SOCIAL SECURITY; MEDICAL CARE FOR THE AGED AMENDMENTS

HEARINGS

BEFORE THE

COMMITTEE ON FINANCE

UNITED STATES SENATE

EIGHTY-EIGHTH CONGRESS

SECOND SESSION

ON

H.R. 11865

AN ACT TO INCREASE BENEFITS UNDER THE FEDERAL OLD-AGE, SURVIVORS, AND DISABILITY INSURANCE SYSTEM, TO PROVIDE CHILD'S INSURANCE BENEFITS BEYOND AGE 18 WHILE IN SCHOOL, TO PROVIDE WIDOW'S BENEFITS AT AGE 60 ON A REDUCED BASIS, TO PROVIDE BENEFITS FOR CERTAIN INDIVIDUALS NOT OTHERWISE ELIGIBLE AT AGE 72, TO IMPROVE THE ACTUARIAL STATUS OF THE TRUST FUNDS, TO EXTEND COVERAGE, AND FOR OTHER PURPOSES

AUGUST 6, 7, 10, 11, 12, 13, AND 14, 1964

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ERRATUM SHEET

HEARINGS HELD BY SENATE COMMITTEE ON FINANCE ON SOCIAL SECURITY AMENDMENTS OF 1964

August 6, 7, 10, 11, 12, 13 and 14, 1964

On page 74, line 5, part of Secretary Celebrezze's reply to the chairman was omitted in the printed hearings. The first sentence of his reply should read as follows:

Secretary CELEBREZZE. I favor both, *providing we can bring both within the reasonable limitations of the tax structure.*

On page 74, line 10, another part of Secretary Celebrezze's reply to the chairman was omitted in the printed hearings. The second sentence in the paragraph should read as follows:

Secretary CELEBREZZE. * * * I favor both the increase and the King-Anderson approach, *providing we can keep it, provided this committee can keep it within a reasonable tax base.*

On page 87, line 35, Secretary Celebrezze's reply is incorrectly recorded in the printed record of the hearings. The verbatim reply is shown below:

Secretary CELEBREZZE. In my opinion, if you passed the Mills bill and *still stayed within the barrier of not breaking* the 10 percent, then you will *never get* medical care for the aged and stay within the 10 percent.

On page 98, after line 42, the following replies to Senator Carlson's question were omitted in the printed record:

"Mr. BALL. *Yes, about another million and a half.*"
"Mr. MYERS. *No, a million and a half total.*"

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SOCIAL SECURITY; MEDICAL CARE FOR THE AGED AMENDMENTS

THURSDAY, AUGUST 6, 1964

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

The committee met, pursuant to notice, at 10:18 a.m., in room 2221, New Senate Office Building, Senator Harry F. Byrd (chairman) presiding.

Present: Senators Byrd, Long, Smathers, Douglas, McCarthy, Hartke, Williams, Carlson, Bennett, Curtis, Morton, Dirksen, and Ribicoff.

Also present: Elizabeth B. Springer, chief clerk; and Fred Arner and Helen Livingston, of the Education and Public Welfare Division, Legislative Reference Service, Library of Congress.

The CHAIRMAN. The committee will come to order.

The hearing today is on the social security bill, H.R. 11865, and amendments proposed thereto relating to medical care for the aged. Two amendments on this subject have been introduced thus far. They are amendment 1163, by Senator Javits, which is a modified version of his bill, S. 2431, and amendment 1178, by Senator Gore, which is identical to the so-called King-Anderson proposal, S. 880, except as to rate schedules and maximum taxable wage base. I place in the record a copy of the bill, the amendments, and a committee print comparing the provisions in amendments 1163 and 1178. If additional medical care for the aged amendments are introduced in the Senate before the completion of these hearings, copies thereof will be inserted in the record also.

(The bill, amendments, and comparison referred to follow:)

[H.R. 11865, 88th Cong., 2d sess.]

AN ACT To increase benefits under the Federal old-age, survivors, and disability insurance system, to provide child's insurance benefits beyond age 18 while in school, to provide widow's benefits at age 60 on a reduced basis, to provide benefits for certain individuals not otherwise eligible at age 72, to improve the actuarial status of the trust funds, to extend coverage, 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 1964".

FIVE PER CENTUM INCREASE IN OLD-AGE, SURVIVORS, AND DISABILITY INSURANCE BENEFITS

SEC. 2. (a) Section 215(a) of the Social Security Act is amended by striking out the table and inserting in lieu thereof the following:

"TABLE FOR DETERMINING PRIMARY INSURANCE AMOUNT AND MAXIMUM FAMILY BENEFITS

"I		II	III		IV	V
(Primary insurance benefit under 1939 Act, as modified)		(Primary insurance amount under 1958 Act, as modified)	(Average monthly wage)		(Primary insurance amount)	(Maximum family benefits)
If an individual's primary insurance benefit (as determined under subsec. (d)) is—		Or his primary insurance amount (as determined under subsec. (c)) is—	Or his average monthly wage (as determined under subsec. (b)) is—		The amount referred to in the preceding paragraphs of this subsection shall be—	And the maximum amount of benefits payable (as provided in sec. 203(a)) on the basis of his wages and self-employment income shall be—
At least—	But not more than—		At least—	But not more than—		
----------	$13.48	$40	----------	$67	$42.00	$63.00
$13.49	14.00	41	$68	69	43.10	64.70
14.01	14.48	42	70	70	44.10	66.20
14.49	15.00	43	71	72	45.20	67.80
15.01	15.60	44	73	74	46.20	69.30
15.61	16.20	45	75	76	47.30	71.00
16.21	16.84	46	77	78	48.30	72.50
16.85	17.60	47	79	80	49.40	74.10
17.61	18.40	48	81	81	50.40	75.60
18.41	19.24	49	82	83	51.50	77.30
19.25	20.00	50	84	85	52.50	78.80
20.01	20.64	51	86	87	53.60	80.40
20.65	21.28	52	88	89	54.60	81.90
21.29	21.88	53	90	90	55.70	83.60
21.89	22.28	54	91	92	56.70	85.10
22.29	22.68	55	93	94	57.80	86.70
22.69	23.08	56	95	96	58.80	88.20
23.09	23.44	57	97	97	59.90	89.90
23.45	23.76	58	98	99	60.90	91.40
23.77	24.20	59	100	101	62.00	93.00
24.21	24.60	60	102	102	63.00	94.50
24.61	25.00	61	103	104	64.10	96.20
25.01	25.48	62	105	106	65.10	97.70
25.49	25.92	63	107	107	66.20	99.30
25.93	26.40	64	108	109	67.20	100.80
26.41	26.94	65	110	113	68.30	102.50
26.95	27.46	66	114	118	69.30	104.00
27.47	28.00	67	119	122	70.40	105.60
28.01	28.68	68	123	127	71.40	107.10
28.69	29.25	69	128	132	72.50	108.80
29.26	29.68	70	133	136	73.50	110.30
29.69	30.36	71	137	141	74.60	112.80
30.37	30.92	72	142	146	75.60	116.80
30.93	31.36	73	147	150	76.70	120.00
31.37	32.00	74	151	155	77.70	124.00

"I (Primary insurance benefit under 1939 Act, as modified)		II (Primary insurance amount under 1958 Act, as modified)	III (Average monthly wage)		IV (Primary insurance amount)	V (Maximum family benefits)
If an individual's primary insurance benefit (as determined under subsec. (d)) is—		Or his primary insurance amount (as determined under subsec. (c)) is—	Or his average monthly wage (as determined under subsec. (b)) is—		The amount referred to in the preceding paragraphs of this subsection shall be—	And the maximum amount of benefits payable (as provided in sec. 203(a) on the basis of his wages and self-employment income shall be—
At least—	But not more than—		At least—	But not more than—		
$32.01	$32.60	$75	$156	$160	$78.80	$128.00
32.61	33.20	76	161	164	79.80	131.20
33.21	33.83	77	165	169	80.90	135.20
33.89	34.50	78	170	171	81.90	139.20
34.51	35.00	79	175	178	83.00	142.40
35.01	35.80	80	179	183	84.00	146.40
35.81	36.40	81	184	188	85.10	150.40
36.41	37.08	82	189	193	86.10	154.40
37.09	37.60	83	194	197	87.20	157.60
37.61	38.20	84	198	202	88.20	161.60
38.21	39.12	85	203	207	89.30	165.60
39.13	39.68	86	208	211	90.30	168.80
39.69	40.33	87	212	216	91.40	172.80
40.34	41.12	88	217	221	92.40	176.80
41.13	41.76	89	222	225	93.50	180.00
41.77	42.44	90	226	230	94.50	184.00
42.45	43.20	91	231	235	95.60	188.00
43.21	43.76	92	236	239	96.60	191.20
43.77	44.44	93	240	244	97.70	195.20
44.45	44.88	94	245	249	98.70	199.20
44.89	45.60	95	250	253	99.80	202.40
		96	254	258	100.80	206.40
		97	259	263	101.90	210.40
		98	264	267	102.90	213.60
		99	268	272	104.00	217.60
		100	273	277	105.00	221.60
		101	278	281	106.10	224.80
		102	282	286	107.10	228.80
		103	287	291	108.20	232.80
		104	292	295	109.20	236.00
		105	296	300	110.30	240.00
		106	301	305	111.30	244.00
		107	306	309	112.40	247.20
		108	310	314	113.40	251.20
		109	315	319	114.50	254.00
		110	320	323	115.50	254.00
		111	324	328	116.60	254.00
		112	329	333	117.60	254.00
		113	334	337	118.70	254.80
		114	338	342	119.70	256.80
		115	343	347	120.80	258.80
		116	348	351	121.80	260.40
		117	352	356	122.90	262.40
		118	357	361	123.90	264.40
		119	362	365	125.00	266.00
		120	366	370	126.00	268.00
		121	371	375	127.10	270.00
		122	376	379	128.10	271.60
		123	380	384	129.20	273.60
		124	385	389	130.20	275.60
		125	390	393	131.30	277.20
		126	394	398	132.30	279.20
		127	399	403	133.40	281.20
			404	407	134.40	282.80
			408	412	135.40	284.80
			413	417	136.40	286.80
			418	421	137.40	288.40
			422	426	138.40	290.40
			427	431	139.40	292.40
			432	436	140.40	294.40
			437	440	141.40	296.00
			441	445	142.40	298.00
			446	450	143.40	300.00"

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

"Primary Insurance Amount Under 1958 Act, as Modified

"(c)(1) For the purposes of column II of the table appearing in subsection (a) of this section, an individual's primary insurance amount shall be computed as provided in, and subject to the limitations specified in, (A) this section as in effect prior to the enactment of the Social Security Amendments of 1964, and (B) the applicable provisions of the Social Security Amendments of 1960.

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

"(A) who became entitled to benefits under section 202(a) or section 223 prior to the second month following the month in which the Social Security Amendments of 1964 are enacted or who died prior to such second month, and

"(B) to whom neither paragraph (4) nor paragraph (5) of subsection (b) is applicable."

(c)(1) Paragraph (2) of section 203(a) of such Act is amended to read as follows:

"(2) when 2 or more persons were entitled (without the application of section 202(j)(1) and section 223(b)) to monthly benefits under sections 202 and 223 for the first month following the month in which the Social Security Amendments of 1964 are enacted on the basis of the wages and self-employment income of such insured individual, such total of benefits shall not be reduced to less than the larger of—

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

"(B) the sum of the amounts derived by multiplying the benefit amount (determined under this title as in effect prior to the enactment of the Social Security Amendments of 1964) of each such person for the month specified therein by 105 percent and raising each such increased amount, if it is not a multiple of $0.10, to the next higher multiple of $0.10."

(2) Paragraph (3) of such section 203(a) is repealed.

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

(e) If an individual was entitled to a disability insurance benefit under section 223 of the Social Security Act for the first month following the month in which this Act is enacted and became entitled to old-age insurance benefits under section 202(a) of such Act, or died, in the month following such first month, then, for purposes of section 215(a)(4) of the Social Security Act, as amended by this Act, the amount in column IV of the table appearing in such section 215(a) for such individual shall be the amount in such column on the line on which in column II appears his primary insurance amount (as determined under section 215(c) of such Act) instead of the amount in column IV equal to his disability insurance benefit.

PAYMENTS OF CHILD'S INSURANCE BENEFITS AFTER ATTAINMENT OF AGE EIGHTEEN IN CASE OF CHILD ATTENDING SCHOOL

SEC. 3. (a) Section 202(d)(1)(B) of the Social Security Act is amended by striking out "either" before "(i)", and by striking out "or (ii)" and inserting in lieu thereof ", (ii) was a full-time student and had not attained the age of twenty-two, or (iii)".

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

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

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

"(E) in the case of a child who is not under a disability (as defined in section 223(c)) at the time he attains the age of 18 and who during no part of the month in which he attains such age is a full-time student, the month in which such child attains the age of 18,

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

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

"(H) in the case of a child who after he attains the age of 18 ceases to be under a disability (as so defined) which began before he attained the age of 18, and who either (i) attains the age of 22 before the close of the third month following the month in which he ceases to be under such disability or (ii) was a full-time student during no part of such third month, the third month following the month in which he ceases to be under such disability, or

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

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

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

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

"(8) For the purposes of this subsection—

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

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

"(C) An 'educational institution' is (i) a school or college or university operated or directly supported by the United States, or by any State or local government or political subdivision thereof, or (ii) a school or college or university which has been approved by a State or accredited by a State-recognized or nationally-recognized accrediting agency or body, or (iii) a school, or college or university for which there is no such agency or body or which has been in operation an insufficient period of time for

such approval or accreditation, but which is approved by the Secretary in accordance with regulations prescribed by him."

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

"Child Aged 18 or Over Attending School

"(s)(1) For the purposes of subsection (b)(1), (g)(1), (q)(4), and (q)(6) of this section and paragraphs (2), (3), and (4) of section 203(c), a child who is entitled to child's insurance benefits under subsection (d) for any month, and who has attained the age of 18 but is not in such month under a disability (as defined in section 223(c)) which began before he attained such age, shall be deemed not entitled to such benefits for such month, unless he was under such a disability in the third month before such month.

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

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

(2) So much of subsection (b)(1) of such section 202 as follows subparagraph (C) is amended by inserting "(subject to subsection (s))" after "shall".

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(d)(1) The amendments made by this section shall apply with respect to monthly insurance benefits under section 202 of the Social Security Act for months after (A) the month in which this Act is enacted, or (B) if later, August 1964; but only, except as provided in paragraph (2), on the basis of an application filed in or after the month in which this Act is enacted.

(2) In the case of an individual who was entitled (without the application of subsection (j)(1) of such section 202) to a child's insurance benefit under subsection (d) of such section for the month in which this Act is enacted, such amendments shall apply with respect to benefits under such section 202 for months after the month in which this Act is enacted.

REDUCED BENEFITS FOR WIDOWS AT AGE 60

SEC. 4. (a)(1) Paragraph (1)(B) of section 202(e) of the Social Security Act is amended by striking out "age 62" and inserting in lieu thereof "age 60".

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

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

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

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

"(B)(i) the number of months in the reduction period for such benefit (determined under paragraph (5)), if such benefit is for a month before the month in which such individual attains retirement age, or

"(ii) the number of months in the adjusted reduction period for such benefit (determined under paragraph (6)), if such benefit is for the month in which such individual attains retirement age or for any month thereafter."

(2) Paragraph (2)(A) of such section is amended—

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

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

(3) Paragraph (2)(C) of such section is amended by striking out "wife's or husband's" and inserting in lieu thereof "wife's, husband's, or widow's".

(4) Paragraph (2)(D) of such section is amended by striking out "wife's or husband's" and inserting in lieu thereof "wife's, husband's, or widow's".

(5) Paragraph (2) of such section is amended by adding at the end thereof the following new subparagraph:

"(E) If the first month for which an individual is entitled to an old-age insurance benefit (whether such first month occurs before, with, or after the month in which such individual attains the age of 65) is a month for which such individual is also (or would, but for subsection (e)(1), be) entitled to a widow's insurance benefit to which such individual was first entitled for a month before she attained the age of 62, then such old-age insurance benefit shall be reduced by whichever of the following is the larger:

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

"(ii) the amount equal to the sum of the amount by which such widow's insurance benefit was reduced for the month in which such individual attained the age of 62 and the amount by which such old-age insurance benefit would be reduced under paragraph (1) if it were equal to the excess of such old-age insurance benefit (before reduction under this subsection) over such widow's insurance benefit (before reduction under this subsection)."

(6) Paragraph (4) of such section is amended by adding at the end thereof the following new subparagraph:

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

(7) Paragraph (5) of such section is amended—

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

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

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

(8) Paragraph (6) of such section is amended—

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

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

"(D) in the case of widow's insurance benefits, any month in which the reduction in the amount of such benefit was determine dunder paragraph (4)(D)."

(9) Section 202(q) of such Act is further amended by adding at the end thereof the following new paragraph:

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

(10) The heading of section 202(q) of such Act is amended by striking out "or Husband's" and inserting in lieu thereof "Husband's, or Widow's".

(c) Section 223(a)(3) of such Act is amended to read as follows:

"(3) If, for any month before the month in which an individual attains age 65, such individual is entitled to an old-age, husband's, widow's, widower's, or parent's insurance benefit, or to a wife's insurance benefit which is reduced under section 202(q), such individual may not, for any month after the first month for which such individual is so entitled, become entitled to disability insurance benefits; and a period of disability may not begin with respect to such individual in any month after such first month."

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

TRANSITIONAL INSURED STATUS

SEC. 5. (a) Title II of the Social Security Act is further amended by adding at the end thereof the following new section:

"TRANSITIONAL INSURED STATUS

"SEC. 226. (a) In the case of any individual who attains the age of 72 but who does not meet the requirements of section 214(a), the 6 quarters of coverage referred to in so much of paragraph (1) of section 214(a) as follows clause (C) shall, instead, be 3 quarters of coverage for purposes of determining entitlement of such individual to benefits under subsection (a) of section 202, and of his wife to benefits under subsection (b) of such section, but, in the case of such wife, only if she attains the age of 72 before 1968 and only with respect to wife's insurance benefits under such subsection (b) for and after the month in which she attains such age. For each month before the month in which any such individual meets the requirements of section 214(a), the amount of his old-age insurance benefit

shall, notwithstanding the provisions of section 202(a), be $35 and the amount of the wife's insurance benefit of his wife shall, notwithstanding the provisions of section 202(b) (and section 202(m)), be $17.50.

"(b) In the case of any individual who has died, who does not meet the requirements of section 214(a), and whose widow attains age 72 before 1968, the 6 quarters of coverage referred to in paragraph (3) of section 214(a) and in so much of paragraph (1) thereof as follows clause (C) shall, for purposes of determining her entitlement to widow's insurance benefits under section 202(e), instead be—

"(1) 3 quarters of coverage if such widow attains the age of 72 in or before 1965,

"(2) 4 quarters of coverage if such widow attains the age of 72 in 1966, or

"(3) 5 quarters of coverage if such widow attains the age of 72 in 1967.

The amount of her widow's insurance benefit for each month shall, notwithstanding the provisions of section 202(e) (and section 202(m)), be $35.

"(c) In the case of any individual who becomes, or upon filing application therefor would become, entitled to benefits under section 202(a) by reason of the application of subsection (a) of this section, who dies, and whose widow attains the age of 72 before 1968, such deceased individual shall be deemed to meet the requirements of subsection (b) of this section for purposes of determining entitlement of such widow to widow's insurance benefits under section 202(b)."

(b) The amendment made by subsection (a) shall apply in the case of monthly benefits under title II of the Social Security Act for and after the second month following the month in which this Act is enacted.

COMPUTATION AND RECOMPUTATION OF BENEFITS

SEC. 6. (a)(1) Subparagraph (C) of section 215(b)(2) of the Social Security Act is amended to read as follows:

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

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

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

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

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

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

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

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

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

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

"(A) who becomes entitled after December 1964 to benefits under section 202(a) or section 223; or

"(B) who dies after December 1964 without being entitled to benefits under section 202(a) or section 223; or

"(C) whose primary insurance amount is required to be recomputed under subsection (f)(2), as amended by the Social Security Amendments of 1964.

"(5) In the case of an individual—

"(A) to whom the provisions of this subsection are not made applicable by paragraph (4), but who, after the first month following the month in which the Social Security Amendments of 1964 are enacted and prior to 1965, met the requirements of this paragraph or paragraph (4), as in effect prior to the enactment of the Social Security Amendments of 1964, or

"(B) who becomes entitled after 1964 to a recomputation under section 102(f)(2)(B) of the Social Security Amendments of 1954,

the provisions of this subsection, as in effect prior to such enactment, shall apply to such individual for the purposes of column III of the table appearing in subsection (a) of this section."

