing.—No tax increase provided for additional cost of the program.

VIEWS OF DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE ON AMENDMENT 6-29-60-Y

See joint report on page 480.

TEXT OF AMENDMENT 6-29-60-Y

Intended to be proposed by Mr. HARTKE to the bill (H.R. 12580), viz: On page 80, between lines 3 and 4, insert the following new sections:

TO INCREASE THE EARNED INCOME LIMITATION

SEC. 211. (a)(1) Paragraphs (1) and (2) of subsection 203 of the Social Security Act are amended by striking out "$1,200" whenever it appears therein and inserting in lieu thereof "$2,400", and (2) such paragraphs and paragraph (1) of subsection (g) of such section are amended by striking out "$100 times" whenever it appears therein and inserting in lieu thereof "$200 times".

(b) The amendments made by subsection (a) shall be effective, in the case of any individual, with respect to taxable years of such individual ending after 1960.

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26. AMENDMENT 6-29-60-Z—INTRODUCED BY SENATOR HARTKE

STAFF ANALYSIS

Increases the social security earnings limitation from $1,200 to $3,000 per year.

Cost.—$2.041 million per year, or 0.03 percent of payroll, on a level premium basis.

Financing.—No tax increase provided in amendment for additional cost of the program.

VIEWS OF DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE ON AMENDMENT 6-29-60-Z

See joint report on page 480.

TEXT OF AMENDMENT 6-29-60-Z

Intended to be proposed by Mr. HARTKE to the bill (H.R. 12580), viz: On page 80, between lines 3 and 4, insert the following new sections:

TO INCREASE THE EARNED INCOME LIMITATION

SEC. 211. (a)(1) Paragraphs (1) and (2) of subsection 203 of the Social Security Act are amended by striking out "$1,200" whenever it appears therein and inserting in lieu thereof "$3,000", and (2) such paragraphs and paragraph (1) of subsection (g) of such section are amended by striking out "$100 times" whenever it appears therein and inserting in lieu thereof "$250 times."

(b) The amendments made by subsection (a) shall be effective, in the case of any individual, with respect to taxable years of such individual ending after 1960.

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27. AMENDMENT 6-30-60-B—INTRODUCED BY SENATOR ANDERSON FOR HIMSELF AND SENATORS HUMPHREY AND McCARTHY

STAFF ANALYSIS

Eligibility.—Individuals age 68 and over who are eligible to receive, but not necessarily receiving, social security old-age and survivors insurance benefits would be entitled to health benefits.

Benefits.—

1. Hospital services, 365 days with an initial deductible amount of $75, repeated after 24 days.
2. Skilled recuperative nursing home services, 180 days.
3. Visiting nurse services, 365 days.

Cost.—$1.55 billion per year, or 0.48 percent of payroll, on a level premium basis; $630 million per year, or 0.30 percent of payroll on an early year basis.

Financing.—Benefits would be payable out of a medical insurance account in the old-age and survivors insurance trust fund, established for this purpose, to be financed by an increase in the contribution rate on both employer and employee of one-fourth of 1 percent, and on the self-employed of three-eighths of 1 percent, beginning in 1961.

NOTE.—The revenues derived from the tax increases provided in the amendment would amount to 0.50 percent of payroll on a level premium basis; thus, the amendment is fully financed.

VIEWS OF DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE ON AMENDMENT 6-30-60-B INCLUDED IN FOLLOWING JOINT REPORT

The Department of Health, Education, and Welfare would recommend against adoption of each of the following four amendments: Amendment No. 1, 6-24-60-C (Mr. McNamara); amendment No. 11, 6-27-60-F (Mr. Morse); amendment No. 20, 6-28-60-G (Mr. Humphrey); and amendment No. 27, 6-30-60-B (Mr. Anderson). Each of these bills proposes to amend title VI of H.R. 12580 to add health insurance benefits to the existing Federal old-age, survivors, and disability insurance system. The reasons for this recommendation are as follows:

1. The proposed extension of the existing old-age, survivors, and disability insurance system to encompass health insurance would make such insurance compulsory and would not be pinpointed to the need for aid in meeting the cost of medical services. Under this approach, the individual would have no opportunity to determine for himself the particular pattern for meeting the threat of large medical expenses that best suits his own needs and desires. In addition, by compulsorily extending health benefits to aged persons eligible for old-age, survivors, and disability insurance, many persons would be included who have the resources and the opportunity to obtain protection against long-term or other expensive illnesses without Government help.