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

(2) Section 215(d)(3) of such Act is amended by striking out "1960" and inserting in lieu thereof "1964" and by striking out "but without regard to whether such individual has six quarters of coverage after 1950".

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

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

"(2) With respect to each year—

"(A) which begins after December 31, 1963, and

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

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

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

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

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

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

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

(2) Effective January 2, 1965, paragraphs (3), (4), and (7) of such section are repealed, and paragraphs (5) and (6) of such section are redesignated as paragraphs (3) and (4), respectively.

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

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

(f)(1) The amendments made by subsection (c) shall apply only to individuals who become entitled to old-age insurance benefits under section 202(a) of the Social Security Act after 1964.

(2) Any individual who would, upon filing an application on January 1, 1965, be entitled to a recomputation of his primary insurance amount for purposes of title II of the Social Security Act shall be deemed to have filed such application on January 1, 1965.

(3) In the case of an individual who died after 1960 and prior to 1965 and who was entitled to old-age insurance benefits under section 202(a) of the Social Security Act at the time of his death, the provisions of section 215(f)(4) of such Act as in effect before the enactment of this Act shall apply.

(4) In the case of a man who attains age 65 prior to 1965, or dies before such year, the provisions of section 215(f)(7) of the Social Security Act as in effect before the enactment of this Act shall apply.

(5) The amendments made by subsection (e) of this section shall apply in the case of individuals who become entitled to disability insurance benefits under section 223 of the Social Security Act after December 1964.

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

(A) by striking out "notwithstanding the amendments made by the preceding subsections of this section," in the first sentence and inserting in lieu thereof "notwithstanding the amendments made by the preceding subsections of this section, or the amendments made by section 6 of the Social Security Amendments of 1964,"; and

(B) by striking out "Social Security Amendments of 1960," in the second sentence and inserting in lieu thereof "Social Security Amendments of 1960, or (if such individual becomes entitled to old-age insurance benefits after 1964, or dies after 1964 without becoming so entitled) as amended by the Social Security Amendments of 1964,".

IMPROVEMENT OF ACTUARIAL STATUS OF DISABILITY INSURANCE TRUST FUND

SEC. 7. (a) Section 201(b)(1) of the Social Security Act is amended by inserting "and before January 1, 1965," after "December 31, 1956,", and by inserting after "1954," the following: "and 0.65 of 1 per centum of such wages paid after December 31, 1964, and so reported,".

(b) Section 201(b)(2) of such Act is amended by inserting after "December 31, 1956," the following: "and before January 1, 1965, and 0.4875 of 1 per centum of the amount of such self-employment income so reported for any taxable year beginning after December 31, 1964,".

COVERAGE FOR DOCTORS OF MEDICINE

SEC. 8. (a)(1) Section 211(c)(5) of the Social Security Act is amended to read as follows:

"(5) The performance of service by an individual in the exercise of his profession as a Christian Science practitioner."

(2) Section 211(c) of such Act is further amended by striking out the last two sentences and inserting in lieu thereof the following: "The provisions of paragraph (4) or (5) shall not apply to service (other than service performed by a member of a religious order who has taken a vow of poverty as a member of such order) performed by an individual during the period for which a certificate filed by him under section 1402(e) of the Internal Revenue Code of 1954 is in effect."

(3) Section 210(a)(6)(C)(iv) of such Act is amended by inserting before the semicolon at the end thereof the following: ", other than as a medical or dental intern or a medical or dental resident-in-training".

(4) Section 210(a)(13) of such Act is amended by striking out all that follows the first semicolon.

(b)(1) Section 1402(c)(5) of the Internal Revenue Code of 1954 (relating to definition of trade or business) is amended to read as follows:

"(5) the performance of service by an individual in the exercise of his profession as a Christian Science practitioner."

(2) Section 1402(c) of such Code is further amended by striking out the last two sentences and inserting in lieu thereof the following: "The provisions of paragraph (4) or (5) shall not apply to service (other than service performed by a member of a religious order who has taken a vow of poverty as a member of such order) performed by an individual during the period for which a certificate filed by him under subsection (e) is in effect."

(3)(A) Section 1402(e)(1) of such Code (relating to filing of waiver certificate by ministers, members of religious orders, and Christian Science practitioners) is amended by striking out "extended to service" and all that follows and inserting in lieu thereof "extended to service described in subsection (c)(4) or (c)(5) performed by him."

(B) Clause (A) of section 1402(e)(2) of such Code (relating to time for filing waiver certificate) is amended to read as follows: "(A) the due date of the return (including any extension thereof) for his second taxable year ending after 1954 for which he has net earnings from self-employment (computed without regard to subsections (c)(4) and (c)(5)) of $400 or more, any part of which was derived from the performance of service described in subsection (c)(4) or (c)(5); or".

(4) Section 3121(b)(6)(C)(iv) of such Code (relating to definition of employment) is amended by inserting before the semicolon at the end thereof the following: ", other than as a medical or dental intern or a medical or dental resident-in-training".

(5) Section 3121(b)(13) of such Code is amended by striking out all that follows the first semicolon.

(c) The amendments made by paragraphs (1) and (2) of subsection (a), and by paragraphs (1), (2), and (3) of subsection (b), shall apply only with respect to taxable years ending after December 31, 1964. The amendments made by paragraphs (3) and (4) of subsection (a), and by paragraphs (4) and (5) of subsection (b), shall apply only with respect to services performed after 1964.

COVERAGE OF TIPS

SEC. 9. (a)(1) Section 209 of the Social Security Act is amended by striking out "or" at the end of subsection (i), by striking out the period at the end of subsection (j) and inserting in lieu thereof "; or", and by adding immediately after subsection (j) the following new subsection:

"(k)(1) Tips paid in any medium other than cash;

"(2) Cash tips received by an employee in any calendar month in the course of his employment by an employer unless the amount of such cash tips is $20 or more."

(2) Section 209 of such Act is further amended by adding at the end thereof the following new paragraph:

"For purposes of this title, tips received by an employee in the course of his employment, on his own behalf and not on behalf of another person, shall be considered remuneration for employment, whether such tips are received by the employee directly from a person other than his employer or are paid over to the employee by his employer. Such tips shall be deemed to be paid to the employee by the employer, and shall be deemed to be so paid at the time a written statement including such tips is furnished to the employer pursuant to section 6053 of the Internal Revenue Code of 1954 or (if no statement including such tips is so furnished) at the close of the 10th day following the calendar month in which they were received."

(b)(1) Section 3102 of the Internal Revenue Code of 1954 (relating to deduction of tax from wages) is amended by adding at the end thereof the following new subsection:

"(c) SPECIAL RULE FOR TIPS.—In the case of tips which constitute wages, subsection (a) shall be applicable only to such tips as are included in a written statement furnished to the employer pursuant to section 6053, and only to the extent that collection can be made by the employer, at or after the time such statement is so furnished and before the close of the 10th day following the calendar month in which the tips were received, by deducting the amount of the tax from such wages of the employee (exclusive of tips, but including funds turned over by the employee to the employer for the purpose of such deduction) as are under control of the employer."

(2) Section 3121(a) of such Code (relating to the definition of wages under the Federal Insurance Contributions Act) is amended by striking out "or" at the end of paragraph (9), by striking out the period at the end of paragraph (10) and inserting in lieu thereof "; or", and by adding after paragraph (10) the following new paragraph:

"(11)(A) tips paid in any medium other than cash;

"(B) cash tips received by an employee in any calendar month in the course of his employment by an employer unless the amount of such cash tips is $20 or more."

(3) Section 3121 of such Code is further amended by adding at the end thereof the following new subsection:

"(q) TIPS.—Tips received by an employee in the course of his employment, on his own behalf and not on behalf of another person, shall be considered remuneration for employment, whether such tips are received by the employee directly from a person other than his employer or are paid over to the employee by his employer. Such tips shall be deemed to be paid to the employee by the employer, and shall be deemed to be so paid at the time a written statement including such tips is furnished to the employer pursuant to section 6053 or (if no statement including such tips is so furnished) at the close of the 10th day following the calendar month in which they were received."

(c)(1) Section 6051(a) of such Code (relating to receipts for employees) is amended by adding at the end thereof the following new sentence: "In the

case of tips received by an employee in the course of his employment, the amounts required to be shown by paragraph (5) shall include only such tips as are reported by the employee to the employer pursuant to section 6053."

(2)(A) Subpart C of part III of subchapter A of chapter 61 of such Code (relating to information regarding wages paid employees) is amended by adding at the end thereof the following new section:

"SEC. 6053. REPORTING OF TIPS.

"Every employee who, in the course of his employment by an employer, receives in any calendar month tips which are wages as defined in section 3121(a) shall report all such tips in one or more written statements furnished to his employer. For purposes of sections 3111, 6051(a), and 6052(c), tips received in any calendar month shall be considered reported pursuant to this section only if they are included in such a statement furnished to the employer on or before the 10th day following such month and only to the extent that the tax imposed with respect to such tips by section 3101 can be collected by the employer under section 3102. Such statements shall be furnished by the employee under such regulations, at such other times before such 10th day, and in such form and manner, as may be prescribed by the Secretary or his delegate."

(B) The table of sections for such subpart C is amended by adding at the end thereof the following:

"Sec. 6053. Reporting of tips."

(3) Section 6652 of such Code (relating to failure to file certain information returns) is amended by redesignating subsection (c) as subsection (d) and by inserting after subsection (b) the following new subsection:

"(c) FAILURE TO REPORT TIPS.—In the case of tips to which the first sentence of section 6053 is applicable, if the employee fails to report any of such tips to the employer pursuant to such section, unless it is shown that such failure is due to reasonable cause and not due to willful neglect, there shall be paid by the employee, in addition to the tax imposed by section 3101 with respect to the amount of the tips which he so failed to report, an amount equal to such tax."

(d) Section 3111 of such Code (relating to rate of tax on employers under the Federal Insurance Contributions Act), as amended by section 16 of this Act, is amended by adding at the end thereof (after and below paragraph (4)) the following new sentence:

"In the case of tips which constitute wages, the tax imposed by this section shall be applicable only to such tips as are reported by the employee to the taxpayer pursuant to section 6053."

(e) The second sentence of section 3102(a) of such Code (relating to requirement of deduction) is amended by inserting before the period at the end thereof the following: "; and an employer who is furnished by an employee a written statement of tips (received in a calendar month) to which paragraph (11)(B) of section 3121(a) is applicable may deduct an amount equivalent to such tax with respect to such tips from any wages of the employee (exclusive of tips) under his control, even though at the time such statement is furnished the total amount of the tips so reported by the employee as received in such calendar month in the course of his employment by such employer is less than $20".

(f) The amendments made by this section shall apply only with respect to tips received by employees after 1964.

GROSS INCOME OF FARMERS

SEC. 10. (a) The second sentence following paragraph (8) in section 211(a) of the Social Security Act is amended by striking out "$1,800" each place it appears and inserting in lieu thereof "$2,400", and by striking out "$1,200" each place it appears and inserting in lieu thereof "$1,600".

(b) The second sentence following paragraph (9) in section 1402(a) of the Internal Revenue Code of 1954 (relating to net earnings from self-employment) is amended by striking out "$1,800" each place it appears and inserting in lieu thereof "$2,400", and by striking out "$1,200" each place it appears and inserting in lieu thereof "$1,600".

(c) The amendments made by this section shall apply only with respect to taxable years beginning after December 31, 1964.

ELIMINATION OF PROHIBITION AGAINST COVERAGE OF POLICEMEN AND FIREMEN

SEC. 11. (a) Subparagraph (A) of section 218(d)(5) of the Social Security Act is amended to read as follows:

"(A) For purposes of this subsection, a retirement system which covers—

"(i) positions of policemen and firemen, or

"(ii) positions of policemen or firemen, or both, and other positions,

shall be deemed to be a separate retirement system with respect to the positions of such policemen or firemen, or both, as the State desires, and no positions of persons other than policemen or firemen may be included in any such separate retirement system."

(b) Section 218(d)(1) of such Act is amended—

(1) by striking out ", and except in the case of positions excluded by paragraph (5)(A)" in the first sentence; and

(2) by striking out "(other than a position excluded by paragraph (5)(A))" in the second sentence.

(c) Section 218(d)(3) of such Act is amended by striking out "excluded by or pursuant to paragraph (5)" each place it appears and inserting in lieu thereof "excluded pursuant to paragraph (5)".

(d)(1) Section 218(d)(7) of such Act is amended by striking out "excluded by or pursuant to paragraph (5)" and inserting in lieu thereof "excluded pursuant to paragraph (5)".

(2) Section 218(d)(8)(D) of such Act is repealed.

(e) Section 218(k)(3) of such Act is repealed.

(f) Section 218(p) of such Act is repealed.

(g) The amendments made by this section shall apply only in the case of agreements or modifications agreed to after November 30, 1964.

INCLUSION OF ALASKA AND KENTUCKY AMONG STATES PERMITTED TO DIVIDE THEIR RETIREMENT SYSTEMS

SEC. 12. The first sentence of section 218(d)(6)(C) of the Social Security Act is amended—

(1) by inserting "Alaska," before "California"; and

(2) by inserting "Kentucky," before "Massachusetts".

ADDITIONAL PERIOD FOR ELECTING COVERAGE UNDER DIVIDED RETIREMENT SYSTEM

SEC. 13. The first sentence of section 218(d)(6)(F) of the Social Security Act is amended by striking out "1963" and inserting in lieu thereof "1966".

COVERAGE FOR CERTAIN ADDITIONAL HOSPITAL EMPLOYEES IN CALIFORNIA

SEC. 14. Section 102(k) of the Social Security Amendments of 1960 is amended by inserting "(1)" immediately after "k", and by adding at the end thereof the following new paragraph:

"(2) Such agreement, as modified pursuant to paragraph (1), may at the option of such State be further modified, at any time prior to the seventh month after the month in which this paragraph is enacted, so as to apply to services performed for any hospital affected by such earlier modification by any individual who after December 31, 1959, was or is employed by such State (or any political subdivision thereof) in any position described in paragraph (1). Such modification shall be effective with respect to (A) all services performed by such individual in any such position on or after January 1, 1962, and (B) all such services, performed before such date, with respect to which amounts equivalent to the sum of the taxes which would have been imposed by sections 3101 and 3111 of the Internal Revenue Code of 1954 if such services had constituted employment for purposes of chapter 21 of such Code at the time they were performed have, prior to the date of the enactment of this paragraph, been paid."

INCREASE OF EARNINGS COUNTED FOR BENEFIT AND TAX PURPOSES

SEC. 15. (a)(1)(A) Section 209(a)(3) of the Social Security Act is amended by inserting "and before 1965" after "1958".

(B) 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 subsection of this section) equal

to $5,400 with respect to employment has been paid to an individual during any calendar year after 1964, is paid to such individual during such calendar year;".

(2)(A) Section 211(b)(1)(C) of such Act is amended by inserting "and before 1965" after "1958", and by striking out "; or" and inserting in lieu thereof "; and".

(B) Section 211(b)(1) of such Act is further amended by adding at the end thereof the following new subparagraph:

"(D) For any taxable year ending after 1964, (i) $5,400, minus (ii) the amount of wages paid to such individual during the taxable year; or".

(3)(A) Section 213(a)(2)(ii) of such Act is amended by striking out "after 1958" and inserting in lieu thereof "after 1958 and before 1965, or $5,400 in the case of a calendar year after 1964".

(B) Section 213(a)(2)(iii) of such Act is amended by striking out "after 1958" and inserting in lieu thereof "after 1958 and before 1965, or $5,400 in the case of a taxable year ending after 1964".

(4) Section 215(e)(1) of such Act is amended by striking out "and the excess over $4,800 in the case of any calendar year after 1958" and inserting in lieu thereof "the excess over $4,800 in the case of any calendar year after 1958 and before 1965, and the excess over $5,400 in the case of any calendar year after 1964".

(b)(1)(A) Section 1402(b)(1)(C) of the Internal Revenue Code of 1954 (relating to definition of self-employment income) is amended by inserting "and before 1965" 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 subparagraph:

"(D) for any taxable year ending after 1964, (i) $5,400, minus (ii) the amount of the wages paid to such individual during the taxable year; or".

(2) Section 3121(a)(1) of such Code (relating to definition of wages) is amended by striking out "$4,800" each place it appears and inserting in lieu thereof "$5,400".

(3) The second sentence of section 3122 of such Code (relating to Federal service) is amended by striking out "$4,800" and inserting in lieu thereof "$5,400".

(4) Section 3125 of such Code (relating to returns in the case of governmental employees in Guam and American Samoa) is amended by striking out "$4,800" where it appears in subsections (a) and (b) and inserting in lieu thereof "$5,400".

(5) Section 6413(c)(1) of such Code (relating to special refunds of employment taxes) is amended—

(A) by inserting "and prior to the calendar year 1965" after "the calendar year 1958";

(B) by inserting after "exceed $4,800," the following "or (C) during any calendar year after the calendar year 1964, the wages received by him during such year exceed $5,400," and

(C) by inserting before the period at the end thereof the following: "and before 1965, or which exceeds the tax with respect to the first $5,400 of such wages received in such calendar year after 1964".

(6) Section 6413(c)(2)(A) of such Code (relating to refunds of employment taxes in the case of Federal employees) is amended by striking out "or $4,800 for any calendar year after 1958" and inserting in lieu thereof "$4,800 for the calendar year 1959, 1960, 1961, 1962, 1963, or 1964, or $5,400 for any calendar year after 1964".

(c) The amendments made by subsections (a)(1) and (a)(3)(A), and the amendments made by subsection (b) (except paragraph (1) thereof), shall apply only with respect to remuneration paid after December 1964. The amendments made by subsections (a)(2), (a)(3)(B), and (b)(1) shall apply only with respect to taxable years ending after 1964. The amendment made by subsection (a)(4) shall apply only with respect to calendar years after 1964.

CHANGES IN TAX SCHEDULES

SEC. 16. (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, 1964, and before January 1, 1968, the tax shall be equal to 6 percent of the amount amount of the self-employment income for such taxable year;

"(2) in the case of any taxable year beginning after December 31, 1965, and before January 1, 1968, the tax shall be equal to 6 percent of the amount of the self-employment income for such taxable year; and

"(3) in the case of any taxable year beginning after December 31, 1967, and before January 1, 1971, the tax shall be equal to 6.8 percent of the amount of the self-employment income for such taxable year; and

"(4) in the case of any taxable year beginning after December 31, 1970, the tax shall be equal to 7.2 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 year 1965, the rate shall be 3.8 percent;

"(2) with respect to wages received during the calendar years 1966 and 1967, the rate shall be 4 percent;

"(3) with respect to wages received during the calendar years 1968, 1969, and 1970, the rate shall be 4.5 percent; and

"(4) with respect to wages received after December 31, 1970, the rate shall be 4.8 percent."

(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 1965, the rate shall be 3.8 percent;

"(2) with respect to wages paid during the calendar years 1966 and 1967, the rate shall be 4 percent;

"(3) with respect to wages paid during the calendar years 1968, 1969, and 1970, the rate shall be 4.5 percent; and

"(4) with respect to wages paid after December 31, 1970, the rate shall be 4.8 percent."

(d)(1) The proviso in section 3201 of such Code (relating to rate of tax on employees under Railroad Retirement Tax Act) is amended by inserting after "at such time" the following: "(determined under the provisions of section 3101 as in effect on June 1, 1964)".

(2) The proviso in section 3211 of such Code (relating to rate of tax on employee representatives under Railroad Retirement Tax Act) is amended by inserting after "at such time" the following: "(determined under the provisions of section 3101 as in effect on June 1, 1964)".

(3) Section 3221(b) of such Code (relating to rate of tax on employers under Railroad Retirement Tax Act) is amended by inserting after "at such time" the following: "(determined under the provisions of section 3111 as in effect on June 1, 1964)".

(e) The amendment made by subsection (a) shall apply only with respect to taxable years beginning after December 31, 1964. The amendments made by subsections (b) and (c) shall apply only with respect to remuneration paid after December 31, 1964.

Passed the House of Representatives July 29, 1964.

Attest:

RALPH R. ROBERTS, *Clerk.*

[H.R. 11865, 88th Cong., 2d sess.]