2. These amendments would establish an exclusively Federal program. This administration has consistently endeavored, however, to strengthen our system of government by encouraging State and local governments to assume responsibility for the many public needs which can be met through Federal-State partnership and by supporting programs to stimulate greater State and local effort in areas of critical national concern. Health care for the aged is an area of activity admirably suited to such a sharing of responsibility. In addition to bolstering the underlying cooperative foundation of our Federal system, with governmental powers divided between State and Nation, Federal-State partnership places the control over daily program operations at the level of government closest to the persons affected by the program. Thus, an individual's needs may be more immediately and effectively reflected in the current operations and the development of the program.

3. The approach proposed in the amendments would constitute a serious threat to the orderly development of present retirement, survivorship, and disability benefit features of the social security system.

The payroll tax for old-age, survivors, and disability insurance is already scheduled ultimately to be 4½ percent each on employees and employers and 6¾ percent on the self-employed. Further liberalization in retirement, survivorship, and disability benefits may call for additional revenues, which can only come from increases in the payroll tax or increases in the earnings base, or both. If health insurance as envisaged in these amendments were to be added to the system, the payroll tax would need to be increased by a total of one-half to 1 percent. As in the case of cash benefits, there would undoubtedly be insistent demands for improving the medical benefits beyond those which can be financed by the tax increase for medical benefit purposes. Increases in both health and cash benefits would place the retirement, survivorship, and disability portions of the system in competition with the health benefits, for available funds, since the revenue possibilities from a payroll tax are not limitless.

It is therefore far better to reserve the payroll tax for the retirement, survivorship, and disability features of the social security system so that the revenue source is not overburdened. Whatever the Government needs to do in the area of health care for the aged should be done by the appropriation of general revenues. Such appropriation would provide for a more equitable distribution of the fiscal load than would a payroll tax on earnings of $4,800 or less.

TEXT OF AMENDMENT 6-30-60-B

Intended to be proposed by Mr. ANDERSON (for himself, Mr. HUMPHREY, and Mr. MCCARTHY) to the bill (H.R. 12580), viz: On page 172, after line 18, insert the following:

SEC. 605. (a) Title II of the Social Security Act is amended by adding after section 225 the following new section:

"MEDICAL INSURANCE BENEFITS

"SEC. 226. (a) (1) Every individual who—

"(A) (i) has attained the age of 68, and

"(B) is entitled, or is deemed entitled, to monthly benefits under section 202, and

"(C) has filed an application under this subsection,

shall be eligible to receive medical insurance benefits during his benefit period (as defined in subsection (b)(3)). Any individual who meets the conditions of subparagraph (A) and (B) shall be deemed to have met the condition of subparagraph (C) upon the filing of an application in accordance with the provisions of subparagraph (A) of subsection (b)(1).

"(2) For purposes of this subsection—

"(A) an individual is deemed entitled to monthly benefits under section 202 for a month if in such month such individual is not entitled to monthly benefits under such section, but would be entitled to such benefits (i) had he filed application therefore in such month, and (ii) for purposes of subsections (b) and (c) of such section 202, had such individual's spouse, if such spouse is not entitled to monthly benefits under subsection (a) of such section for such month, been entitled to benefits under such subsection for such month upon the filing of an application in such month;

"(B) an individual shall be deemed entitled to monthly benefits under section 202 for the month in which he died if he would have been entitled, or deemed to be entitled, to such monthly benefits for such month had he not died in such month;

"(3) Medical insurance benefits shall mean inpatient hospital services, skilled nursing home recuperative services, and visiting nurse services (as defined in subsection (d)).

"(4) No application filed pursuant to subparagraph (C) of paragraph (1) prior to the third month preceding the month in which the applicant attains the age of 68, shall be accepted as an application for purposes of such paragraph.

"PAYMENT OF MEDICAL INSURANCE BENEFITS

"(b)(1) Payment of medical insurance benefits which an individual is eligible to receive during his benefit period shall be made in accordance with the provisions of this section, but only if—

"(A) application is filed for such payment in such form and in such manner and by such person as the Secretary may by regulation prescribe, and such application is filed no earlier than the first day of the third month preceding the month in which his benefit period begins or no later than the last day of the twelfth month succeeding the month in which his benefit period ends, and

"(B) the inpatient hospital services, skilled nursing home recuperative services, or visiting nurse services, as the case may be, are furnished after referral by a physician, and such physician certifies in writing that such services are or were required for his medical treatment, except that such referral shall not be required for inpatient hospital services in case of an emergency which makes such referral impracticable; periodic recertification that such services which extend over a period of time are required shall be a condition of the continuing payment of such benefits.

"(2) Payment of medical insurance benefits which an individual is eligible to receive may be made for the following services if furnished in the United States—

"(A) inpatient hospital services furnished to such individual during a benefit period on a total of not more than 365 days; provided that the payments made with respect to any benefit period of an individual shall be reduced (but not below zero) by an initial deduction equal to $75. In the case of continuous hospitalization in excess of 24 days in a benefit period the payments shall be reduced by a further deduction equal to $75,

"(B) skilled nursing home recuperative services furnished to such individual during a benefit period on a total of not more than 180 days; except that this subparagraph shall not apply unless such services are furnished to such individual upon transfer from a hospital to a skilled nursing facility, and

"(C) visiting nurse services furnished to such individual during a benefit period on a total of not more than 365 visits.

"(3) For purposes of this section—

"(A) a benefit period with respect to an individual shall mean a period (i) beginning with the first day in which such individual both is furnished inpatient hospital services, skilled nursing home recuperative services, or visiting nurse services and is eligible to receive medical insurance benefits and (ii) ending with the three hundred and sixty-fourth day following such first day; except that if any of such services are being furnished such individual in a continuous period in which occurs such three hundred and sixty-fourth day and the succeeding day, then, for purposes of determining the beginning of a benefit period, such succeeding day shall be the first day in which such services are furnished,

"(B) a continuous period during which the services referred to in subparagraph (A) are being furnished to an individual for purposes of such subparagraph shall mean—

"(i) with respect to inpatient hospital services or skilled nursing home recuperative services, a consecutive number of days in which such services are furnished; and

"(ii) with respect to visiting nurse services, one or more visits in which such services are furnished, but only if the number of days elapsing between two successive visits in which such services are furnished does not exceed thirty.

"EVIDENCE AND DETERMINATIONS OF ELIGIBILITY

"(c) The provisions of section 205 relating to the making and review of determinations shall be applicable to determinations as to (i) whether an individual is eligible to receive medical insurance benefits, (ii) the number of days of services or visits, as specified in subsection (b)(2), for which an individual is eligible by reason of the provisions of this section, and (iii) whether, or the extent to which, the cost of the services furnished to an individual may be paid for out of the Medical Insurance Account of the Federal Old-Age and Survivors Insurance Trust Fund, and the amount of such payment.

"DESCRIPTION OF MEDICAL INSURANCE BENEFITS

"(d) For the purpose of this section—

"(1) The term 'inpatient hospital services' means the following items furnished to an inpatient by a hospital: (A) bed and board in a hospital, in semiprivate accommodations unless they are unavailable, or unless other accommodations are required for medical reasons; and (B) such medical, nursing, interns', laboratory and X-ray, ambulance, and other services, and such drugs, supplies, and appliances required for his care and treatment in the hospital or provided in connection with surgery which in the opinion of medical authority is medically necessary (whether furnished directly by the hospital or by arrangement through other persons);

"(2) The term 'skilled nursing home recuperative services' means the following items furnished to an inpatient in a skilled nursing facility: (A) skilled nursing care provided by a registered professional nurse or a licensed practical nurse which is prescribed by a physician as required for the recuperative care of the patient; (B) medical and other services required for his treatment in the nursing facility; and (C) bed and board in connection with the furnishing of such skilled nursing care;