AMENDMENT NO. 1163

AMENDMENTS Intended to be proposed by Mr. JAVITS (for himself, Mr. CASE, Mr. KEATING, Mr. KUCHEL, Mrs. SMITH, and Mr. COOPER) to H.R. 11865, an Act to increase benefits under the Federal Old-Age, Survivors, and Disability Insurance System, to provide child's insurance benefits beyond age 18 while in school, to provide widow's benefits at age 60 on a reduced basis, to provide benefits for certain individuals not otherwise eligible at age 72, to improve the actuarial status of the Trust Funds, to extend coverage, and for other purposes, viz:

On the first page of the bill, strike out lines 3 and 4, and insert in lieu thereof the following:

"TITLE I—SOCIAL SECURITY AMENDMENTS

"SEC. 101. This title may be cited as the 'Social Security Amendments of 1964'."

On page 3, line 3, strike out "SEC. 2." and insert in lieu thereof "SEC. 102.".

On page 6, line 13, strike out "SEC. 3." and insert in lieu thereof "SEC. 103.".

On page 15, line 11, strike out "SEC. 4." and insert in lieu thereof "SEC. 104.".

On page 20, line 10, strike out "SEC. 5." and insert in lieu thereof "SEC. 105.".

On page 22, line 11, strike out "SEC. 6." and insert in lieu thereof "SEC. 106.".

On page 28, line 5, strike out "section 6" and insert in lieu thereof "section 106".

On page 28, line 16, strike out "SEC. 7." and insert in lieu thereof "SEC. 107.".

On page 29, line 2, strike out "SEC. 8." and insert in lieu thereof "SEC. 108.".

On page 31, line 18, strike out "SEC. 9." and insert in lieu thereof "SEC. 109.".

On page 36, line 6, strike out "section 16" and insert in lieu thereof "section 116".

On page 37, line 8, strike out "SEC. 10." and insert in lieu thereof "SEC. 110.".

On page 38, line 3, strike out "SEC. 11." and insert in lieu thereof "SEC. 111.".

On page 39, line 12, strike out "SEC. 12." and insert in lieu thereof "SEC. 112.".

On page 39, line 19, strike out "SEC. 13." and insert in lieu thereof "SEC. 113.".

On page 39, line 24, strike out "SEC. 14." and insert in lieu thereof "SEC. 114.".

On page 40, line 23, strike out "SEC. 15." and insert in lieu thereof "SEC. 115.".

On page 44, line 8, strike out "SEC. 16." and insert in lieu thereof "SEC. 116.".

On page 44, line 17, strike out "5.7 percent" and insert in lieu thereof "6.0075 percent".

On page 44, line 21, strike out "6 percent" and insert in lieu thereof "6.3075 percent".

On page 45, line 3, strike out "6.8 percent" and insert in lieu thereof "7.0575 percent".

On page 45, line 7, strike out "7.2 percent" and insert in lieu thereof "7.5075 percent".

On page 45, line 19, strike out "3.8 percent" and insert in lieu thereof "4.005 percent".

On page 45, line 21, strike out "4 percent" and insert in lieu thereof "4.205 percent".

On page 46, line 3, strike out "4.5 percent" and insert in lieu thereof "4.705 percent".

On page 46, line 5, strike out "4.8 percent" and insert in lieu thereof "5.005 percent".

On page 46, line 17, strike out "3.8 percent" and insert in lieu thereof "4.005 percent".

On page 46, line 19, strike out "4 percent" and insert in lieu thereof "4.205 percent".

On page 46, line 21, strike out "4.5 percent" and insert in lieu thereof "4.705 percent".

On page 46, line 24, strike out "4.8 percent" and insert in lieu thereof "5.005 percent".

At the end of the bill, add the following:

"TITLE II—HEALTH CARE INSURANCE FOR THE AGED

SEC. 201. This title may be cited as the "Health Care Insurance Act. of 1964".

PART A—HOSPITAL INSURANCE BENEFITS FOR THE AGED

FINDINGS AND DECLARATIONS OF PURPOSE

SEC. 202. (a) The Congress finds that the rising costs of health care for the great majority of that portion of our population sixty-five years of age or over are a major threat to their independence and dignity; and that most of the older citizens cannot afford to pay for adequae private insurance health care coverage. Difficulty in meeting health care expenses which are more than twice as high as those of persons under sixty-five years of age has led to an increase in dependency and in the medically indigent with subsequent burdening of public relief programs. It is in the interest of the general welfare that a problem of such national proportions as this one be met by a dual public-private program of well-balanced basic health care in which the costs of hospital care and related services required by older citizens be met through contributory social insurance, and medical, surgical, and related services be met through a basic national private insurance plan which would be available to all persons in the aged group at the same basic premium cost.

"(b) The purposes of this title are (1) to provide all individuals sixty-five years of age or over with basic protection against the costs of hospital care and related services and to utilize social insurance for financing the protection so provided, and (2) to provide for the establishment of a national association composed of private carriers which shall make available to all individuals, sixty-five years of age or over, a nonprofit, tax-exempt standard health insurance policy at reasonable cost.

"(c) It is hereby declared to be the policy of the Congress that skilled nursing facility services for which payment may be made under this title shall be utilized in lieu of inpatient hospital services where skilled nursing facility services would suffice in meeting the medical needs of the patient and that home health services for which payment may be made under this title shall be utilized in lieu of inpatient hospital or skilled nursing facility services where home health services would suffice.

"(d) It is further declared to be the policy of the Congress that no individual who receives aid or assistance (including medical or any other type of remedial care) under a State plan approved under titles I, IV, X, XIV, or XVI of the Social Security Act shall receive less benefits or be otherwise disadvantaged by reason of the enactment of this title."

BENEFITS

SEC. 203. The Social Security Act is amended by adding after title XVII the following new title:

"TITLE XVIII—HOSPITAL INSURANCE BENEFITS FOR THE AGED

"PROHIBITION AGAINST ANY FEDERAL INTERFERENCE

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

"FREE CHOICE BY PATIENT GUARANTEED

"SEC. 1802. Any individual entitled to have payment made under this title for services furnished him may obtain inpatient hospital services, skilled nursing facility services, or home health services from any provider of services with which an agreement is in effect under this title and which undertakes to provide him such services.

"DESCRIPTION OF SERVICES

"SEC. 1803. For purposes of this title—

"Inpatient Hospital Services

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

"(1) bed and board,

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

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

excluding, however—

"(4) medical or surgical services provided by a physician, resident, or intern, except services provided in the field of pathology, radiology, physiatry, or anesthesiology, and except services provided in the hospital by an intern or a resident-in-training under a teaching program approved by the Council on Medical Education and Hospitals of the American Medical Association (or, in the case of an osteopathic hospital, approved by the Bureau of Professional Education, Committee on Hospitals of the American Osteopathic Association), and

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

"Skilled Nursing Facility Services

"(b) The term 'skilled nursing facility services' means the following items and services furnished to an inpatient in a skilled nursing facility (but only after transfer from a hospital in which he was an inpatient, in case of a skilled nursing facility which is not affiliated or under the common control with a hospital), and (except as provided in paragraph (3)) by such skilled nursing facility—

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

"(2) bed and board in connection with the furnishing of such nursing care,

"(3) physical, occupational, or speech therapy furnished by the skilled nursing facility or by others under arrangements with them made by the facility,

"(4) medical social services,

"(5) such drugs, biologicals, supplies, appliances, and equipment, furnished for use in the skilled nursing facility, as are customarily furnished by such facility for the care and treatment of inpatients,

"(6) medical services provided by an intern or resident-in-training of the hospital, with which the facility is affiliated or under common control, under a teaching program of such hospital approved as provided in subsection (a)(4), and

"(7) such other services necessary to the health of the patient as are generally provided by skilled nursing facilities;

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

"Home Health Services

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

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

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

"(3) medical social services,

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

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

"(6) medical services provided by a intern or resident-in-training of the hospital, with which the home health agency is affiliated or under common control, under a teaching program of such hospital approved as provided in subsection (a)(4);

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

"Drugs and Biologicals

"(d) The term 'drugs' and the term 'biologicals', except for purposes of subsection (c)(5) of this section, include only such drugs and biologicals, respectively, as are included in the 'United States Pharmacopoeia', 'National Formulary', 'New and Non-Official Drugs', or 'Accepted Dental Remedies', or are approved by the pharmacy and drug therapeutics committee, or equivalent committee) of the medical staff of the hospital furnishing such drugs or biologicals (or of the hospital with which the skilled nursing facility furnishing such drugs or biologicals is affiliated or is under common control).

"Arrangements for Certain Services

"(e) As used in this section, the term 'arrangements' is limited to arrangements under which receipt of payment by the hospital, skilled nursing facility, or home health agency (whether in its own right or as agent), as the case may be, with respect to services for which an individual is entitled to have payment made under this title, discharges the liability of such individual or any other person to pay for the services.

"DURATION OF SERVICES AND BENEFIT PERIOD

"Duration of Services

"SEC. 1804. (a) Payment under this title for services furnished any individual during a benefit period may not be made for—

"(1) inpatient hospital services furnished to him during such period after such services have been furnished to him for forty-five days during such period; or

"(2) skilled nursing facility services furnished to him during such period after such services have been furnished to him for one hundred and eighty days during such period.

For purposes of the preceding provisions of this subsection, inpatient hospital services or skilled nursing facility services shall be counted only if payment is or would, except for this subsection and except for the failure to comply with the procedural and other requirements of or under section 1809(a)(1), be made with respect to such services under this title. Payment under this title for home health services furnished an individual during a calendar year may not be made for any such services after such services have been furnished him during two hundred and forty days in such year.

"BENEFIT PERIOD

"(b) For the purposes of this section, a 'benefit period' with respect to any individual means a period of consecutive days—

"(1) beginning with the first day (not included in a previous benefit period) (A) on which such individual is furnished inpatient hospital services or skilled nursing facility services and (B) which occurs in a month for which he is entitled to insurance benefits under this title, and

"(2) ending with the forty-fifth day thereafter on each of which he is neither an inpatient in a hospital nor an inpatient in a skilled nursing facility (whether or not such forty-five days are consecutive), but only if such days occur within a period of not more than one hundred and eighty consecutive days.

"ENTITLEMENT TO BENEFITS

"SEC. 1805. (a) Every individual who—

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

"(2) is entitled to monthly insurance benefits under section 202, and

"(3) has elected under section 1818 to be entitled to benefits under this title,

shall be entitled to insurance benefits under this title for each month for which he is entitled to such benefits under section 202, beginning with the first month after December 1964 with respect to which he meets the conditions specified in paragraphs (1), (2), and (3).

"(b) For the purposes of this section—

"(1) entitlement of an individual to insurance benefits under this title for a month shall consist of entitlement to have payment made under, and subject to the limitations in, this title on his behalf for inpatient hospital services, skilled nursing facility services, and home health services furnished him in the United States during such month; and

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

"(c) Notwithstanding the preceding provisions of this section, no payments may be made under this title for inpatient hospital services, or home health services furnished an individual prior to January 1, 1965, or for skilled nursing facility services furnished him prior to July 1, 1965.

"DEFINITIONS OF PROVIDERS OF SERVICES

"SEC. 1806. For purposes of this title—

"(a) The term 'hospital' (except for purposes of section 1804(b)(2), section 1809(f), paragraph (6) of this subsection, and so much of section 1803(b) as precedes paragraph (1) thereof) means an institution which—

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

"(2) maintains clinical records on all patients,

"(3) has bylaws in effect with respect to its staff of physicians,

"(4) continuously provides twenty-four-hour nursing service rendered or supervised by a registered professional nurse,

"(5) has in effect a hospital utilization review plan which meets the requirements of subsection (e),

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

"(7) meets such other of the requirements prescribed for the accreditation of hospitals by the Joint Commission on the Accreditation of Hospitals, as the Secretary finds necessary in the interest of the health and safety of individuals who are furnished services by or in the institution.

For purposes of section 1804(b)(2), such term includes any institution which meets the requirements of paragraph (1) of this subsection. For purposes of section 1809(f) (including determination of whether an individual received

inpatient hospital services for purposes of such section 1809(f)), and so much of section 1803(b) as precedes paragraph (1) thereof, such term includes any institution which meets the requirements of paragraphs (1), (2), (4), and (6) of this subsection. Notwithstanding the preceding provisions of this subsection, such term shall not, except for purposes of section 1804(b)(2), include any institution which is primarily for the care and treatment of tuberculosis or mentally ill patients.

"Skilled Nursing Facility

"(b) The term 'skilled nursing facility' means (except for purposes of section 1804(b)(2) and except for services provided after transfer from a hospital) an institution (or a distinct part of an institution) which is affiliated or under common control with a hospital having an agreement in effect under section 1810 and which—

"(1) is primarily engaged in providing to inpatients (A) skilled nursing care and related services for patients who require planned medical or nursing care or (B) rehabilitation services,

"(2) has policies, which are established by a group of professional personnel (associated with the facility), including one or more physicians and one or more registered professional nurses, to govern the skilled nursing care and related medical or other services it provides and which include a requirement that every patient must be under the care of a physician,

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

"(4) maintains clinical records on all patients,

"(5) continuously provides twenty-four-hour nursing service rendered or supervised by a registered professional nurse,

"(6) operates under a utilization review plan, which has been made applicable to it under subsection (g), of the hospital with which it is affiliated or under common control, or in the case of an unaffiliated institution, an alternative plan meeting requirements established by the Secretary,

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

"(8) meets such other conditions of participation under this section as the Secretary may find necessary in the interest of the health and safety of individuals who are furnished services by or in such institution:

except that such term shall not (other than for purposes of section 1804(b)(2)) include any institution which is primarily for the care and treatment of tuberculosis or mentally ill patients. For purposes of section 1804(b)(2), such term includes any institution which meets the requirements of paragraph (1) of this subsection. In the case of skilled nursing facility services provided after transfer from a hospital, such a facility need not be affiliated or under common control with a hospital.

"Home Health Agency

"(c) The term 'home health agency' means an agency which is affiliated or under common control with a hospital having an agreement in effect under section 1810 and which—

"(1) is a public agency, or a private nonprofit organization exempt from Federal income taxation under section 501 of the Internal Revenue Code of 1954,

"(2) is primarily engaged in providing skilled nursing services or other therapeutic services,

"(3) has policies, jointly developed, to govern the service (referred to in paragraph (2), which it provides,

"(4) maintains clinical records on all patients,

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

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

except that such term shall not include any agency which is primarily for the care and treatment of tuberculosis or mentally ill patients.

"Physician

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

"Utilization Review

"(e) A utilization review plan of a hospital shall be deemed sufficient if it is applicable to services furnished by the institution to individuals entitled to benefits under this title and if it provides—

"(1) for the review, on a sample or other basis, of admissions to the institution, the duration of stays therein, and the professional services furnished, (A) with respect to the medical necessity of the services, and (B) for the purpose of promoting the most efficient use of available health facilities and services;

"(2) for such review to be made by either (A) a hospital staff committee composed of two or more physicians, with or without participation of other professional personnel, or (B) a group outside the hospital which is similarly composed;

"(3) for such review, in each case in which inpatient hospital services are furnished to such individuals during a continuous period, as of the twenty-first day of such period and as of such subsequent days of such period as may be specified in regulations, with such review to be made as promptly after such twenty-first or subsequent specified day as possible, and in no event later than one week following such day;

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

The provisions of clause (A) of paragraph (2) shall not apply to any hospital where, because of the small size of the institution or for such other reasons as may be included in regulations, it is impracticable for the institution to have a properly functioning staff committee for the purposes of this subsection.

"Provider of Services

"(f) The term 'provider of services' means a hospital, skilled nursing facility, or home health agency.

"Skilled Nursing Facilities Affiliated or Under Common Control With Hospitals

"(g) A hospital and a skilled nursing facility shall be deemed to be affiliated or under common control if, by reason of a written agreement between them or by reason of a written undertaking by a person or body which controls both of them, there is reasonable assurance that—

"(1) the facility will be operated under standards which are developed jointly by, or are agreed to by, the two institutions, with respect to—

"(A) skilled nursing and related health services (other than physicians' services),

"(B) a system of clinical records, and

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

"(2) timely transfer of patients will be effected between the hospital and the skilled nursing facility whenever such transfer is medically appropriate, and provision is made for the transfer or the joint use (to the extent practicable) of clinical records of the two institutions; and

"(3) the utilization review plan of the hospital will be extended to include review of admissions to, duration of stays in, and the professional services furnished in the skilled nursing facility and including review of such indi-

vidual cases (and at such intervals) as may be specified in this title or in regulations thereunder, and with notice to the facility, the individual, and his attending physician in case of a finding (after opportunity for consultation to such attending physician) that further skilled nursing facility services are not medically necessary.

"Home Health Agency Affiliated or Under Common Control With Hospitals

"(h) A hospital and a home health agency shall be deemed to be affiliated or under common control if, by reason of a written agreement between them or by reason of a written undertaking by a person or body which controls both of them, there is reasonable assurance that—

"(1) the policies governing the skilled nursing or other therapeutic services provided by the agency shall be developed jointly or agreed to by the hospital and the agency, and

"(2) the agency will maintain such clinical or other records as may be agreed to by the hospital.

"States and United States

"(i) The terms 'State' and 'United States' shall have the same meaning as when used in title II.

"Additional Skilled Nursing Facilities

"(j) The Secretary shall, as soon as practicable, study the best ways of increasing the availability of skilled nursing facility care for beneficiaries under this title under conditions assuring good quality of care; and, on the basis of such study and after consultation with associations of nursing homes, the American Hospital Association, the Joint Commission on Accreditation of Hospitals, and other appropriate professional organizations, he may determine that additional nursing facilities in which such conditions assuring good quality of care exist constitute skilled nursing facilities under subsection (b) if they meet the requirements of such subsection (other than the requirement of affiliation and other than the requirement that a hospital utilization review plan be made applicable) and if the Secretary finds that such action will not create (or increase) any actuarial imbalance in the Federal Hospital Insurance Trust Fund. The Secretary shall report to the Congress from time to time, and in any event by July 1, 1966, the results of the study under this subsection and any action taken as a result thereof.

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

"SEC. 1807. In carrying out his functions, relating to determination of conditions of participation by providers of services, under section 1806(a)(7), section 1806(b)(8), or section 1806(c)(6) the Secretary shall consult with the Advisory Council on Health Insurance for the Aged established by section 235 of the Health Care Insurance Act of 1964, appropriate State agencies, and recognized national listing or accrediting bodies. Such conditions prescribed under any of such sections may be varied for different areas or different classes of institutions or agencies and may, at the request of a State, provide (subject to the limitation provided in section 1806(a)(7)) higher requirements for such State than for other States.

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

"SEC. 1808. (a) The Secretary may, pursuant to agreement, utilize the services of State health agencies or other appropriate State agencies for the purposes of (1) determining whether an institution is a hospital or skilled nursing facility, of whether an agency is a home health agency, or (2) providing consultative services to institutions or agencies to assist them (A) to qualify as hospitals, skilled nursing facilities, or home health agencies, (B) to establish and maintain fiscal records necessary for purposes of this title, and (C) to provide information which may be necessary to permit determination under this title as to whether payments are due and the amounts thereof. To the extent that the

Secretary finds it appropriate, an institution or agency which such a State agency certifies is a hospital, skilled nursing facility, or home health agency may be treated as such by the Secretary. The Secretary shall pay any such State agency, in advance or by way of reimbursement, as may be provided in the agreement with it (and may make adjustments in such payments on account of overpayments or underpayments previously made), for the reasonable cost of performing the functions specified in the first sentence of this subsection, and for the fair share of the costs attributable to the planning and other efforts directed toward coordination of activities in carrying out its agreement and other activities related to the provision of services similar to those for which payment may be made under this title, or related to the facilities and personnel required for the provision of such services, or related to improving the quality of such services.

"(b)(1) An institution shall be deemed to meet the conditions of participation under section 1806(a) (except paragraph (5) thereof) if such institution is accredited as a hospital by the Joint Commission on the Accreditation of Hospitals. If such Commission, as a condition for accreditation of a hospital, hereafter requires a utilization review plan or imposes another requirement which serves substantially the same purpose, the Secretary is authorized to find that all institutions so accredited by the Commission comply also with section 1806(a)(5).

"(2) If the Secretary finds that accreditation of an institution by a national accreditation body, other than the Joint Commission on the Accreditation of Hospitals, provides reasonable assurance that any or all of the conditions of section 1806 (a), (b), or (c), as the case may be, are met, he may, to the extent he deems it appropriate, treat such institution as meeting the condition or conditions with respect to which he made such finding.