"(3) The term 'visiting nurse services' means professional nursing care in a place of residence maintained as an individual's home, prescribed by a physician and provided through a visiting nursing agency;

"(4) The term 'hospital' means an institution which (A) is operated in accordance with the laws of the jurisdiction in which it is located pertaining to hospitals and in accordance with standards established by the authorities responsible for such standards in such jurisdiction; (B) is primarily engaged in providing diagnostic and therapeutic facilities for surgical and medical diagnosis,

treatment, and care of injured and sick persons by or under the supervision of staff physicians or surgeons; (C) maintains adequate medical records; and (D) continuously provides twenty-four-hour nursing service by registered graduate nurses. The term 'hospital' shall not include a tuberculosis or mental hospital;

"(5) The term 'skilled nursing home' means a facility which (A) is licensed to provide skilled nursing services by the State in which it is located; (B) has beds for the care of patients who require continuing planned medical and nursing care; (C) is under the continuous supervision of a registered nurse or physician; and (D) is operated in connection with a hospital or has medical policies established by one or more physicians (who are responsible for the execution of such policies) to govern the skilled nursing care and related medical care and other services which it provides;

"(6) The term 'visiting nurse agency' means a public or other nonprofit agency operated in accordance with medical policies which are established by one or more physicians (who are responsible for supervising the execution of such policies) and which govern the visiting nurse services it provides; and

"(7) The term 'physician' means an individual (including a physician within the meaning of section 1101(a)(7)) licensed to practice surgery or medicine by the State in which he provides surgical or medical services.

"AGREEMENTS WITH PROVIDERS OF SERVICES

"(e)(1) The Secretary of Health, Education, and Welfare shall, at the request of any hospital, skilled nursing facility, or visiting nurse agency (hereinafter referred to as a provider of services), enter into an agreement with such hospital, facility, or agency for the payment of costs of services furnished to individuals eligible to receive medical insurance benefits. Each such agreement shall contain such provision, not inconsistent with the provisions of this section, as may be mutually agreed to by the Secretary and such provider of services.

"(2) Any agreement entered into pursuant to paragraph (1) shall provide that—

"(A) the provider of services will not charge any individual eligible to receive medical insurance benefits or any other person for services which are furnished such individual and for which payment may be made under subsection (b), and that if any charge is made, necessary action will be taken to cancel such charge and refund any payment made by such other individual or any other person for such services;

"(B) the Secretary will pay to any provider of services the reasonable cost of services specified in subparagraph (A), but only if the provider of services furnishes such information with respect to such costs on such forms as the Secretary may by regulation require; the Secretary shall determine such reasonable costs and in making such determinations is authorized to use such method or methods of estimating as he may by regulation prescribe;

"(C) no payment will be made to any provider of services for any inpatient hospital service which such provider is obligated by a law of, or a contract with, the United States to render such service at public expense;

"(D) where a provider of services furnishes to an individual eligible to receive medical insurance benefits at his request services which are described in subsection (d), but are in excess of the service usually encompassed by the service so described, the Secretary shall pay to such provider of services only the equivalent of the reasonable cost of the service so described and that the provider of services may charge such individual for any additional cost of the service furnished at such request; and

"(E) such agreement may be terminated by (i) the provider of services at such time and upon such notice to the Secretary and to the public as the Secretary may specify by regulations and (ii) the Secretary at such time and upon such notice to the provider of services as may be specified by regulations, but only after the Secretary has determined that such provider of services is not complying substantially with the provisions of such agreement or that such provider no longer substantially meets the provisions of subsection (d) and has notified such provider of such determination.

"(3) Nothing in this section shall—

"(A) preclude the Secretary from making payment for the reasonable cost of services furnished to an individual eligible to receive such services by any hospital which is not a party to an agreement under this subsection

but only if (i) such services were emergency services and (ii) the Secretary would be authorized to pay for such services had the Secretary and such hospital entered into an agreement under this section;

"(B) preclude providers of services to be represented by an individual, association, or organization authorized by such provider of services to act on its behalf; or

"(C) be construed to give the Secretary supervision or control over the practice of medicine, the manner in which medical services are provided, or over the administration or operation, the selection, tenure, or compensation of personnel of any hospital, skilled nursing home, or visiting nurse agency which has entered into an agreement under this section.