"CONDITIONS OF AND LIMITATIONS ON PAYMENT FOR SERVICES

"Requirement of Requests and Certifications

"SEC. 1809. (a) Except as provided in subsection (f), payment for services furnished an individual may be made only to eligible providers of services and only if—

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

"(2) a physician certifies (and recertifies, where such services are furnished over a period of time, in such cases and with such frequency, appropriate to the case involved, as may be provided in regulations) that—

"(A) in the case of inpatient hospital services, such services are or were required for such individual's medical treatment, or such services are or were required for inpatient diagnostic study;

"(B) in the case of skilled nursing facility services, such services are or were required because the individual needed skilled nursing care on a continuing basis for any of the conditions with respect to which he was receiving inpatient hospital services prior to transfer to the skilled nursing facility or for a condition requiring such care which arose after such transfer and while he was still in the facility for treatment of the condition or conditions for which he was receiving such inpatient hospital services;

"(C) in the case of home health services, such services are or were required because the individual needed skilled nursing care on an intermittent basis or because he needed physical or speech therapy; a plan for furnishing such services to such individual has been established and is periodically reviewed by a physician; and such services are or were furnished while the individual was under the care of a physician;

"(3) with respect to inpatient hospital services or skilled nursing facility services furnished such individual after the twenty-first day of a continuous period of such services, there was not in effect, at the time of admission of such individual to the hospital, a decision under section 1810(e) (based on a finding that timely utilization review of long-stay cases is not being made in such hospital or facility);

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

"Determination of Costs of Services

"(b) The amount paid to any provider of services with respect to services for which payment may be made under this title shall be the reasonable cost of such services, as determined in accordance with regulations establishing the method or methods to be used in determining such costs for various types or classes of institutions, services, and agencies. In prescribing such regulations, the Secretary shall consider, among other things, the principles generally applied by national organizations (which have developed such principles) in computing the amount of payment, to be made by persons other than the recipients of services, to providers of services on account of services furnished to such recipients by such providers. Such regulations may provide for payment on a per diem, per unit, per capita, or other basis, may provide for using different methods in different circumstances, and may provide for the use of estimates of costs of particular items or services.

"Amount of Payment for More Expensive Services

"(c)(1) In case the bed and board furnished as part of inpatient hospital services or skilled nursing facility services is in accommodations more expensive than two-, three-, or four-bed accommodations and the use of such more expensive accommodations rather than such two-, three-, or four-bed accommodations was not at the request of the patient, payment with respect to such services may not exceed an amount equal to the reasonable cost of such services if furnished in such two-, three-, or four-bed accommodations unless the more expensive accommodations were required for medical reasons.

"(2) Where a provider of services with which an agreement under this title is in effect furnishes to an individual, at his request, items or services which are in excess of or more expensive than the items or services with respect to which payment may be made under this title, the Secretary shall pay to such provider of services only the equivalent of the reasonable cost of the items or services with respect to which payment under this title may be made.

"Amount of Payment Where Less Expensive Service Furnished

"(d) In case the bed and board furnished as part of inpatient hospital services or skilled nursing facility services in accommodations other than, but not more expensive than, two-, three-, or four-bed accommodations and the use of such other accommodations rather than two-, three-, or four-bed accommodations was neither at the request of the patient nor for a reason which the Secretary determines is consistent with the purposes of this title, the amount of the payment with respect to such services under this title shall be the reasonable cost of such services minus the difference between the charge customarily made by the hospital or skilled nursing facility for such services in two-, three-, or four-bed accommodations and the charge customarily made by it for such services in the accommodations furnished.

"No Payments to Federal Providers of Services

"(e) No payment may be made under this title (except under subsection (f) of this section) to any Federal provider of services, except a provider of services which the Secretary determines, in accordance with regulations, is providing services to the public generally as a community institution or agency and no such payment may be made to any provider of services for any item or service which such provider is obligated by a law of, or a contract with, the United States to render at public expense.

"Payment for Emergency Inpatient Hospital Services

"(f) Payments shall also be made to any hospital for inpatient hospital services furnished, by the hospital or under arrangements (as defined in section 1803(e) with it, to an individual entitled to insurance benefits under this title even though such hospital does not have an agreement in effect under this title if (A) such services were emergency services and (B) the Secretary would be required to make such payment if the hospital had such an agreement in effect and otherwise met the conditions of payment hereunder. Such payment shall be made only in amounts determined as provided in subsection (b) and then only if such hospital agrees to comply, with respect to the emergency services provided, with the provisions of section 1810(a).

"Payment for Services Prior to Notification of Noneligibility

"(g) Notwithstanding that an individual is not entitled to have payment made under this title for inpatient hospital services, skilled nursing facility services or home health services furnished by any provider of services, payment shall be made to such provider of services (unless such provider elects not to receive such payment or, if payment has already been made, refunds such payment within the time specified by the Secretary) for such services which are furnished to the individual prior to notification from the Secretary of his lack of entitlement if such payments are not otherwise precluded under this title and if such provider complies with the rules established hereunder with respect to such payments, has acted in good faith and without knowledge of such lack of entitlement, and has acted reasonably in assuming entitlement existed.

"AGREEMENTS WITH PROVIDERS OF SERVICES

"SEC. 1810. (a) Any provider of services shall be eligible for payments under this title if it files with the Secretary an agreement not to charge any individual or any other person for items or services for which such individual is entitled to have payment made under this title (or for which he would be so entitled if such provider had complied with the procedural and other requirements under or pursuant to this title or for which such provider is paid pursuant to the provisions of section 1809(g), and to make adequate provision for return (or other disposition, in accordance with regulations) of any moneys incorrectly collected from such individual or other person, and, where the provider of services has furnished, at the request of such individual, items or services which are in excess of or more expensive than the items or services with respect to which payment may be made under this title, such provider may also charge such individual or other person for such more expensive items or services but not more than the difference between the amount customarily charged by it for the items or services furnished at such request and the amount customarily charged by it for the items or services with respect to which payment may be made under this title.

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

"(1) by the provider of services at such time and upon such notice to the Secretary and the public as may be provided in regulations, except that the time such agreement is thereby required by the Secretary to continue in effect after such notice may not exceed six months after such notice, or

"(2) by the Secretary at such time and upon such notice to the provider of services and the public as may be specified in regulations, but only after the Secretary has determined, and has given such provider notification thereof, (A) that such provider of services is not complying substantially with the provisions of such agreement, or with the provisions of this title and regulations thereunder, or (B) that such provider no longer substantially meets the applicable provisions of section 1806, or (C) that such provider of services has failed to provide such information as the Secretary finds necessary to determine whether payments are or were due under this title and the amounts thereof, or has refused to permit such examination of its fiscal and other records by or on behalf of the Secretary as may be necessary to verify such information.

Any termination shall be applicable—

"(3) in the case of inpatient hospital services or skilled nursing facility services, with respect to such services furnished to any individual who is admitted to the hospital or skilled nursing facility furnishing such services on or after the effective date of such termination, and

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

"(c) Nothing in this title shall preclude any provider of services or any group or groups of such providers from being represented by an individual, association, or organization authorized by such provider or providers of services to act on their behalf in negotiating with respect to their participation under this title and the terms, methods, and amounts of payments for services to be provided thereunder.

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

"(e) If the Secretary finds that timely review in accordance with section 1806(e) of long-stay cases in a hospital or skilled nursing facility is not being made with reasonable regularity, he may, in lieu of terminating his agreement with such hospital or facility, decide that, with respect to any individual admitted to such hospital or skilled nursing facility after a date specified by him, no payment shall be made for inpatient hospital services or skilled nursing facility services after the twenty-first day of a continuous period of such services. Such decision may be made only after such notice to the hospital, or (in the case of a skilled nursing facility) to the hospital and the facility, and to the public as may be prescribed by regulations, and its effectiveness shall be rescinded when the Secretary finds that the reason therefor has been removed and there is reasonable assurance that it will not recur.

"PAYMENT TO PROVIDERS OF SERVICES

"SEC. 1811. The Secretary shall periodically determine the amount which should be paid to each provider of services under this title with respect to the services furnished by it, and the provider shall be paid, at such time or times as the Secretary believes appropriate and prior to audit or settlement by the General Accounting Office, from the Federal Hospital Insurance Trust Fund the amounts so determined; except that such amounts 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.

"REVIEW OF DETERMINATIONS

"SEC. 1812. Any individual dissatisfied with any determination made by the Secretary that he is not entitled to insurance benefits under this title or that he is not entitled to have payment made under this title with respect to any class of services furnished him, shall be entitled to a hearing thereon by the Secretary to the same extent as is provided in section 205(b) with respect to decisions of the Secretary, and to judicial review of the Secretary's final decision after such hearing as is provided in section 205(g).

"OVERPAYMENTS TO INDIVIDUALS

"SEC. 1813. (a) Any payment under this title to any provider of services with respect to inpatient hospital services, skilled nursing facility services, or home health services, furnished any individual shall be regarded as a payment to such individual.

"(b) Where—

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

"(2) any payment has been made under section 1809(g) to a provider of services for services furnished an individual,

proper adjustments shall be made, under regulations prescribed by the Secretary, by decreasing subsequent payments—

"(3) to which such individual is entitled under title II,

"(4) if such individual dies before such adjustment has been completed, to which any other individual is entitled under title II with respect to the wages and self-employment income which were the basis of benefits of such deceased individual under such title.

"(c) There shall be no adjustment as provided in subsection (b) (nor shall there be recovery) in any case where the incorrect payment has been made (including payments under section 1809(g)) for services furnished to an individual who is without fault and where such adjustment (or recovery) would defeat the purposes of title II or would be against equity and good conscience.

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

"USE OF PRIVATE ORGANIZATIONS IN THE ADMINISTRATION OF THIS TITLE

"SEC. 1814. (a) Through agreements entered into between the Secretary and qualified voluntary organizations (including organizations which have been designated by any group of providers of services, or by any association of such providers on behalf of its members), the Secretary shall utilize such organizations—

"(1) to make determinations (subject to such review by the Secretary as may be provided for in the agreement between the organization and the Secretary) of the amount of payments required pursuant to this title to be made to providers of services;

"(2) to receive, with the consent of the providers of services concerned, payments under section 1811 on behalf of such providers;

"(3) to make payments to providers of services of amounts to which they are entitled under section 1811;

(4) to make such audits of the records of providers of services as may be necessary to insure that proper payments are made under this title;

"(5) to assist in the application of safeguards against unnecessary utilization of services furnished by providers of services to individuals entitled to have payment made under this title with respect to services furnished them; and

"(6) otherwise to assist in discharging administrative duties necessary to carry out the purposes of this title.

"(b) To the maximum extent practicable the Secretary shall utilize, in accordance with the provisions of this section, the services of qualified voluntary organizations in the administration of this title. Voluntary organizations may submit proposals to the Secretary with respect to their furnishing services in the administration of this title. The Secretary shall carefully evaluate all such proposals with a view to entering into agreements with qualified voluntary organizations for their services in the administration of this title whenever he determines that the utilization of such services will contribute to the efficient and economic administration of this title.

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

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

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

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

"(e) An agreement with an organization under this section may require any of its officers or employees certifying payments or disbursing funds pursuant to the agreement, or otherwise participating in carrying out the agreement, to give surety bond to the United States in such amount as the Secretary may deem appropriate, and may provide for the payment of the charges for such bond from the Federal Hospital Insurance Trust Fund.

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

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

"REGULATIONS

"SEC. 1815. When used in this title, the term 'regulations' means, unless the context otherwise requires, regulations prescribed by the Secretary.

"APPLICATION OF CERTAIN PROVISIONS OF TITLE II

"SEC. 1816. The provisions of sections 206, 208, and 216(j), and of subsections (a), (d), (e), (f), and (h) of section 205 shall also apply with respect to this title to the same extent as they are applicable with respect to title II.

"DESIGNATION OF ORGANIZATION OR PUBLICATION BY NAME

"SEC. 1817. Designation in this title, by name, of any nongovernmental organization or publication shall not be affected by change of name of such organization or publication, and shall apply to any successor organization or publication which the Secretary finds serves the purpose for which such designation is made."

"ELECTION FOR ENTITLEMENT TO BENEFITS UNDER THIS TITLE

"SEC. 1818. (a) No individual who is entitled to monthly insurance benefits for any month under section 202 shall be entitled to benefits under this title for such month unless he shall, prior to the beginning of such month, have filed with the Secretary (in such form and in such manner as the Secretary shall be regulations prescribe) a certificate electing to become entitled to insurance benefits under this title. Such a certificate, once filed, may not thereafter be revoked (except for cause by leave of the Secretary pursuant to such regulations) and shall be effective with respect to months after the month in which it is filed.

"(b) If an individual becomes entitled to insurance benefits under this title by reason of filing a certificate as provided in subsection (a) he shall suffer a reduction in the amount of the monthly insurance benefits to which he is entitled under section 202. Such reduction shall be equal to 5 per centum of the amount of such monthly insurance benefits (as determined under title II), and shall be effective with respect to months for which such certificate is effective."

FEDERAL HOSPITAL INSURANCE TRUST FUND

SEC. 204. (a) Section 201 of the Social Security Act is amended by redesignating subsections (c), (d), (e), (f), (g), and (h) as subsections (d), (e), (f), (g), and (h), and (i), respectively, and by adding after subsection (b) the following new subsection:

"(c) There is hereby created on the books of the Treasury of the United States a trust fund to be known as the 'Federal Hospital Insurance Trust Fund'. The Federal Hospital 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 Hospital Insurance Trust Fund for the fiscal year ending June 30, 1965, and for each fiscal year thereafter, out of any moneys in the Treasury not otherwise appropriated, amounts equivalent to 100 per centum of—

"(1) 0.68 of 1 per centum of the wages (as defined in section 3121 of the Internal Revenue Code of 1954) paid after December 31, 1964, 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) 0.51 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, 1964, 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."

(b)(1) The heading of 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 HOSPITAL INSURANCE TRUST FUND".

(2) Subsection (a) of section 201 of such Act is amended by inserting "and the amounts specified in clause (1) of subsection (c) of this section" immediately before the semicolon in clause (3) thereof, by inserting "and the amount specified in clause (2) of subsection (c) of this section" immediately before the period in clause (4) thereof, and by striking out the last sentence and inserting in lieu thereof: "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 Hospital 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 adjustment 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."

(c) The first sentence of the subsection of such section 201 herein redesignated as subsection (d) 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 Hospital Insurance Trust Fund".

(d) Paragraph (1) of the subsection of such section 201 herein redesignated as subsection (h) is amended by striking out "titles II and VIII" and "this title" wherever they appear and inserting in lieu thereof "this title and title XVIII".

(e) The last sentence of paragraph (2) of such subsection is amended by striking out "and clause (1) of subsection (b)" and inserting in lieu thereof ", clause (1) of subsection (b), and clause (1) of subsection (c)".

(f) The subsection of such section herein redesignated as subsection (i) is amended by adding at the end thereof the following new sentence: "Payments required to be made under title XVIII shall be made only from the Federal Hospital Insurance Trust Fund."

(g) Section 218(h)(1) of such Act is amended by striking out "and (b)(1)" and inserting in lieu thereof ", (b)(1), and (c)(1)".

(h) Section 221(e) of such Act is amended—

(A) by striking out "Trust Funds" wherever that appears and inserting in lieu thereof "Trust Funds (except the Federal Hospital Insurance Trust Fund)";

(B) by striking out "subsection (g) of section 201" and inserting in lieu thereof "subsection (h) of section 201"; and

(C) by inserting "under this title" before the period at the end thereof.

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

TRANSITIONAL PROVISION FOR ELIGIBILITY FOR PRESENTLY UNINSURED INDIVIDUALS

SEC. 205. (a) Anyone who—

(1) has attained the age of sixty-five,

(2) (A) attained such age before 1967, or (B) has not less than three quarters of coverage (as defined in title II of the Social Security Act or section 5(1) of the Railroad Retirement Act of 1937), whenever acquired, for

each calendar year elapsing after 1964 and before the year in which he attained such age,

(3) is not, and upon filing application therefor would not be, entitled to monthly insurance benefits under section 202 of the Social Security Act and does not meet the requirements set forth in subparagraph (B) of section 21(b) of the Railroad Retirement Act of 1937, and

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

shall (subject to the limitations in this section) be deemed, solely for purposes of section 1805 of the Social Security Act, to be entitled to monthly insurance benefits under such section 202 for each month, beginning with the first month in which he meets the requirements of this subsection and ending with the month or, upon filing application in such month, would become, in which he dies or if earlier, the month before the month in which he becomes entitled to monthly insurance benefits under such section 202 or meets the requirements set forth in subparagraph (B) of section 21(b) of the Railroad Retirement Act of 1937.

(b) The provisions of subsection (a) shall apply only in the case of an individual who—

(1) is a resident of the United States (as defined in section 210 of the Social Security Act), and

(2) is a citizen of the United States or has resided in the United States (as so defined) continuously for not less than 10 years.

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

(1) is a member of any organization referred to in section 210(a)(17) of the Social Security Act,

(2) has been convicted of any offense listed in section 202(u) of the Social Security Act,

(3) is an employee of the United States, or

(4) is eligible for the benefits of the Federal Employees Health Benefits Act of 1959 or the Retired Federal Employees Health Benefits Act.

(d) There are authorized to be appropriated to the Federal Hospital Insurance Trust Fund (established by section 201 of the Social Security Act) from time to time such sums as the Secretary deems necessary, on account of—

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

(2) the additional administrative expenses resulting therefrom, and

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

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

TECHNICAL AMENDMENTS

Suspension in Case of Aliens

SEC. 206. (a) Subsection (t) of section 202 of such Act is amended by adding at the end thereof the following new paragraph:

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

Persons Convicted of Subversive Activities

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

Advisory Council of Social Security Financing

(c)(1) Subsection (a) of section 116 of the Social Security Amendments of 1956 is amended by striking out "and of the Federal Disability Insurance Trust Fund" and inserting in lieu thereof ", of the Federal Disability Insurance Trust Fund and of the Federal Hospital Insurance Trust Fund". Such sub-

section is further amended by inserting before the period at the end thereof "and the insurance benefits program under title XVIII of the Social Security Act".

(2) Subsection (d) of such section 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 Hospital Insurance Trust Fund".

(3) Subsection (f) of such section is amended by striking out ", the adequacy of benefits under the program, and all other aspects of the program" and inserting in lieu thereof "and the insurance benefits program under title XVIII of the Social Security Act, the adequacy of benefits under the programs, and all other aspects of the programs".

TECHNICAL AMENDMENT

SEC. 207. Section 3121(1)(6) of the Internal Revenue Code of 1954 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 Hospital Insurance Trust Fund,". The amendment made by this section shall be effective January 1, 1965.

PART B—RAILROAD RETIREMENT AMENDMENTS

HOSPITAL INSURANCE BENEFITS FOR THE AGED UNDER THE RAILROAD RETIREMENT ACT

SEC. 210. (a) The Railroad Retirement Act of 1937 is amended by adding after section 20 of such Act the following new section:

"HOSPITAL INSURANCE BENEFITS FOR THE AGED

"SEC. 21. (a) For the purposes of this section, and subject to the conditions hereinafter provided, the Board shall have the same authority to determine the rights of individuals described in subsection (b) of this section to have payments made on their behalf for insurance benefits consisting of inpatient hospital services, skilled nursing facility services, and home health services within the meaning of title XVIII of the Social Security Act as the Secretary of Health, Education, and Welfare has under such title XVIII with respect to individuals to whom such title applies. The rights of individuals described in subsection (b) of this section to have payment made on their behalf for the services referred to in the next preceding sentence shall be the same as those of individuals to whom title XVIII of the Social Security Act applies and this section shall be administered by the Board as if the provisions of such title XVIII were applicable, references to the Secretary of Health, Education, and Welfare were to the Board, references to the Federal Hospital Insurance Trust Fund were to the Railroad Retirement Account, references to the United States or a State included Canada or a subdivision thereof, and the provisions of section 1807 of such title XVIII were not included in such title. For purposes of section 11, a determination with respect to the rights of an individual under this section shall, except in the case of a provider of services, be considered to be a decision with respect to an annuity.