"(4) Where an agreement under this section between a provider of services and the Secretary has been terminated, the Secretary may, notwithstanding any other provision of this section, enter into another agreement under this section with such provider but only if such provider conforms to the standards set forth in subsection (c) and the Secretary determine that another agreement with such provider will effectuate the purposes of this section.

"(5) The Secretary shall from time to time determine the amount to be paid to each provider of services under an agreement with respect to the services furnished and shall certify such amounts to the Secretary of the Treasury, except that such amount may be reduced or increased, as the case may be, by any sum by which the Secretary finds that the amount paid to such provider of services for any prior period was greater or less than the amount which should have been paid to it for such period. The Secretary of the Treasury, prior to audit or settlement by the General Accounting Office, shall make payment from the Medical Insurance Account, at the time or times fixed by the Secretary, in accordance with such certification.

"FREE CHOICE BY PATIENT

"(f) Any individual eligible to receive medical insurance benefits under this section may obtain inpatient hospital services, skilled nursing home services, or visiting nurse services, from any provider of services which has entered into an agreement with the Secretary and which admits such individual or undertakes to provide him services.

"MEDICAL INSURANCE BENEFITS ADVISORY COUNCIL

"(g) For the purpose of advising and assisting the Secretary in the formulation of policy and the promulgation of regulations in connection with the administration of this section, there is hereby created a Medical Insurance Benefits Advisory Council which shall consist of the Commissioner of Social Security, who shall serve as chairman ex officio, and twelve members to be appointed by the Secretary. Not less than four of the appointed members shall be representatives of the general public, and the remainder of the appointed members shall be persons who are outstanding in the fields pertaining to hospitals and health activities. Each appointed member shall hold office for a term of four years, except that any member appointed to fill a vacancy occurring prior to the expiration of the term for which his predecessor was appointed shall be appointed for the remainder of such term, and the terms of office of the member first taking office shall expire, as described by the Secretary at the time of appointment, three at the end of the first year, three at the end of the second year, three at the end of the third year, and three at the end of the fourth year after the date of appointment. An appointed member shall not be eligible to serve continuously for more than two terms but shall be eligible for reappointment if he has not served immediately preceding his reappointment. The advisory council is authorized to appoint such special advisory and technical committees as may be useful in carrying out its functions. Appointed members of the advisory council and members of its advisory or technical committees, while serving on business of the advisory council, shall receive compensation at rates fixed by the Secretary, and shall also be entitled to receive an allowance for actual and necessary travel and for subsistence expenses while so serving away from their places of residence. The advisory council shall meet as frequently as the Secretary deems necessary, but not less than once each year. Upon request of four or more members, it shall be the duty of the Secretary to call a meeting of the advisory council.

"RULEMAKING POWERS OF THE SECRETARY

"(h) The Secretary shall have the power and authority to make rules and regulations and to establish procedures, not inconsistent with the provisions of this section, which are necessary or appropriate to carry out such provisions, and shall adopt reasonable rules and regulations to regulate and provide for the nature and extent of the proofs and evidence and the method of taking and furnishing the same in order to establish the right of individuals to medical insurance benefits hereunder.

"CERTIFYING AND DISBURSING OFFICERS

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

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

MEDICAL INSURANCE ACCOUNT

(b)(1) Section 201 of the Social Security Act is amended by redesignating subsections (b), (c), (d), (e), (f), (g), and (h) as (c), (d), (e), (f), (g), (i), and (j), respectively.

(2) Section 201 of such Act is further amended by adding after subsection (a) the following new subsection:

"(b) There is hereby created in the Federal Old-Age and Survivors Insurance Trust Fund an account to be known as the Medical Insurance Account. For the fiscal year ending June 30, 1961, and for each fiscal year thereafter, out of moneys appropriated to the Trust Fund pursuant to subsection (a), there shall be credited from time to time to the Medical Insurance Account in such Trust Fund, amounts equal to the sum of—

"(1) the amounts determined by multiplying one-half of 1 per centum by the amounts of wages (as certified to the Secretary of the Treasury for purposes of paragraph (3) of subsection (a)) paid after December 31, 1960, and

"(2) the amounts determined by multiplying three-eighths of 1 per centum by the amounts of self-employment income (as certified to the Secretary of the Treasury for purposes of paragraph (4) of subsection (a)) for any taxable year beginning after December 31, 1960."