"(b) Except as otherwise provided in this section, every individual who—

"(A) has attained age sixty-five, and

"(B) (i) is entitled to an annuity, or (ii) would be entitled to an annuity had he ceased compensated service and, in the case of a spouse, had such spouse's husband or wife ceased compensated service, or (iii) had been awarded a pension under section 6, or (iv) bears a relationship to an employee which, by reason of section 3(e), has been, or would be, taken into account in calculating the amount of an annuity of such employee or his survivor,

shall be entitled to have payment made for the services referred to in subsection (a), and in accordance with the provisions of such subsection. The payments for services herein provided for shall be made from the Railroad Retirement Account (in accordance with, and subject to, the conditions applicable under section 10(b) in making payment of other benefits) to the hospital, skilled nursing facility, or home health agency providing such services, including such services provided in Canada to individuals to whom this subsection applies but only to the extent that the amount of payments for services otherwise hereunder

provided for an individual exceeds the amount payable for like services provided pursuant to the law in effect in the place in Canada which such services are furnished.

"(c) No individual shall be entitled to have payment made for the same services, which are provided for in this section, under both this section and title XVIII of the Social Security Act, and no individual shall be entitled to have payment made under both this section and such title XVIII for more than the number of days of inpatient hospital services determined as provided in section 1804 of such Act or more than one hundred and eighty days of skilled nursing facilities services during any benefit period or more than two hundred and forty days in any calendar year in which home health services are furnished. In any case in which an individual would, but for the preceding sentence, be entitled to have payment for such services made under both this section and such title XVIII, payment for such services to which such individual is entitled shall be made in accordance with the procedures established pursuant to the next succeeding sentence, upon certification by the Board or by the Secretary of Health, Education, and Welfare. It shall be the duty of the Board and such Secretary with respect to such cases jointly to establish procedures designed to minimize duplications of requests for payment for services, of elections for purposes of determining the number of days of inpatient hospital services for which payment may be made, and of determinations and to assign administrative functions between them so as to promote the greatest facility, efficiency, and consistency of administration of this section and title XVIII of the Social Security Act; and, subject to the provisions of this subsection, to assure that the rights of individuals under this section or title XVIII of the Social Security Act shall not be impaired or diminished by reason of the administration of this section and title XVIII of the Social Security Act. The procedures so established may be included in regulations issued by the Board and by the Secretary of Health, Education, and Welfare to implement this section and such title XVIII, respectively.

"(d) Any agreement entered into by the Secretary of Health, Education, and Welfare pursuant to title XVIII of the Social Security Act shall be entered into on behalf of both such Secretary and the Board. The preceding sentence shall not be construed to limit the authority of the Board to enter on its own behalf into any such agreement relating to services provided in Canada or in any facility devoted primarily to railroad employees.

"(e) A request for payment for services filed under this section shall be deemed to be a request for payment for services filed as of the same time under title XVII of the Social Security Act, and a request for payment for services filed under such title shall be deemed to be a request for payment for services filed as of the same time under this section.

"(f) The Board and the Secretary of Health, Education, and Welfare shall furnish each other with such information, records, and documents as may be considered necessary to the administration of this section or title XVIII of the Social Security Act.

"(g) There are authorized to be appropriated to the Railroad Retirement Account from time to time such sums as the Board finds sufficient to cover—

"(1) the costs of payments made from such Account under this section,

"(2) the additional administrative expenses resulting from such payments, and

"(3) any loss of interest to such Account resulting from such payments,

in cases where such payments are not includible in determinations under section 5(k)(2)(A)(iii) of this Act, provided such payments could have been made as a result of section 103 of the Health Care Insurance Act of 1964 but for eligibility under subparagraph (B) of subsection (b) of this section."

Amendment Preserving Relationship Between Railroad Retirement Act and Old-Age, Survivors, and Disability Insurance Systems

(b) Section 1(q) of such Act is amended by striking out "1961" and inserting in lieu thereof "1964".

Financial Interchange Between Railroad Retirement Account and Federal Hospital Insurance Trust Fund

(c)(1) Section 5(k)(2) of such Act is amended—

(A) by striking out subparagraphs (A) and (B) and redesignating subparagraphs (C), (D), and (E) as subparagraphs (A), (B), and (C), respectively;

(B) by striking out the second sentence and the sixth sentence of the subparagraph redesignated as subparagraph (A) by subparagraph (A) of this paragraph;

(C) by adding at the end of the subparagraph redesignated as subparagraph (A) by subparagraph (A) of this paragraph the following new subdivision:

"(iii) At the close of the fiscal year ending June 30, 1965, and each fiscal year thereafter, the Board and the Secretary of Health, Education, and Welfare shall determine the amount, if any, which, if added to or subtracted from the Federal Hospital Insurance Trust Fund, would place such Fund in the same position in which it would have been if service as an employee after December 31, 1936, had been included in the term 'employment' as defined in the Social Security Act and in the Federal Insurance Contributions Act. Such determination shall be made no later than June 15 following the close of the fiscal year. If such amount is to be added to the Federal Hospital Insurance Trust Fund the Board shall, within ten days after the determination, certify such amount to the Secretary of the Treasury for transfer from the Retirement Account to the Federal Hospital Insurance Trust Fund; if such amount is to be subtracted from the Federal Hospital Insurance Trust Fund, the Secretary of Health, Education, and Welfare shall, within ten days after the determination, certify such amount to the Secretary of the Treasury for transfer from the Federal Hospital Insurance Trust Fund to the Retirement Account. The amount so certified shall further include interest (at the rate determined under subparagraph (B) for the fiscal year under consideration) payable from the close of such fiscal year until the date of certification.";

(D) by striking out "subparagraph (B) and (C)" where it appears in the subparagraph redesignated as subparagraph (B) by subparagraph (A) of this paragraph and inserting in lieu thereof "subparagraph (A)"; by striking out "(D)" wherever it appears in the subparagraph redesignated as subparagraph (A) by subparagraph (A) of this paragraph and inserting in lieu thereof "(B)"; and

(E) by amending the subparagraph redesignated as subparagraph (C) by subparagraph (A) of this paragraph to read as follows:

"(C) The Secretary of the Treasury is authorized and directed to transfer to the Federal Old-Age and Survivors Insurance Trust Fund, the Federal Disability Insurance Trust Fund, or the Federal Hospital Insurance Trust Fund from the Retirement Account or to the Retirement Account from the Federal Old-Age and Survivors Insurance Trust Fund, the Federal Disability Insurance Trust Fund, or the Federal Hospital Insurance Trust Fund, as the case may be, such amounts as, from time to time, may be determined by the Board and the Secretary of Health, Education, and Welfare pursuant to the provisions of subparagraph (A), and certified by the Board or the Secretary of Health, Education, and Welfare for transfer from the Retirement Account or from the Federal Old-Age and Survivors Insurance Trust Fund, the Federal Disability Insurance Trust Fund, or the Federal Hospital Insurance Trust Fund."

(2) The amendments made by paragraph (1) of this subsection shall be effective January 1, 1965.

PART C—MISCELLANEOUS PROVISIONS

STUDIES AND RECOMMENDATIONS

SEC. 220. The Secretary of Health, Education, and Welfare shall carry on studies and develop recommendations to be submitted from time to time to the Congress relating to (1) the adequacy of existing facilities for health care for purposes of the program established by this title; and (2) methods for encouraging the further development of efficient and economical forms of health care which are a constructive alternative to inpatient hospital care.

PART D—COMPLEMENTARY PRIVATE HEALTH INSURANCE FOR INDIVIDUALS AGED SIXTY-FIVE OR OVER

PURPOSE

SEC. 230. The Congress hereby declares that it is the purpose of this part to provide, for all individuals aged sixty-five or over, the opportunity to secure at reasonable cost private health insurance which will insure them against the cost of health services which are not covered under the program established by title XVIII of the Social Security Act.

DEFINITIONS

SEC. 231. For purposes of the succeeding provisions of this part—

(a) the term "health insurance policy" means the policy, contract, agreement, or other arrangement entered into between a carrier and another person whereby the carrier, in consideration of the payment to it of a periodic premium, undertakes to provide, pay for, or reimburse the cost of, health services for the individual (or group of individuals) who are the beneficiaries of such policy, contract, agreement, or other arrangement;

(b) the "standard policy" of insurance to be devised pursuant to the provisions of section 232(c) may include any of the "health insurance benefits" described in subsection (c), and shall include at least the following health insurance benefits—

(1) payment of part or all of most charges for or toward physician's services whether performed at the physician's office or any other place;

(2) payment, in accordance with a schedule, for or toward the costs of surgery performed in or out of a hospital;

(3) payment of not less than the first $15 of charge for consultation with a physician who is a specialist in any area of medicine or surgery; and

(4) payment, in accordance with a schedule of fees for or toward charges for diagnostic care, and laboratory and X-ray services;

(c) the term "health insurance benefits" or the term "benefits" when used in connection with health insurance, means insurance against all or any part of the costs of any or all of the following—

(1) services provided by physicians, surgeons, dentists, or any other medical or remedial care recognized under State law;

(2) diagnostic care, and laboratory and X-ray services;

(3) prescribed drugs, eyeglasses, dentures, and prosthetic devices;

(4) private-duty nursing services;

(5) home health care services;

(6) inpatient hospital services;

(7) skilled nursing services;

but only to the extent that any such care, services, or benefits are not covered under the program established by title XVIII of the Social Security Act;

(d) the term "carrier" means a voluntary association, corporation, partnership, or other nongovernmental organization which is lawfully engaged in providing, paying for, or reimbursing the costs of, health services for individuals or groups under health insurance policies in consideration of premiums payable to the carrier and which meets reasonable standards prescribed by the Secretary;

(e) the term "premium" means the amount of the consideration charged by a carrier for coverage by a health insurance policy offered by the carrier; and

(f) the term "Secretary" means the Secretary of Health, Education, and Welfare.

AUTHORIZATION OF ASSOCIATION

SEC. 232. (a) In order to carry out the purposes of this part, there is hereby authorized to be established, subject to the approval of the Secretary, an association to be known as the National Association of Carriers To Provide Health Insurance for Individuals Aged Sixty-five or Over (hereinafter referred to as the "association").

(b) The association shall be composed of carriers which shall have voluntarily joined together for the purpose of carrying out the purposes of this part, and membership therein shall be open to all responsible carriers which desire

to participate in the activities of the association and agree to abide by the rules and regulations governing the association as set forth in, or promulgated pursuant to, the provisions of this part.

(c) (1) It shall be the function of the association to devise (in cooperation with and subject to the approval of the Secretary), and offer for sale through its members, a health insurance policy offering health insurance benefits for the aged designed to complement the health insurance benefits provided for eligible individuals under title XVIII of the Social Security Act. Such policy shall offer at least the health insurance benefits described in section 231(b). All the terms and conditions of such policy as well as the terms and conditions under which it is offered and sold shall be uniform, except that the association may provide that the amount of the premium to be paid for such a policy and the extent of the benefits provided thereunder shall vary in different areas of the United States as well as within different areas of any State, whenever necessary to reflect differences in the cost of securing health services of the type for which benefits are provided under such policy.

(2) The policy devised by the association pursuant to paragraph (1) shall in the succeeding provisions of this part be referred to as the "standard policy". In order to minimize the factor of adverse selection in the sale of the standard policy, the association shall establish appropriate limitations upon the period, during each year, when such policy may be offered to new subscribers.

(3) The association with the approval of the Secretary shall develop and circulate among its members minimum standards with respect to health insurance for the purpose of enabling its members, or any of them, to devise and offer for sale one or more health insurance policies each of which may serve as an alternative to the standard policy. Such standards shall require that any such policy shall fulfill the same purposes as does the standard policy and will represent to the subscriber thereof a dollar value which is not less than that represented by the standard policy. Any member of the association desiring to offer for sale any such policy shall first submit to the association and to the Secretary copies of the proposed policy, together with any information related thereto which the association shall deem pertinent. If the association and the Secretary after due consideration, find that such proposed policy fulfills the same purposes as does the standard policy and will represent to the subscriber thereof a dollar value which is not less than that represented by the standard policy, they shall approve such proposed policy. Upon the approval by the association and the Secretary of any such proposed policy, such policy may thereafter be offered for sale by any carrier which is a member of the association in the same manner and subject to the same conditions as obtain with respect to the standard policy. In this part any such policy shall be referred to as an "alternative policy".

(4) All premiums receivable on account of the standard policy or alternative policies sold by members of the association shall be covered into a common fund (hereinafter referred to as the "reserve fund") established by the association for the purpose of receiving such premiums, and all benefits payable on account of such policies as well as the reasonable administrative expenses incurred in connection with such policies shall be paid from the reserve fund. The association shall invest such portion of the reserve fund as is not, in their judgment, required to meet current withdrawals. Moneys in the reserve fund may be invested only in interest-bearing obligations of the United States or in obligations guaranteed as to both principal and interest by the United States. The assets of the reserve fund shall be the property of the association and the expenses of the association shall be defrayed from moneys in such fund.

(5) In order to hold within proper limits the portion of the premiums paid for the standard policy or alternative policies which are attributable to expenses in connection with the sale and administration of such policies, appropriate limitations shall be placed upon the amounts which members of the association may claim from the reserve fund on account of such expenses. Such limitation shall be established by the association, subject to the approval of the Advisory Council (established pursuant to section 235) and of the Secretary.

(6) The association, in cooperation with the Advisory Council and with the approval of the Secretary, shall devise programs designed to enable persons who have not attained age sixty-five and are still employed to purchase the insurance provided by the standard policy or an alternative policy on a prepaid basis.

(d) The management of the reserve fund and the administration of the activities of the association shall be vested in an executive committee which

shall consist of three individuals elected by the Advisory Council authorized to be established by section 235.

(e) Members of the association are authorized and encouraged to offer supplementary health insurance policies designed to provide to subscribers of the standard policy or an alternative policy coverage in addition to that provided by such policy. Such policies need not be uniform and may be offered at premiums which would permit a fair profit to the members offering them. Such policies may be offered for sale in conjunction with the standard policy or an alternative policy, but in such case, shall be offered in such a manner as to enable the prospective subscriber clearly to distinguish between the benefits and premiums provided by the standard policy or the alternative policy and the benefits and premiums provided by the supplementary policy.

(f) The association is authorized, with the approval of the Secretary and the Advisory Council, to adopt two separate and distinct symbols, one of which may be used in connection with the sale of the standard policy and which shall signify public endorsement of such policy and the other of which may be used in connection with the sale of alternative policies and which shall signify official public endorsement of such alternative policies.

(g) Nothing in this part shall be construed to authorize any control to be exercised over carriers who are members of the association with respect to any policy of insurance offered by them other than standard policies (as described in subsection (c)(2)) and alternative policies (as described in subsection (c)(3)); and the right of such carriers to offer other insurance policies shall be unaffected by their membership in the association.

REGIONAL DIVISIONS OF THE ASSOCIATION

SEC. 233. (a) Any one or more members of the association which desire to confine their business of offering for sale the standard policy or alternative policies, or both, to a particular geographical region may, pursuant to rules established by the association (with the approval of the Secretary), establish a regional division of the association for the purpose of offering such policies for sale in such region.

(b) Membership in any regional division of the association shall be open to all members of the association which desire to confine their sale of the standard policy or alternative policies, or both, to the geographical region with respect to which such division is established.

(c) Members of any such division shall, in lieu of depositing in the reserve fund provided for in section 232(c)(4) premiums received by them on account of any such policies sold by them, deposit such premiums in a common fund to be known as the regional reserve fund for such region. The regional reserve fund for any regional division of the association shall be managed by the members of such division, in accordance with regulations prescribed by the executive committee of the association with the approval of the Secretary and the Advisory Council. Any such regional reserve fund shall serve the same purposes and shall be subject to the same requirements as are prescribed with respect to the reserve fund provided for in section 232(c)(4). The assets of any such regional reserve fund shall be the property of the regional division of the association for which such fund is established, and the expenses of such division shall be defrayed from moneys in such fund.

(d) The executive committee of the association, with the approval of the Secretary and the Advisory Council, shall prescribe regulations governing the manner in which any regional division of the association shall be operated. Such regulations shall vest responsibility for the management and operation of the division in the membership thereof, but shall contain necessary safeguards to insure that the division will be managed and operated in such a manner as to carry out in the region with respect to which it is established purposes and functions which are the same as those of the association.

ESTABLISHMENT OF ASSOCIATION

SEC. 234. (a) Whenever five or more carriers shall have applied to the Secretary to form the association (provided for in section 232) the Secretary shall, as soon as he is satisfied that such carriers are ready, willing, and able to carry out the functions of the association (as set forth in section 232) in accordance with the requirements contained in such section, he shall declare the association (as so provided for) to be established by such carriers.

(b) The Secretary shall have the duty and the authority to make such rules and regulations as may be necessary or desirable to insure that the association, in carrying out its functions, complies with the requirements of section 232 and fulfills the purposes of this title.

ADVISORY COUNCIL

SEC. 235. (a) For the purpose of consulting with and advising the Secretary with respect to the administration of title XVIII of the Social Security Act, for the purpose of electing the executive committee of the association, and for the purpose of advising and assisting the association, the executive committee, and the Secretary in carrying out their respective functions under this part, there is hereby created an "Advisory Council on Health Insurance for the Aged" (hereinafter referred to as the "Advisory Council").

(b) The Advisory Council shall conduct a continuing study and investigation of the programs of insurance provided for in this part and in title XVIII of the Social Security Act with a view to assisting in the formulation and implementation of national policy in the field of health care for the aged. The Council shall from time to time make reports to the President (for transmittal by him to the Congress) of its findings and recommendations resulting from such study and investigation.

(c) In order to assist the Advisory Council in carrying out its duties the Council is authorized to employ, in accordance with the civil service laws and the Classification Act of 1949, as amended, such staff as may be necessary.

(d) The Advisory Council shall consist of twenty-four members who shall be appointed by the President. Members of the Advisory Council shall be selected by the President with a view to providing a broad representation, among the membership of the Council, of the insurance industry, labor, business, medical profession, consumers, and other interested elements of society. Not less than four members of the Council shall be persons whom the insurance industry shall have approved as having adequate insurance experience. The members of the Advisory Council shall elect a member of the Advisory Council as Chairman thereof.

(e) Each 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 only for the remainder of such term, and except that the terms of office of the members first taking office shall expire, as designated by the President at the time of appointment, four at the end of the first year, four at the end of the second year, four at the end of the third year, and four at the end of the fourth year. A member shall not be eligible to serve continuously or more than two terms.

(f) Members of the Advisory Council, while attending meetings or conferences of the Council or otherwise serving on business of the Council shall receive compensation at rates fixed by the Secretary, but not exceeding $100 per day, and while so serving away from their homes or regular places of business they may be allowed travel expenses, including per diem in lieu of subsistence, as authorized by section 5 of the Administrative Expenses Act of 1946 (5 U.S.C. 73b–2) for persons in the Government service employed intermittently. The Advisory Council shall meet as frequently as it deems necessary, but not less often than two times per year. Upon request of thirteen or more of its members, it shall be the duty of the Chairman to call a meeting of the Advisory Council.

EXEMPTION OF ASSOCIATION FROM CERTAIN LAWS

SEC. 236. (a) The association and each carrier which is a member of the association shall, with respect to so much of its business operations as is concerned exclusively with offering for sale, selling, and administering, the standard policy or alternative policies (as described in section 232(c)), be considered to be a charitable and benevolent institution, and as such, be exempt from—

(1) regulation by a State or political subdivision thereof,

(2) Federal or State income taxation,

(3) All State taxes on such policies or premiums payable on account thereof, and

(4) the provisions of the Act of July 2, 1890, as amended (known as the Sherman Act); the Act of October 15, 1914, as amended (known as the Clayton Act); and the Federal Trade Commission Act.

(b) Any operation of a carrier which is the subject of an exemption provided in subsection (a) shall be subject to the exclusive regulation of the Secretary.

COMPLIANCE PROVISIONS

SEC. 237. (a) If, after reasonable opportunity for hearing extended to the carrier concerned, it is determined by the Secretary that a carrier has failed to comply with any requirement of this part, or with any regulation promulgated pursuant to this part, the Secretary may declare either that the membership of such carrier in the association is permanently terminated or that such membership is suspended until such time as the Secretary is satified that such carrier will no longer fail to comply with such requirement or such regulation.

(b) During any period that the membership of any carrier is inoperative by reason of action taken by the Secretary pursuant to subsection (a), such carrier shall not be entitled to any exemption provided by section 236(a), and shall not, for any purpose, represent itself as being a member of the association. Any carrier who, in offering for sale any health insurance policy, falsely represents itself to be a member of the association shall be fined not more than $10,000.

HEARINGS AND JUDICIAL REVIEW

SEC. 238. (a) Prior to promulgating any regulation, issuing any order, making any finding of fact, or taking any other action under this part which affects the association or any member thereof, the Secretary shall hold an appropriate hearing on the matter and provide adequate opportunity to representatives of the association and to any interested member thereof to be present and present testimony at such hearing.

(b) If the association, or any member thereof, is dissatisfied with any action of the Secretary on which a hearing is required to be held under subsection (a), the association, or such member, as the case may be, may appeal to the United States District Court for the District of Columbia by filing with such court a notice of appeal. The jurisdiction of the court shall attach upon the filing of such notice. A copy of the notice of appeal shall be forthwith transmitted by the clerk of the court to the Secretary, or any officer designated by him for that purpose. The Secretary shall thereupon file in the court the record of the proceedings on which he based his action. The action of the Secretary shall be reviewed by the court (on the record) in accordance with the provisions of the Administrative Procedure Act."

[H.R. 11865, 88th Cong., 2d sess.]

AMENDMENT No. 1178

AMENDMENTS Intended to be proposed by Mr. GORE for himself, Mr. MCCARTHY, Mr. BARTLETT, Mr. CLARK, Mr. DODD, Mr. DOUGLAS, Mr. HART, Mr. HUMPHREY, Mr. MCINTYRE, Mr. MCNAMARA, Mr. MUSKIE, Mr. RANDOLPH, Mr. RIBICOFF, and Mr. WILLIAMS of New Jersey) to H.R. 11865, an Act to increase benefits under the Federal Old-Age, Survivors, and Disability Insurance System, to provide child's insurance benefits beyond age 18 while in school, to provide widow's benefits at age 60 on a reduced basis, to provide benefits for certain individuals not otherwise eligible at age 72, to improve the actuarial status of the Trust Funds, to extend coverage, and for other purposes, viz:

On the first page of the bill, strike out lines 3 and 4, and insert in lieu thereof the following:

TABLE I—SOCIAL SECURITY AMENDMENTS

SEC. 101. This title may be cited as the "Social Security Amendments of 1964".

On page 3, line 3, strike out "SEC. 2." and insert in lieu thereof "SEC. 102.".
On page 6, line 13, strike out "SEC. 3." and insert in lieu thereof "SEC. 103.".
On page 15, line 11, strike out "SEC. 4." and insert in lieu thereof "SEC. 104.".
On page 20, line 10, strike out "SEC. 5." and insert in lieu thereof "SEC. 105.".
On page 22, line 11, strike out "SEC. 6." and insert in lieu thereof "SEC. 106.".
On page 28, line 5, strike out "section 6" and insert in lieu thereof "section 106".
On page 28, line 16, strike out "SEC. 7." and insert in lieu thereof "SEC. 107.".
On page 29, line 2, strike out "SEC. 8." and insert in lieu thereof "SEC. 108.".
On page 31, line 18, strike out "SEC. 9." and insert in lieu thereof "SEC. 109.".

On page 36, line 6, strike out "section 16" and insert in lieu thereof "section 116".
On page 37, line 8, strike out "SEC. 10." and insert in lieu thereof "SEC. 110.".
On page 38, line 3, strike out "SEC. 11." and insert in lieu thereof "SEC. 111.".
On page 39, line 12, strike out "SEC. 12." and insert in lieu thereof "SEC. 112.".
On page 39, line 19, strike out "SEC. 13." and insert in lieu thereof "SEC. 113.".
On page 39, line 24, strike out "SEC. 14." and insert in lieu thereof "SEC. 114.".
On page 40, line 23, strike out "SEC. 15." and insert in lieu thereof "SEC. 115.".
On page 44, line 8, strike out "SEC. 16." and insert in lieu thereof "SEC. 116.".
On page 44, line 17, strike out "5.7 percent" and insert in lieu thereof "6.3 percent".
On page 44, line 21, strike out "6 percent" and insert in lieu thereof "6.6 percent".
On page 45, line 3, strike out "6.8 percent" and insert in lieu thereof "7.4 percent".
On page 45, line 7, strike out "7.2 percent" and insert in lieu thereof "7.8 percent".
On page 45, line 19, strike out "3.8 percent" and insert in lieu thereof "4.2 percent".
On page 45, line 21, strike out "4 percent" and insert in lieu thereof "4.4 percent".
On page 46, line 3, strike out "4.5 percent" and insert in lieu thereof "4.9 percent".
On page 46, line 5, strike out "4.8 percent" and insert in lieu thereof "5.2 percent".
On page 46, line 17, strike out "3.8 percent" and insert in lieu thereof "4.2 percent".
On page 46, line 19, strike out "4 percent" and insert in lieu thereof "4.4 percent".
On page 46, line 21, strike out "4.5 percent" and insert in lieu thereof "4.9 percent".
On page 46, line 24, strike out "4.8 percent" and insert in lieu thereof "5.2 percent".
At the end of the bill, add the following:

"TITLE II—HEALTH CARE INSURANCE FOR THE AGED

"SEC. 201. This title may be cited as the "Hospital Insurance Act of 1964".

"PART A—HOSPITAL INSURANCE BENEFITS FOR THE AGED

"FINDINGS AND DECLARATION OF PURPOSE

"SEC. 201. (a) The Congress hereby finds that (1) the heavy costs of hospital care and related health care are a grave threat to the security of aged individuals, (2) most of them are not able to qualify for and to afford private insurance adequately protecting them against such costs, (3) many of them are accordingly forced to apply for private or public aid, accentuating the financial difficulties of hospitals and private or public welfare agencies and the burdens on the general revenues, and (4) it is in the interest of the general welfare for financial burdens resulting from hospital services and related services required by these individuals to be met primarily through social insurance.

"(b) The purposes of this Act are (1) to provide aged individuals entitled to benefits under the old-age, survivors, and disability insurance system or the railroad retirement system with basic protection against the costs of inpatient hospital services, and to provide, in addition, as an alternative to inpatient hospital care, protection against the costs of certain skilled nursing facility services, home health services, and outpatient hospital diagnostic services; to utilize social insurance for financing the protection so provided; to encourage, and make it possible for, such individuals to purchase protection against other health costs by providing in such basic social insurance protection a set of benefits which can easily be supplemented by a State, private insurance, or other methods; to assure adequate and prompt payment on behalf of these individuals to the providers of these services; and to do these things in a manner consistent with the dignity and self-respect of each individual, without interfering in any way with the free choice of physicians or other health personnel or facilities

by the individual, and without the exercise of any Federal supervision or control over the practice of medicine by any doctor or over the manner in which medical services are provided by any hospital; and (2) to provide such basic protection, financed from general revenues, to those persons who are now age 65 or over or who will reach age 65 within the next several years and who are not eligible for benefits under the old-age, survivors, and disability insurance or railroad retirement systems.

"(c) It is hereby declared to be the policy of the Congress that skilled nursing facility services for which payment may be made under this Act shall be utilized in lieu of inpatient hospital services where skilled nursing facility services would suffice in meeting the medical needs of the patient, and that home health services for which payment may be made under this Act shall be utilized in lieu of inpatient hospital or skilled nursing facility services where home health services would suffice.

"(d) It is further declared to be the policy of the Congress that no individual who receives aid or assistance (including medical or other type of remedial care) under a State plan approved under I, IV, X, XIV, or XVI of the Social Security Act shall receive less benefits or be otherwise disadvantaged by reason of the enactment of this Act.

"PART A—HOSPITAL INSURANCE BENEFITS FOR THE AGED

"BENEFITS

"SEC. 202. The Social Security Act is amended by adding after title XVII the following new title:

"'TITLE XVIII—HOSPITAL INSURANCE BENEFITS FOR THE AGED

"'PROHIBITION AGAINST ANY FEDERAL INTERFERENCE

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

"'FREE CHOICE BY PATIENT GUARANTEED

"'SEC. 1802. Any individual entitled to have payment made under this title for services furnished him may obtain inpatient hospital services, skilled nursing facility services, home health services, or outpatient hospital diagnostic services from any provider of services with which an agreement is in effect under this title and which undertakes to provide him such services.

"'DESCRIPTION OF SERVICES

"'SEC. 1803. For purposes of this title—

"'Inpatient Hospital Services

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

"'(1) bed and board,

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

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

excluding, however—

"'(4) medical or surgical services provided by a physician, resident, or intern, except services provided in the field of pathology, radiology, physiatry, or anesthesiology, and except services provided in the hospital by an intern or a resident-in-training under a teaching program approved by the Council on Medical Education and Hospitals of the American Medical Association (or, in the case of an osteopathic hospital, approved by a recognized body approved for the purpose by the Secretary), and

"'(5) the services of a private-duty nurse.

"'Skilled Nursing Facility Services

"'(b) The term "skilled nursing facility services" means the following items and services furnished to an inpatient in a skilled nursing facility, after transfer from a hospital in which he was an inpatient, and (except as provided in paragraph (3) by such skilled nursing facility—

"'(1) nursing care provided by or under the supervision of a registered professional nurse,

"'(2) bed and board in connection with the furnishing of such nursing care,

"'(3) physical, occupational, or speech therapy furnished by the skilled nursing facility or by others under arrangements with them made by the facility,

"'(4) medical social services,

"'(5) such drugs, biologicals, supplies, appliances, and equipment, furnished for use in the skilled nursing facility, as are customarily furnished by such facility for the care and treatment of inpatients,

"'(6) medical services provided by an intern or resident-in-training of the hospital, with which the facility is affiliated or under common control, under a teaching program of such hospital approved as provided in subsection (a) (4), and

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

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

"'Home Health Services

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

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

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

"'(3) medical social services,

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

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

"'(6) in the case of a home health agency which is affiliated or under common control with a hospital, medical services provided by an intern or resident-in-training of such hospital, under a teaching program of such hospital approved as provided in subsection (a) (4);

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

"'Outpatient Hospital Diagnostic Services

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

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

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

excluding, however—

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

"'(4) any services furnished under such arrangements unless (A) furnished in the hospital or in other facilities operated by or under the supervision of the hospital, and (B) in the case of professional services, furnished by or under the responsibility of members of the hospital medical staff acting as such members.

"'Drugs and Biologicals

"'(e) The term "drugs" and the term "biologicals", except for purposes of subsection (c)(5) of this section, include only such drugs and biologicals, respectively, as are included in the United States Pharmacopoeia, National Formulary, New and Non-Official Drugs, or Accepted Dental Remedies, or are approved by the pharmacy and drug therapeutics committee (or equivalent committee) of the medical staff of the hospital furnishing such drugs or biologicals (or of the hospital with which the skilled nursing facility furnishing such drugs or biologicals is affiliated or is under common control).

"'Arrangements for Certain Services

"'(f) As used in this section, the term "arrangements" is limited to arrangements under which receipt of payment by the hospital, skilled nursing facility, or home health agency (whether in its own right or as agent), as the case may be, with respect to services for which an individual is entitled to have payment made under this title, discharges the liability of such individual or any other person to pay for the services.

"'DEDUCTIBLE; DURATION OF SERVICES

"'Deductible

"'SEC. 1804. (a)(1) Except as provided in subsection (c), payment for inpatient hospital services furnished an individual during any benefit period shall be reduced by a deduction equal to $20, or if greater, $10 multiplied by the number of days, not exceeding nine, for which he received such services in such period.

"'(2) Payment for outpatient hospital diagnostic services furnished an individual during any thirty-day period shall be reduced by a deduction equal to $20. For purposes of the preceding sentence, a thirty-day period for any individual is a period of thirty consecutive days beginning with the first day (not including in a previous such period) on which he is entitled to benefits under this title and on which outpatient hospital diagonstic services are furnished him.

"'Duration of Services

"'(b) Payment under this title for services furnished any individual during a benefit period may not be made for—

"'(1) inpatient hospital services furnished to him during such period after such services have been furnished to him for 90 days during such period, except as provided in subsection (c); or

"'(2) skilled nursing facility services furnished to him during such period after such services have been furnished to him for 180 days during such period.

For purposes of the preceding provisions of this subsection, inpatient hospital services or skilled nursing facility services shall be counted only if payment is or would, except for this subsection and except for the failure to comply with the procedural and other requirements of or under section 1809(a)(1), be made with respect to such services under this title. Payment under this title for home health services furnished an individual during a calendar year may not be made for any such services after such services have been furnished him during 240 visits in such year.

"'Election as to Duration of Inpatient Hospital Services and Deductible

"'(c)(1) An individual may elect, instead of the number of days in a benefit period for which payment may be made for inpatient hospital services furnished to him specified in subsection (b)(1)—

"'(A) to have such number of days for each benefit period increased to 180, and, in such case, the payment under this title for inpatient hospital services furnished him during any benefit period shall, instead of being reduced by the deduction specified in subsection (a)(1), be reduced by a deduction equal to either (i) 2½ times the average per diem rate for such services, determined under paragraph (4), or (ii) if less, the charges customarily made for such services by the hospital which furnished them, or

"'(B) to have such number of days reduced to 45 for each benefit period and, in such case, the reduction, provided in subsection (a)(1), in the payment under this title for inpatient hospital services furnished during any benefit period shall not apply to him.

"'(2) An individual may make an election under paragraph (1) only on such form or forms and in such manner as the Secretary may prescribe. Any such election shall be valid only if made before the month preceding, and after the fourth month preceding, the first month in which he both has attained the age of 65 and is eligible for the benefits referred to in section 1805(a)(2); except that if such first month occurs before January 1966, such election shall be valid only if made after May 1965 and before December 1965. For purposes of the preceding sentence, (A) an individual shall be regarded as eligible for benefits for a month if he is or, upon filing application for such benefits in such month, would be entitled to such benefits, and (B) an individual to whom section 204 of the Hospital Insurance Act of 1964 applies shall be deemed eligible for the benefits referred to in such section 1805(a)(2) for and after the month in which he attains the age of 65

"'(3) An individual shall be permitted only one election under this subsection and such election shall be irrevocable.

"'(4) The Secretary shall, between July 1 and October 1 of the calendar year 1967 and of each calendar year thereafter, promulgate the average per diem rate for inpatient hospital services which shall be applicable in the case of benefit periods beginning during the succeeding year. Such promulgation shall be based on the best information available to the Secretary (at the time the determination is made) as to the amounts paid under this title on account of inpatient hospital services furnished, during the calendar year preceding such determination, by hospitals, with which agreements under section 1810 are in effect, to individuals who are entitled to have such payments made with respect to such services; and the amount so determined shall be rounded to the nearest $1, or, if it is a multiple of $0.50 but not of $1, to the next higher $1. For benefit periods beginning prior to the calendar year 1968, such average per diem rate shall be $37.

"'Benefit Period

"'(d) For the purposes of this section, a "benefit period" with respect to any individual means a period of consecutive days—

"'(1) beginning with the first day (not included in a previous benefit period) (A) on which such individual is furnished inpatient hospital services or skilled nursing facility services and (B) which occurs in a month for which he is entitled to insurance benefits under this title, and

"'(2) ending with the ninetieth day thereafter on each of which he is neither an inpatient in a hospital nor an inpatient in a skilled nursing facility (whether or not such 90 days are consecutive), but only if such 90 days occur within a period of not more than 180 consecutive days.

"'ENTITLEMENT TO BENEFITS

"'SEC. 1805. (a) Every individual who—

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

"'(2) is entitled to monthly insurance benefits under section 202,

shall be entitled to insurance benefits under this title for each month for which he is entitled to such benefits under section 202, beginning with the first month after December 1965 with respect to which he meets the conditions specified in paragraphs (1) and (2).

"'(b) For the purposes of this section—

"'(1) entitlement of an individual to insurance benefits under this title for a month shall consist of entitlement to have payment made under, and subject to the limitations in, this title on his behalf for inpatient hospital services, skilled nursing facility services, home health services, and outpatient hospital diagnostic services furnished him in the United States during such month; and

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

"'(c) Notwithstanding the preceding provisions of this section, no payments may be made under this title for inpatient hospital services, outpatient hospital diagnostic services, or home health services furnished an individual prior to January 1, 1966, or for skilled nursing facility services furnished him prior to July 1, 1966.

"'DEFINITIONS OF PROVIDERS OF SERVICES

"'SEC. 1806. For purposes of this title—

"'Hospital

"'(a) The term "hospital" (except for purposes of section 1804(d)(2), section 1809(f), paragraph (6) of this subsection, and so much of section 1803(b) as precedes paragraph (1) thereof) means an institution which—

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

"'(2) maintains clinical records on all patients,

"'(3) has bylaws in effect with respect to its staff of physicians,

"'(4) continuously provides twenty-four-hour nursing service rendered or supervised by a registered professional nurse,

"'(5) has in effect a hospital utilization review plan which meets the requirements of subsection (e),

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

"'(7) meets such other of the requirements prescribed for the accreditation of hospitals by the Joint Commission on the Accreditation of Hospitals, as the Secretary finds necessary in the interest of the health and safety of individuals who are furnished services by or in the institution.

For purposes of section 1804(d)(2), such term includes any institution which meets the requirements of paragraph (1) of this subsection. For purposes of section 1809(f) (including determination of whether an individual received inpatient hospital services for purposes of such section 1809(f), and so much of section 1803(b) as precedes paragraph (1) thereof, such term includes any institution which meets the requirements of paragraphs (1), (2), (4), and (6) of this subsection. Notwithstanding the preceding provisions of this subsection, such term shall not, except for purposes of section 1804(d)(2), include any institution which is primarily for the care and treatment of tuberculosis or mentally ill patients.

"'Skilled Nursing Facility

"'(b) The term "skilled nursing facility" means (except for purposes of section 1804(d)(2)) an institution (or a distinct part of an institution) which is affiliated or under common control with a hospital having an agreement in effect under section 1810 and which—

"'(1) is primarily engaged in providing to inpatients (A) skilled nursing care and related services for patients who require planned medical or nursing care or (B) rehabilitation services,

"'(2) has policies, which are established by a group of professional personnel (associated with the facility), including 1 or more physicians and 1 or more registered professional nurses, to govern the skilled nursing care and related medical or other services it provides and which include

a requirement that every patient must be under the care of a physician,

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

"'(4 maintains clinical records on all patients.

"'(5) continuously provides twenty-four-hour nursing service rendered or supervised by a registered professional nurse,

"'(6) operates under a utilization review plan, which has been made applicable to it under subsection (g), of the hospital with which it is affiliated or under common control,

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

"'(8) meets such other conditions of participation under this section as the Secretary may find necessary in the interest of the health and safety of individuals who are furnished services by or in such institutions;

except that such term shall not (other than for purposes of section 1804(d)(2)) include any institution which is primarily for the care and treatment of tuberculosis or mentally ill patients. For purposes of section 1804(d)(2), such term includes any institution which meets the requirements of paragraph (1) of this subsection.

"'Home Health Agency

"'(c) The term "home health agency" means an agency which—

"'(1) is a public agency, or a private nonprofit organization exempt from Federal income taxation under section 501 of the Internal Revenue Code of 1954,

"'(2) is primarily engaged in providing skilled nursing services or other therapeutic services,

"'(3) has policies, established by a group of professional personnel (associated with the agency), including 1 or more physicians and 1 or more registered professional nurses, to govern the service (referred to in paragraph (2)) which it provides,

"'(4) maintains clinical records on all patients,

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

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

except that such term shall not include any agency which is primarily for the care and treatment of tuberculosis or mentally ill patients.

"'Physician

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

"'Utilization Review

"'(e) A utilization review plan of a hospital shall be deemed sufficient if it is applicable to services furnished by the institution to individuals entitled to benefits under this title and if it provides—

"'(1) for the review, on a sample or other basis, of admissions to the institution, the duration of stays therein, and the professional services furnished, (A) with respect to the medical necessity of the services, and (B) for the purpose of promoting the most efficient use of available health facilities and services;

"'(2) for such review to be made by either (A) a hospital staff committee composed of 2 or more physicians, with or without participation of

other professional personnel, or (B) a group outside the hospital which is similarly composed;

"'(3) for such review, in each case in which inpatient hospital services are furnished to such individuals during a continuous period, as of the twenty-first day, and as of such subsequent days as may be specified in regulations, with such review to be made as promptly after such twenty-first or subsequent specified day as possible, and in no event later than 1 week following such day;

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

The provisions of clause (A) of paragraph (2) shall not apply to any hospital where, because of the small size of the institution or for such other reason or reasons as may be included in regulations, it is impracticable for the institution to have a properly functioning staff committee for the purposes of this subsection.

"'Provider of Services

"'(f) The term "provider of services" means a hospital, skilled nursing facility, or home health agency.