(3) Subsection (c) (redesignated as (d) by paragraph (1) of this subsection) of section 201 of such Act is amended by inserting after "Trust Funds" in paragraph (2) the following: "(including the operation and status of the Medical Insurance Account in the Federal Old-Age and Survivors Insurance Trust Fund)"; by inserting "or the Medical Insurance Account" after "Trust Funds" each time it appears in paragraph (3); by inserting "or such account, as the case may be", after "Trust Fund" in paragraph (3); and by inserting "and the Medical Insurance Account" after "Trust Funds" each time it appears in the sentence immediately preceding the last sentence of such subsection.

(4) Section 201 of such Act is further amended by adding after subsection (f) (redesignated as (g) by paragraph (1) of this subsection) the following new subsection:

"(h)(1) After the close of each fiscal year, the Secretary of the Treasury shall determine the average of the amounts in the Medical Insurance Account during such year for purposes of determining the amount of interest that should be credited to such Account from the interest that was credited to the Federal Old-Age and Survivors Insurance Trust Fund during such fiscal year. There shall be credited to the Account from the amounts appropriated to the Federal Old-Age and Survivors Insurance Trust Fund an amount for interest which is in the same ratio to the interest credited to the Federal Old-Age and Survivors Insurance Trust Fund for such fiscal year as the average of the amounts in the Medical Insurance Account during such fiscal year is to the average of the amounts in the Federal Old-Age and Survivors Insurance Trust Fund during such fiscal year.

"(2) The proper share of the proceeds from the sale or redemption of any obligations in the Federal Old-Age and Survivors Insurance Trust Fund which are credited to such Trust Fund shall be credited to the Medical Insurance Account."

(5) Subsection (g) (redesignated as (i) by paragraph (1) of this subsection) of section 201 of such Act is amended by striking out the last two sentences of paragraph (1) and inserting in lieu thereof the following: "After the close of each fiscal year, the Secretary of Health, Education, and Welfare shall analyze the costs of administration of this title incurred during such fiscal year in order to determine the portion of such costs which should be borne by each of the Trust Funds (including the cost which should be borne by the Medical Insurance Account) and shall certify to the Managing Trustee the amount, if any, which should be transferred from one to the other of such Trust Funds (including the crediting of funds in the Federal Old-Age and Survivors Insurance Trust Fund to the Medical Insurance Fund) in order to insure that each of the Trust Funds (including such Account) has borne its proper share of the costs of administration of this title incurred during such fiscal year. The Managing Trustee is authorized and directed to transfer any such amount from one to the other of such Trust Funds in accordance with any certification so made."

(6) Subsection (g) (redesignated as (i) by paragraph (1) of this subsection) of section 201 of such Act is further amended by inserting immediately preceding the period at the end of paragraph (2) the following: "; payment made from the Federal Old-Age and Survivors Insurance Trust Fund shall include moneys credited to the Medical Insurance Account in such amounts as the Managing Trustee determines as necessary for such Account to bear a proper share of such payments."

(7) Subsection (h) (redesignated as (j) by paragraph (1) of this subsection) of section 201 of such Act is amended by inserting immediately preceding the period at the end thereof the following: "and in the case of payments required to be made under section 226, such payments shall be made only from the funds credited to the Medical Insurance Account."

EFFECTIVE DATE

(c) Subsection (a) of this section shall become effective on July 1, 1961, on the basis of applications filed on or after April 1, 1961, under section 226 of the Social Security Act, as added to such Act by such subsection (a); any such application filed prior to July 1, 1961, shall be deemed filed on July 1, 1961. Payments under such section 226 shall be made only with respect to hospital services, skilled nursing home recuperative services, visiting nurse services furnished on or after July 1, 1961. The terms used in this section shall have the meaning assigned to them in title II of the Social Security Act.