"'Skilled Nursing Facilities Affiliated or Under Common Control With Hospitals

"'(g) A hospital and a skilled nursing facility shall be deemed to be affiliated or under common control if, by reason of a written agreement between them or by reason of a written undertaking by a person or body which controls both of them, there is reasonable assurance that—

"'(1) the facility will be operated under standards which are developed jointly by, or are agreed to by, the two institutions, with respect to—

"'(A) skilled nursing and related health services (other than physicians' services),

"'(B) a system of clinical records, and

"'(C) appropriate methods and procedures for the dispensing and administering of drugs and biologicals;

"'(2) timely transfer of patients will be effected between the hospital and the skilled nursing facility whenever such transfer is medically appropriate, and provision is made for the transfer or the joint use (to the extent practicable) of clinical records of the two institutions; and

"'(3) the utilization review plan of the hospital will be extended to include review of admissions to, duration of stays in, and the professional services furnished in the skilled nursing facility and including review of such individual cases (and at such intervals) as may be specified in this title or in regulations thereunder, and with notice to the facility, the individual, and his attending physician in case of a finding (after opportunity for consultation to such attending physician) that further skilled nursing facility services are not medically necessary.

"States and United States

"'(h) The term "State" and "United States" shall have the same meaning as when used in title II.

"'(i) The Secretary shall, as soon as practicable after December 31, 1965, study the best ways of increasing the availability of skilled nursing facility care for beneficiaries under this title under conditions assuring good quality of care; and, on the basis of such study and after consultation with associations of nursing homes, the American Hospital Association, the Joint Commission on Accreditation of Hospitals, and other appropriate professional organizations, he may determine that additional nursing facilities in which such conditions assuring good quality of care exist constitute skilled nursing facilities under subsection (b) if they meet the requirements of such subsection (other than the requirement of affiliation and other than the requirement that a hospital utilization review plan be made applicable) and if the Secretary finds that such action will not create (or increase) any actuarial imbalance in the Federal Hospital Insurance Trust Fund. The Secretary shall report to the Congress from time to time, and in any event by July 1, 1967, the results of the study under this subsection and any action taken as a result thereof.

"'USE OF STATE AGENCIES AND OTHER ORGANIZATIONS TO DEVELOP CONDITIONS OF PARTICIPATION FOR PROVIDERS OF SERVICE

"'SEC. 1807. In carrying out his functions, relating to determination of conditions of participation by providers of services, under section 1806(a)(7), section 1806(b)(8), or section 1806(c)(6), the Secretary shall consult with the Hospital Insurance Benefits Advisory Council established by section 1812, appropriate State agencies, and recognized national listing or accrediting bodies. Such conditions prescribed under any of such sections may be varied for different areas or different classes of institutions or agencies and may, at the request of a State, provide (subject to the limitation provided in section 1806(a)(7)) higher requirements for such State than for other States.

"'USE OF STATE AGENCIES AND OTHER ORGANIZATIONS TO DETERMINE COMPLIANCE BY PROVIDERS OF SERVICES WITH CONDITIONS OF PARTICIPATION

"'SEC. 1808. (a) The Secretary may, pursuant to agreement, utilize the services of State health agencies or other appropriate State agencies for the purposes of (1) determining whether an institution is a hospital or skilled nursing facility, or whether an agency is a home health agency, or (2) providing consultative services to institutions or agencies to assist them (A) to qualify as hospitals, skilled nursing facilities, or home health agencies, (B) to establish and maintain fiscal records necessary for purposes of this title, and (C) to provide information which may be necessary to permit determination under this title as to whether payments are due and the amounts thereof. To the extent that the Secretary finds it appropriate, an institution or agency which such a State agency certifies is a hospital, skilled nursing facility, or home health agency may be treated as such by the Secretary. The Secretary shall pay any such State agency, in advance or by way of reimbursement, as may be provided in the agreement with it (and may make adjustments in such payments on account of overpayments or underpayments previously made), for the reasonable cost of performing the functions specified in the first sentence of this subsection, and for the fair share of the costs attributable to the planning and other efforts directed toward coordination of activities in carrying out its agreement and other activities related to the provision of services similar to those for which payment may be made under this title, or related to the facilities and personnel required for the provision of such services, or related to improving the quality of such services.

"'(b)(1) An institution shall be deemed to meet the conditions of participation under section 1806(a) (except paragraph (5) thereof) if such institution is accredited as a hospital by the Joint Commission on the Accreditation of Hospitals. If such Commission, as a condition for accreditation of a hospital, hereafter requires a utilization review plan or imposes another requirement which serves substantially the same purpose, the Secretary is authorized to find that all institutions so accredited by the Commission comply also with section 1806(a)(5).

"'(2) If the Secretary finds that accreditation of an institution by a national accreditation body, other than the Joint Commission on the Accreditation of Hospitals, provides reasonable assurance that any or all of the conditions of section 1806 (a), (b), or (c), as the case may be, are met, he may, to the extent he deems it appropriate, treat such institution as meeting the condition or conditions with respect to which he made such finding.

"'CONDITIONS OF AND LIMITATIONS ON PAYMENT FOR SERVICES

"'Requirement of Requests and Certifications

"'SEC. 1809. (a) Except as provided in subsection (f), payment for services furnished an individual may be made only to eligible providers of services and only if—

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

"'(2) a physician certifies (and recertifies, where such services are furnished over a period of time, in such cases and with such frequency, appropriate to the case involved, as may be provided in regulations) that—

"'(A) in the case of inpatient hospital services, such services are or were required for such individual's medical treatment, or such services are or were required for inpatient diagnostic study;

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

"'(C) in the case of skilled nursing facility services, such services are or were required because the individual needed skilled nursing care on a continuing basis for any of the conditions with respect to which he was receiving inpatient hospital services prior to transfer to the skilled nursing facility or for a condition requiring such care which arose after such transfer and while he was still in the facility for treatment of the condition or conditions for which he was receiving such inpatient hospital services;

"'(D) in the case of home health services, such services are or were required because the individual needed skilled nursing care on an intermittent basis or because he needed physical or speech therapy; a plan for furnishing such services to such individual has been established and is periodically reviewed by a physician; and such services are or were furnished while the individual was under the care of a physician;

"'(3) with respect to inpatient hospital services or skilled nursing facility services furnished such individual after the twenty-first day of a continuous period of such services, there was not in effect, at the time of admission of such individual to the hospital, a decision under section 1810(e) (based on a finding that timely utilization review of long-stay cases is not being made in such hospital or facility);

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

"'Determination of Costs of Services

"'(b) The amount paid to any provider of services with respect to services for which payment may be made under this title shall be the reasonable cost of such services, as determined in accordance with regulations establishing the method or methods to be used in determining such costs for various types or classes of institutions, services, and agencies. In prescribing such regulations, the Secretary shall consider, among other things, the principles generally applied by national organizations (which have developed such principles) in computing the amount of payment, to be made by persons other than the recipients of services, to providers of services on account of services furnished to such recipients by such providers. Such regulations may provide for payment on a per diem, per unit, per capita, or other basis, may provide for using different methods in different circumstances, and may provide for the use of estimates of costs of particular items or services.

"'Amount of Payment for More Expensive Services

"'(c)(1) In case the bed and board furnished as part of inpatient hospital services or skilled nursing facility services is in accommodations more expensive than two-, three-, or four-bed accommodations and the use of such more expensive accommodations rather than such two-, three-, or four-bed accommodations was not at the request of the patient, payment with respect to such services may not exceed an amount equal to the reasonable cost of such services if furnished in such two-, three-, or four-bed accommodations unless the more expensive accommodations were required for medical reasons.

"'(2) Where a provider of services with which an agreement under this title is in effect furnishes to an indivdual, at his request, items or services which are in excess of or more expensive than the items or services with respect to which payment may be made under this title, the Secretary shall pay to such provider of services only the equivalent of the reasonable cost of the items or services with respect to which payment under this title may be made.

"'Amount of Payment Where Less Expensive Services Furnished

"'(d) In case the bed and board furnished as part of inpatient hospital services or skilled nursing facility services in accommodations other than, but not more expensive than, two-, three-, or four-bed accommodations and the use of such other accommodations rather than two-, three-, or four-bed accommodations was neither at the request of the patient nor for a reason which the Secretary determines is consistent with the purposes of this title, the amount of the payment with respect to such services under this title shall be the reasonable cost of such services minus the difference between the charge customarily made by the hospital or skilled nursing facility for such services in two-, three-, or four-bed accommodations and the charge customarily made by it for such services in the accommodations furnished.

"'No Payments to Federal Providers of Services

"'(e) No payment may be made under this title (except under subsection (f) of this section) to any Federal provider of services, except a provider of services which the Secretary determines, in accordance with regulations, is providing services to the public generally as a community institution or agency; and no such payment may be made to any provider of services for any item or service which such provider is obligated by a law of, or a contract with, the United States to render at public expense.

"'Payments for Emergency Inpatient Hospital Services

"'(f) Payments shall also be made to any hospital for inpatient hospital services or outpatient hospital diagnostic services furnished, by the hospital or under arrangements (as defined in section 1803(f)) with it, to an individual entitled to health insurance benefits under this title even though such hospital does not have an agreement in effect under this title if (A) such services were emergency services and (B) the Secretary would be required to make such payment if the hospital had such an agreement in effect and otherwise met the conditions of payment hereunder. Such payment shall be made only in amounts determined as provided in subsection (b) and then only if such hospital agrees to comply, with respect to the emergency services provided, with the provisions of section 1816(a).

"'Payment for Services Prior to Notification of Noneligibilty

"'(g) Notwithstanding that an individual is not entitled to have payment made under this title for inpatient hospital services, skilled nursing facility services, home health services, or outpatient hospital diagnostic services furnished by any provider of services, payment shall be made to such provider of services (unless such provider elects not to receive such payment or, if payment has already been made, refunds such payment within the time specified by the Secretary) for such services which are furnished to the individual prior to notification from the Secretary of his lack of entitlement if such payments are not otherwise precluded under this title and if such provider complies with the rules established hereunder with respect to such payments, has acted in good faith and without knowledge of such lack of entitlement, and has acted reasonably in assuming entitlement existed.

"'AGREEMENTS WITH PROVIDERS OF SERVICES

"'SEC. 1810. (a) Any provider of services shall be eligible for payments under this title if it files with the Secretary an agreement not to charge any individual or any other person for items or services for which such individual is entitled to have payment made under this title (or for which he would be so entitled if such provider had complied with the procedural and other requirements under or pursuant to this title or for which such provider is paid pursuant to the provisions of section 1809(g)), and to make adequate provision for return (or other disposition, in accordance with regulations) of any moneys incorrectly collected from such individual or other person, except that such provider of services may charge such individual or other person the amount of any deduction imposed pursuant to subsection (a) or (c) of section 1804 with respect to such services (not in excess of the amount customarily charged for such services by such provider) and, where the provider of services has furnished, at the request of such individual, items or services which are in excess of or more

expensive than the items or services with respect to which payment may be made under this title, such provider may also charge such individual or other person for such more expensive items or services but not more than the difference between the amount customarily charged by it for the items or services furnished at such request and the amount customarily charged by it for the items or services with respect to which payment may be made under this title.

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

"'(1) by the provider of services at such time and upon such notice to the Secretary and the public as may be provided in regulations, except that the time such agreement is thereby required by the Secretary to continue in effect after such notice may not exceed 6 months after such notice, or

"'(2) by the Secretary at such time and upon such notice to the provider of services and the public as may be specified in regulations, but only after the Secretary has determined, and has given such provider notification thereof, (A) that such provider of services is not complying substantially with the provisions of such agreement, or with the provisions of this title and regulations thereunder, or (B) that such provider no longer substantially meets the applicable provisions of section 1806, or (C) that such provider of services has failed to provide such information as the Secretary finds necessary to determine whether payments are or were due under this title and the amounts thereof, or has refused to permit such examination of its fiscal and other records by or on behalf of the Secretary as may be necessary to verify such information.

Any termination shall be applicable—

"'(3) in the case of inpatient hospital services or skilled nursing facility services, with respect to such services furnished to any individual who is admitted to the hospital or skilled nursing facility furnishing such services on or after the effective date of such termination,

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

"'(5) with respect to outpatient hospital diagnostic services furnished on or after the effective date of such termination.

"'(c) Nothing in this title shall preclude any provider of services or any group or groups of such providers from being represented by an individual, association, or organization authorized by such provider or providers of services to act on their behalf in negotiating with respect to their participation under this title and the terms, methods, and amounts of payments for services to be provided thereunder.

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

"'(e) If the Secretary finds that timely review in accordance with section 1806(e) of long-stay cases in a hospital or skilled nursing facility is not being made with reasonable regularity, he may, in lieu of terminating his agreement with such hospital or facility, decide that, with respect to any individual admitted to such hospital or skilled nursing facility after a date specified by him, no payment shall be made for inpatient hospital services or skilled nursing facility services after the twenty-first day of a continuous period of such services. Such decision may be made only after such notice to the hospital, or (in the case of a skilled nursing facility) to the hospital and the facility, and to the public as may be prescribed by regulations, and its effectiveness shall be rescinded when the Secretary finds that the reason therefor has been removed and there is reasonable assurance that it will not recur.

"'PAYMENT TO PROVIDERS OF SERVICES

"'SEC. 1811. The Secretary shall periodically determine the amount which should be paid to each provider of services under this title with respect to the services furnished by it, and the provider shall be paid, at such time or times as the Secretary believes appropriate and prior to audit or settlement by the General Accounting Office, from the Federal Hospital Insurance Trust Fund the amounts so determined; except that such amounts 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.

"'HOSPITAL INSURANCE BENEFITS ADVISORY COUNCIL

"'SEC. 1812. For the purpose of advising the Secretary on matters of general policy in the administration of this title and in the formulation of regulations under this title, there is hereby created a Hospital Insurance Benefits Advisory Council which shall consist of 14 persons, not otherwise in the employ of the United States, appointed by the Secretary without regard to the civil service laws. The Secretary shall from time to time appoint one of the members to serve as Chairman. Not less than 4 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 4 years, except that any member appointed to fill a vacancy occurring prior to the expiration of the term for which his predecessor was appointed shall be appointed for the remainder of such term, and except that the terms of office of the members first taking shall expire, as designated by the Secretary at the time of appointment, 3 at the end of the first year, 4 at the end of the second year, 3 at the end of the third year, and 4 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 2 terms. The Secretary may, at the request of the Council, appoint such special advisory or 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 attending meetings or conferences thereof or otherwise serving on business of the Advisory Council or of such a committee or committees, shall be entitled to receive compensation at rates fixed by the Secretary, but not exceeding $100 per day, and while so serving away from their homes or regular places of business they may be allowed travel expenses, including per diem in lieu of subsistence, as authorized by section 5 of the Administrative Expenses Act of 1946 (5 U.S.C. 73b–2) for persons in the Government service employed intermittently. The Advisory Council shall meet as frequently as the Secretary deems necessary. Upon request of 4 or more members, it shall be the duty of the Secretary to call a meeting of the Advisory Council.

"'REVIEW OF DETERMINATIONS

"'SEC. 1813. Any individual dissatisfied with any determination made by the Secretary that he is not entitled to insurance benefits under this title or that he is not entitled to have payment made under this title with respect to any class of services furnished him, shall be entitled to a hearing thereon by the Secretary to the same extent as is provided in section 205(b) with respect to decisions of the Secretary, and to judicial review of the Secretary's final decision after such hearing as is provided in section 205(g).

"'OVERPAYMENTS TO INDIVIDUALS

"'SEC. 1814. (a) Any payment under this title to any provider of services with respect to inpatient hospital services, skilled nursing facility services, home health services, or outpatient hospital diagnostic services, furnished any individual shall be regarded as a payment to such individual.

"'(b) Where—

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

"'(2) any payment has been made under section 1809(g) to a provider of services for services furnished an individual,

proper adjustments shall be made, under regulations prescribed by the Secretary, by decreasing subsequent payments—

"'(3) to which such individual is entitled under title II, or

"'(4) if such individual dies before such adjustment has been completed, to which any other individual is entitled under title II with respect to the wages and self-employment income which were the basis of benefits of such deceased individual under such title.

"'(c) There shall be no adjustment as provided in subsection (b) (nor shall there be recovery) in any case where the incorrect payment has been made (including payments under section 1809(g)) for services furnished to an individual who is without fault and where such adjustment (or recovery) would defeat the purposes of title II or would be against equity and good conscience.

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

"'USE OF PRIVATE ORGANIZATIONS TO FACILITATE PAYMENT TO PROVIDERS OF SERVICE

"'SEC. 1815. (a) The Secretary is authorized to enter into an agreement with any organization, which has been designated by any group of providers of services, or by an association of such providers on behalf of its members, to receive payments under section 1811 on behalf of such providers, providing for the determination by such organization (subject to such review by the Secretary as may be provided for the agreement) of the amount of payments required pursuant to this title to be made to such providers, and for making such payments. The Secretary shall not enter into an agreement with any organization under this section unless he finds it consistent with effective and efficient administration of this title.

"'(b) To the extent that the Secretary finds that performance of any of the following functions by an organization with which he has entered into an agreement under subsection (a) will be advantageous and will promote the efficient administration of this title, he may also include in the agreement provision that the organization shall (with respect to providers of services which are to receive payments through the organization)—

"'(1) serve as a center for, and communicate to providers, any information or instructions furnished to it by the Secretary, and serve as a channel of communication from providers to the Secretary;

"'(2) make such audits of the records of providers as may be necessary to insure that proper payments are made under this title;

"'(3) assist in the application of safeguards against unnecessary utilization of services furnished by providers to individuals entitled to have payment made under this title with respect to services furnished them;

"'(4) perform such other duties as are necessary to carry out the functions specified in subsection (a) and this subsection.

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

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

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

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

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

"'(f) An agreement with an organization under this section may require any of its officers or employees certifying payments or disbursing funds pursuant

to the agreement, or otherwise participating in carrying out the agreement, to give surety bond to the United States in such amount as the Secretary may deem appropriate, and may provide for the payment of the charges for such bond from the Federal Hospital Insurance Trust Fund.

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

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

"'OPTION TO INDIVIDUALS TO OBTAIN SUPPLEMENTARY PRIVATE HEALTH INSURANCE PROTECTION

"'SEC. 1816. (a) Nothing contained in this title shall be construed to preclude any State from providing, or any individual from purchasing or otherwise securing, protection against the cost of health or medical care services in addition to those for which payment may be made under this title.

"'(b) The Secretary shall consult with providers of hospital or other medical care services, and with insurance companies and other similar organizations providing protection against the costs of any of such services, and representatives of such providers, insurance companies, or other similar organizations, and with appropriate State and other public or private agencies or organizations to the end that they are encouraged and assisted in developing and providing protection, which supplements that provided under this title, against the costs of health or other medical care services for which payments may not be made under this title.

"'REGULATIONS

"'SEC. 1817. When used in this title, the term "regulations" means, unless the context otherwise requires, regulations prescribed by the Secretary.

"'APPLICATION OF CERTAIN PROVISIONS OF TITLE II

"'SEC. 1818. The provisions of sections 206, 208, and 216(j), and of subsections (a), (d), (e), (f), and (h) of section 205 shall also apply with respect to this title to the same extent as they are applicable with respect to title II.

"'DESIGNATION OF ORGANIZATION OR PUBLICATION BY NAME

"'SEC. 1819. Designation in this title, by name, of any nongovernmental organization or publication shall not be affected by change of name of such organization or publication, and shall apply to any successor organization or publication which the Secretary finds serves the purpose for which such designation is made.'

"FEDERAL HOSPITAL INSURANCE TRUST FUND

"SEC. 203. (a) Section 201 of the Social Security Act is amended by redesignating subsections (c), (d), (e), (f), (g), and (h) as subsections (d), (e), (f), (g), (h), and (i), respectively, and by adding after subsection (b) the following new subsection:

"'(c) There is hereby created on the books of the Treasury of the United States a trust fund to be known as the "Federal Hospital Insurance Trust Fund". The Federal Hospital 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 Hospital Insurance Trust Fund for the fiscal year ending June 30, 1966, and for each fiscal year thereafter, out of any moneys in the Treasury not otherwise appropriated, amounts equivalent to 100 per centum of—

"'(1) 0.68 of 1 per centum of the wages (as defined in section 3121 of the Internal Revenue Code of 1954) paid after December 31, 1965, 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) 0.51 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, 1965, 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.'

"(b)(1) The heading of 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 HOSPITAL INSURANCE TRUST FUND'.