AMENDMENTS TO THE INTERNAL REVENUE CODE OF 1954

CHANGES IN TAX SCHEDULES

SELF-EMPLOYMENT INCOME TAX

SEC. 606. (a) Section 1401 of the Internal Revenue Code of 1954 (relating to rate of tax on self-employment income) is amended to read as follows:

"SEC. 1401. RATE OF TAX.

"In addition to other taxes, there shall be imposed for each taxable year, on the self-employment income of every individual, a tax as follows—

"(1) in the case of any taxable year beginning after December 31, 1959, and before January 1, 1961, the tax shall be equal to 4½ percent of the amount of the self-employment income for such taxable year;

"(2) in the case of any taxable year beginning after December 31, 1960, and before January 1, 1963, the tax shall be equal to 4⅞ percent of the amount of the self-employment income for such taxable year;

"(3) in the case of any taxable year beginning after December 31, 1962, and before January 1, 1966, the tax shall be equal to 5⅝ percent of the amount of the self-employment income for such taxable year;

"(4) in the case of any taxable year beginning after December 31, 1965, and before January 1, 1969 the tax shall be equal to 6⅜ percent of the amount of the self-employment income for such taxable year; and

"(5) in the case of any taxable year beginning after December 31, 1968, the tax shall be equal to 7⅛ percent of the amount of the self-employment income for such taxable year."

TAX ON EMPLOYEES

(b) Section 3101 of such Code (relating to rate of tax on employees under the Federal Insurance Contributions Act) is amended to read as follows:

"SEC. 3101. RATE OF TAX.

"In addition to other taxes, there is hereby imposed on the income of every individual a tax equal to the following percentages of the wages (as defined in section 3121(a)) received by him with respect to employment (as defined in section 3121(b))—

"(1) with respect to wages received during the calendar year 1960, the rate shall be 3 percent;

"(2) with respect to wages received during the calendar years 1961 and 1962, the rate shall be 3¼ percent;

"(3) with respect to wages received during the calendar years 1963 to 1965, both inclusive, the rate shall be 3¾ percent;

"(4) with respect to wages received during the calendar years 1966 to 1968, both inclusive, the rate shall be 4¼ percent; and

"(5) with respect to wages received after December 31, 1968, the rate shall be 4¾ percent."

TAX ON EMPLOYERS

(c) Section 3111 of such Code (relating to rate of tax on employers under the Federal Insurance Contributions Act) is amended to read as follows:

"SEC. 3111. RATE OF TAX.

"In addition to other taxes, there is hereby imposed on every employer an excise tax, with respect to having individuals in his employ, equal to the following percentages of the wages (as defined in section 3121(a)) paid by him with respect to employment (as defined in section 3121 (b))—

"(1) with respect to wages paid during the calendar year 1960 the rate shall be 3 percent;

"(2) with respect to wages paid during the calendar years 1961 and 1962, the rate shall be 3¼ percent;

"(3) with respect to wages paid during the calendar years 1963 to 1965, both inclusive, the rate shall be 3¾ percent;

"(4) with respect to wages paid during the calendar years 1966 to 1968, both inclusive, the rate shall be 4¼ percent; and

"(5) with respect to wages paid after December 31, 1968 the rate shall be 4¾ percent."

STUDY OF HEALTH NEEDS OF INDIVIDUALS

SEC. 607. Section 702 of the Social Security Act is amended by inserting "(a)" after "702"; by adding at the end thereof the following new subsection:

"(b) The Secretary shall conduct a continuing study and investigation of the health needs of individuals who have reached retirement age, and the means by which such needs may most effectively and efficiently be met. In connection with such study and investigation, the Secretary shall institute and conduct appropriate demonstration programs relating to the health needs of such individuals and the manner and means by which such needs may be fulfilled. The Secretary is authorized to provide for the carrying on of such research studies pertaining to health care and the administration of such care as may be recommended by the advisory council designated pursuant to section 226(g). Such research studies may be carried on directly by the Department of Health, Education, and Welfare, by others under contracts negotiated for, or grants made by the Secretary for, such purpose."

The CHAIRMAN. The committee will be adjourned.

(Whereupon, at 4:35 p.m., the committee adjourned, subject to the call of the Chair.)

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