"(2) Subsection (a) of section 201 of such Act is amended by inserting 'and the amounts specified in clause (1) of subsection (c) of this section' immediately before the semicolon in clause (3) thereof, by inserting 'and the amount specified in clause (2) of subsection (c) of this section' immediately before the period in clause (4) thereof, and by striking out the last sentence and inserting in lieu thereof: '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 Hospital 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 adjustment 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.'

"(c) The first sentence of the subsection of such section 201 herein redesignated as subsection (d) 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 Hospital Insurance Trust Fund'.

"(d) Paragraph (1) of the subsection of such section 201 herein redesignated as subsection (h) is amended by striking out 'titles II and VIII' and 'this title' wherever they appear and inserting in lieu thereof 'this title XVIII'.

"(e) The last sentence of paragraph (2) of such subsection is amended by striking out 'and clause (1) of subsection (b)' and inserting in lieu thereof ', clause (1) of subsection (b), and clause (1) of subsection (c)'.

"(f) The subsection of such section herein redesignated as subsection (i) is amended by adding at the end thereof the following new sentence: 'Payments required to be made under title XVIII shall be made only from the Federal Hospital Insurance Trust Fund.'

"(g) Section 218(h)(1) of such Act is amended by striking out 'and (b)(1)' and inserting in lieu thereof ', (b)(1), and (c)(1)'.

"(h) Section 221(c) of such Act is amended—

"(A) by striking out 'Trust Funds' wherever that appears and inserting in lieu thereof 'Trust Funds (except the Federal Hospital Insurance Trust Fund)';

"(B) by striking out 'subsection (g) of section 201) and inserting in lieu thereof 'subsection (h) of section 201'; and

"(C) by inserting 'under this title' before the period at the end thereof.

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

"TRANSITIONAL PROVISION FOR ELIGIBILITY FOR PRESENTLY UNINSURED INDIVIDUALS

"SEC. 204. (a) Anyone who—

"(1) has attained the age of 65,

"(2)(A) attained such age before 1968, or (B) has not less than 3 quarters of coverage (as defined in title II of the Social Security Act or section 5(1) of the Railroad Retirement Act of 1937), whenever acquired, for each calendar year elapsing after 1965 and before the year in which he attained such age,

"(3) is not, and upon filing application therefor would not be, entitled to monthly insurance benefits under section 202 of the Social Security Act and does not meet the requirements set forth in subparagraph (B) of section 21(b) of the Railroad Retirement Act of 1937, and

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

shall (subject to the limitations in this section) be deemed, solely for purposes of section 1805 of the Social Seclurity Act, to be entitled to monthly insurance benefits under such section 202 for each month, beginning with the first month in which he meets the requirements of this subsection and ending with the month in which he dies or, if earlier, the month before the month in which he becomes entitled to monthly insurance benefits under such section 202 or meets the requirements set forth in subparagraph (B) of section 21(b) of the Railroad Retirement Act of 1937.

"(b) The provisions of subsection (a) shall apply only in the case of an individual who—

"(1) is a resident of the United States (as defined in section 210 of the Social Security Act), and

"(2) is a citizen of the United States or has resided in the United States (as so defined) continuously for not less than 10 years.

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

"(1) is a member of any organization referred to in section 210(a)(17) of the Social Security Act,

"(2) has been convicted of any offense listed in section 202(u) of the Social Security Act,

"(3) is an employee of the United States, or

"(4) is eligible for the benefits of the Federal Employees Health Benefits Act of 1959 or the Retired Federal Employees Health Benefits Act.

"(d) There are authorized to be appropriated to the Federal Hospital Insurance Trust Fund (established by section 201 of the Social Security Act) from time to time such sums as the Secretary deems necessary, on account of—

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

"(b) the additional administrative expenses resulting thereform, and

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

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

"TECHNICAL AMENDMENTS

"Suspension in Case of Aliens

"SEC. 205. (a) Subsection (t) of section 202 of such Act is amended by adding at the end thereof the following new paragraph:

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

"Persons Convicted of Subversive Activities

"(b) Subsection (u) of such section is amended by striking out 'and' before the phrase 'in determining the amount of any such benefit payable to such individual for any such month,' and inserting after such phrase 'and in determining whether such individual is entitled to insurance benefits under title XVIII for any such month,'.

"Advisory Council on Social Security Financing

"(c)(1) Subsection (a) of section 116 of the Social Security Amendments of 1956 is amended by striking out 'and the Federal Disability Insurance Trust Fund' and inserting in lieu thereof ', of the Federal Disability Insurance Trust Fund, and of the Federal Hospital Insurance Trust Fund'. Such subsection is further amended by inserting before the period at the end thereof 'and the insurance benefits program under title XVIII of the Social Security Act'.

"(2) Subsection (d) of such section 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 Hospital Insurance Trust Fund'.

"(3) Subsection (f) of such section is amended by striking out ', the adequacy of benefits under the program, and all other aspects of the program' and inserting in lieu thereof 'and the insurance benefits program under title XVIII of the Social Security Act, the adequacy of benefits under the programs, and all other aspects of the programs'.

"TECHNICAL AMENDMENT TO INTERNAL REVENUE CODE

"SEC. 206. Section 3121(1)(6) of the Internal Revenue Code of 1954 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 Hospital Insurance Trust Fund,'. The amendment made by this section shall be effective January 1, 1966.

"PART B—RAILROAD RETIREMENT AMENDMENTS

"HOSPITAL INSURANCE BENEFITS FOR THE AGED UNDER THE RAILROAD RETIREMENT ACT

"SEC. 210. (a) The Railroad Retirement Act of 1937 is amended by adding after section 20 of such Act the following new section:

"'Hospital Insurance Benefits for the Aged

"'SEC. 21. (a) For the purposes of this section, and subject to the conditions hereinafter provided, the Board shall have the same authority to determine the rights of individuals described in subsection (b) of this section to have payments made on their behalf for insurance benefits consisting of inpatient hospital services, skilled nursing facility services, home health services, and outpatient hospital diagnostic services within the meaning of title XVIII of the Social Security Act as the Secretary of Health, Education, and Welfare has under such title XVIII with respect to individuals to whom such title applies. The rights of individuals described in subsection (b) of this section to have payment made on their behalf for the services referred to in the next preceding sentence shall be the same as those of individuals to whom title XVIII of the Social Security Act applies and this section shall be administered by the Board as if the provisions of such title XVIII were applicable, references to the Secretary of Health, Education, and Welfare were to the Board, references to the Federal Hospital Insurance Trust Fund were to the Railroad Retirement Account, references to the United States or a State included Canada or a subdivision thereof, and the provisions of sections 1807 and 1812 of such title XVIII were not included in such title. For purposes of section 11, a determination with respect to the rights of an individual under this section shall, except in the case of a provider of services, be considered to be a decision with respect to an annuity.

"'(b) Except as otherwise provided in this section, every individual who—

"'(A) has attained age sixty-five, and

"'(B)(i) is entitled to an annuity, or (ii) would be entitled to an annuity had he ceased compensated service and, in the case of a spouse, had such spouse's husband or wife ceased compensated service, or (iii) had been awarded a pension under section 6, or (iv) bears a relationship to an employee which, by reason of section 3(e), has been, or would be, taken into account in calculating the amount of an annuity of such employee or his survivor.

shall be entitled to have payment made for the services referred to in subsection (a), and in accordance with the provisions of such subsection. The payments for services herein provided for shall be made from the Railroad Retirement Account (in accordance with, and subject to, the conditions applicable under section 10(b) in making payment of other benefits) to the hospital, skilled nursing facility, or home health agency, providing such services, including such services provided in Canada to individuals to whom this subsection applies but only to the extent that the amount of payments for services otherwise hereunder provided for an individual exceeds the amount payable for like services provided

pursuant to the law in effect in the place in Canada where such services are furnished.

"'(c) No individual shall be entitled to have payment made for the same services, which are provided for in this section, under both this section and title XVIII of the Social Security Act, and no individual shall be entitled to have payment made under both this section and such title XVIII for more than the number of days of inpatient hospital services determined as provided in section 1804 of such Act or more than 180 days of skilled nursing facilities services during any benefit period, or more than two hundred and forty visits in any calendar year in which home health services are furnished. In any case in which an individual would, but for the preceding sentence, be entitled to have payment for such services made under both this section and such title XVIII, payment for such services to which such individual is entitled shall be made in accordance with the procedures established pursuant to the next succeeding sentence, upon certification by the Board or by the Secretary of Health, Education, and Welfare. It shall be the duty of the Board and such Secretary with respect to such cases jointly to establish procedures designed to minimize duplications of requests for payment for services, of elections for purposes of determining the number of days of inpatient hospital services for which payment may be made, and of determinations and to assign administrative functions between them so as to promote the greatest facility, efficiency, and consistency of administration of this section and title XVIII of the Social Security Act; and, subject to the provisions of this subsection to assure that the rights of individuals under this section or title XVIII of the Social Security Act shall not be impaired or diminished by reason of the administration of this section and title XVIII of the Social Security Act. The procedures so established may be included in regulations issued by the Board and by the Secretary of Health, Education, and Welfare to implement this section and such title XVIII, respectively.

"'(d) Any agreement entered into by the Secretary of Health, Education, and Welfare pursuant to title XVIII of the Social Security Act shall be entered into on behalf of both such Secretary and the Board. The preceding sentence shall not be construed to limit the authority of the Board to enter on its own behalf into any such agreement relating to services provided in Canada or in any facility devoted primarily to railroad employees.

"'(e)(1) A request for payment for services filed under this section shall be deemed to be a request for payment for services filed as of the same time under title XVIII of the Social Security Act, and a request for payment for services filed under such title shall be deemed to be a request for payment for services filed as of the same time under this section.

"'(2) An election filed under this section for purposes of determining the number of days of inpatient hospital services for which payment may be made, as provided in section 1804(c) of the Social Security Act, shall be deemed an election filed as of the same time under section 1804(c) of such Act, and such an election filed under such section 1804(c) shall be deemed to have been filed at the same time under this section.

"'(f) The Board and the Secretary of Health, Education, and Welfare shall furnish each other with such information, records, and documents as may be considered necessary to the administration of this section or title XVIII of the Social Security Act.'

"Amendment Preserving Relationship Between Railroad Retirement and Old-Age, Survivors, Disability, and Hospital Insurance Systems

"(b) Section (1)(q) of such Act is amended by striking out '1961' and inserting in lieu thereof '1964'.

"Financial Interchange Between Railroad Retirement Account and Federal Hospital Insurance Trust Fund

"(c)(1) Section 5(k)(2) of such Act is amended—

"(A) by striking out subparagraphs (A) and (B) and redesignating subparagraphs (C), (D), and (E) as subparagraphs (A), (B), and (C), respectively;

"(B) by striking out the second sentence and the last sentence of the subpara-

graph redesignated as subparagraph (A) by subparagraph (A) of this paragraph;

"(C) by adding at the end of the subparagraph redesignated as subparagraph (A) by subparagraph (A) of this paragraph the following new subdivision:

"'(iii) At the close of the fiscal year ending June 30, 1966, and each fiscal year thereafter, the Board and the Secretary of Health, Education, and Welfare shall determine the amount, if any, which, if added to or subtracted from the Federal Hospital Insurance Trust Fund, would place such fund in the same position in which it would have been if service as an employee after December 31, 1936, had been included in the term "employment" as defined in the Social Security Act and in the Federal Employment Contributions Act. Such determination shall be made not later than June 15 following the close of the fiscal year. If such amount is to be added to the Federal Hospital Insurance Trust Fund the Board shall, within ten days after the determination, certify such amount to the Secretary of the Treasury for transfer from the Retirement Account to the Federal Hospital Insurance Trust Fund; if such amount is to be substracted from the Federal Hospital Insurance Trust Fund the Secretary of Health, Education, and Welfare shall, within ten days after the determination, certify such amount to the Secretary of the Treasury for transfer from the Federal Hospital Insurance Trust Fund to the Retirement Account. The amount so certified shall further include interest (at the rate determined under subparagraph (B) for the fiscal year under consideration) payable from the close of such fiscal year until the date of certification.';

"(D) by striking out 'subparagraph (B) and (C)' where it appears in the subparagraph redesignated as subparagraph (B) by subparagraph (A) of this paragraph and inserting in lieu thereof 'subparagraph (A)'; and

"(E) by amending the subparagraph redesignated as subparagraph (C) by subparagraph (A) of this paragraph to read as follows:

"'(C) The Secretary of the Treasury is authorized and directed to transfer to the Federal Old-Age and Survivors Insurance Trust Fund, the Federal Disability Insurance Trust Fund, or the Federal Hospital Insurance Trust Fund from the Retirement Account or to the Retirement Account from the Federal Old-Age and Survivors Insurance Trust Fund, the Federal Disability Insurance Trust Fund, as the case may be, such amounts as, from time to time, may be determined by the Board and the Secretary of Health, Education, and Welfare pursuant to the provisions of subparagraph (A), and certified by the Board or the Secretary of Health, Education, and Welfare for transfer from the Retirement Account or from the Federal Old-Age and Survivors Insurance Trust Fund, the Federal Disability Insurance Trust Fund, or the Federal Hospital Insurance Trust Fund.'

"(2) The amendments made by paragraph (1) of this subsection shall be effective January 1, 1966. Such amendments and the amendments made by section 202(a) shall not be construed to increase or diminish the sums to be transferred, under the provisions of section 5(k)(2) of the Railroad Retirement Act before their amendment by paragraph (1) of this subsection, between the railroad Retirement Account and the Federal Old-Age and Survivors Insurance Trust Fund or the Federal Disability Insurance Trust Fund.

"PART C—MISCELLANEOUS PROVISIONS

"STUDIES AND RECOMMENDATIONS

"SEC. 220. The Secretary of Health, Education, and Welfare shall carry on studies and develop recommendations to be submitted from time to time to the Congress relating to (1) the adequacy of existing facilities for health care for purposes of the program established by this Act; (2) methods for encouraging the further development of efficient and economical forms of health care which are a constructive alternative to inpatient hospital care; (3) the feasibility of providing additional types of health insurance benefits within the financial resources provided by this Act; and (4) the effects of the deductibles upon beneficiaries, hospitals, and the financing of the program."

Amendment 1178, Introduced by Senator Gore (Similar to S. 880)	*Amendment 1163, Introduced by Senator Javits (As modified by Senator Javits during hearings)*
GENERAL DESCRIPTION	
Under social security (old-age and survivors insurance) and railroad retirement administrative mechanisms, provides (1) hospital, nursing home, home health, and outpatient diagnostic services to persons 65 or over eligible to receive (or receiving) social security or railroad retirement benefits financed by an increase in taxes for workers and employers under these systems; (2) similar benefits out of Federal general revenue for certain uninsured individuals 65 or over.	Contains similar provisions, under the Social Security and Railroad Retirement Acts, with major differences noted below. Provides that no person shall be entitled to health insurance benefits unless he signs a certificate irrevocably electing such benefits and agrees to take a 5 percent reduction in cash benefits. In addition, provides for a program of complementary health benefits for the aged, providing medical, surgical, and related services through the establishment of a national association of private insurance carriers to make available to aged persons a nonprofit, tax-exempt standard health insurance policy at reasonable cost.
I. BENEFITS FURNISHED UNDER SOCIAL SECURITY AND RAILROAD RETIREMENT	
Scope of Benefits	
Benefits would consist of payments to health facilities and organizations for services rendered to eligible individuals. Such payments may be made for the following kinds of services: (1) Inpatient hospital care for 90 days per benefit period[1] subject to deductible of $10 per day for the first 9 days, but not less than $20; *or, upon election,* 45 days per period with no deductible, *or, upon election,* 180 days with a deductible of the lesser of (*a*) 2½ times the average per diem rate for such services throughout the Nation under the program (until 1967 the bill sets the per diem rate at $37, thus the deductible initially will be $92.50) or (*b*) charges customarily made for such services by the hospital which furnished them. There may be only one election under this provision and it is irrevocable. The election must be made the month preceding the month in which the individual has both attained age 65 and is eligible for benefits.	Same as the Gore amendment with the following changes: (1) Inpatient hospital care may be furnished only for 45 days per benefit period,[2] with no deductible. No provision for election of 90 of 180 days of hospital care with deductibles.

[1] A period of consecutive days beginning with the 1st day an individual is furnished with hospital or nursing home services and ending after he has been out of the hospital or nursing home for 90 days. The 90 days need not be consecutive but must occur within a period of not more than 180 consecutive days.

[2] Same as the definition of benefit period in the Gore amendment except that the period ends after an individual has been out of the hospital or nursing home for 45 days.

Amendment 1178, Introduced by Senator Gore (Similar to S. 880)—Continued	*Amendment 1163, Introduced by Senator Javits (As modified by Senator Javits during hearings)*—Con.
***Scope of Benefits*—Continued**	
(2) Skilled nursing facility services up to 180 days in a benefit period after transfer from a hospital in an institution which is affiliated or under common control with a hospital;[3]	(2) Skilled nursing facility services up to 180 days in a benefit period provided (*a*) in an institution which is affiliated or under common control with a hospital, or (*b*) in an institution which need not be affiliated or under common control with a hospital in case of services provided after transfer from a hospital;[3]
(3) Home health services up to 240 visits a year;	(3) Home health services up to 240 visits a year furnished by a home health agency which is affiliated or under common control with a hospital;
(4) Outpatient diagnostic services—no durational limit but subject to a $20 deductible per 30-day period.	(4) Outpatient diagnostic services are not provided.
Eligibility for Benefits	
(1) All persons who— (a) are age 65 or over; and (b) are eligible to receive (or receiving) social security or railroad retirement benefits. (2) All persons not insured under social security or railroad retirement who either— (a) have reached age 65 before 1967; *or* (b) have reached age 65 after 1966 if they have 3 quarters of coverage for each year elapsing after 1964 and before the year they reach age 65.	Same.
Excluded from (2) would be nonresidents or resident aliens with less than 10 years in the United States, members of certain subversive organizations, persons convicted of certain subversive crimes, employees of the Federal Government, and persons eligible for benefits under the Federal employee or retired Federal employee health plans.	Same.

retirement eligibles there would be an increase in the tax on employers and employees and the self-employed, as follows:

Contribution rates

Year	Employer and employee, each			Self-employed		
	Present law	H.R. 11865	Amendment 1178	Present law	H.R. 11865	Amendment 1178
1965	3.625	3.8	4.2	5.4	5.7	6.3
1966-67	4.125	4.0	4.4	6.2	6.0	6.6
1968-70	4.625	4.5	4.9	6.9	6.8	7.4
1971	4.625	4.8	5.2	6.9	7.2	7.8

There will be an increase in the maximum taxable earnings under social security from $4,800 to $5,400, effective January 1, 1965. A separate trust fund for the hospital insurance program would be established.

(2) For ineligibles under social security and railroad retirement there would be an authorization of appropriation out of general revenues.

Same.

Contribution rates

Year	Employer and employee, each			Self-employed		
	Present law	H.R. 11865	Amendment 1163	Present law	H.R. 11865	Amendment 1163
1965	3.625	3.8	4.08	5.4	5.7	6.12
1966-67	4.125	4.0	4.28	6.2	6.0	6.14
1968-70	4.625	4.5	4.78	6.9	6.8	7.22
1971	4.625	4.8	5.08	6.9	7.2	7.62

Same.

Same.

II. COMPLEMENTARY PRIVATE HEALTH INSURANCE FOR THE AGED

No provision.

Authorizes the establishment of an association of insurance carriers ("National Association of Carriers To Provide Health Insurance for Individuals Aged 65 or Over") whose principal function is to devise and offer for sale through its members a "standard policy" of health insurance for eligible aged persons.

The standard policy *must* provide the following benefits—

(1) Payment of part or all of most charges for physician's services performed in the office or elsewhere;

(2) Payment, in accordance with a fee schedule, for part or all costs of surgery performed in or out of a hospital;

(3) Payment of at least the first $15 of consultation fee of a medical or surgical specialist;

(4) Payment, in accordance with a fee schedule, for part or all charges for diagnostic care, and laboratory and X-ray services.

[3] On the basis of a study, the Secretary of Health, Education, and Welfare may authorize the participation of facilities which, though not affiliated with hospitals, operate under conditions assuring the provision of adequate care, providing this action will not create (or increase) an actuarial imbalance in the trust funds.

Amendment 1178, Introduced by Senator Gore
(Similar to S. 880)—Continued

Financing—Continued

II. COMPLEMENTARY PRIVATE HEALTH INSURANCE FOR THE AGED—continued

No provision.

Amendment 1163, Introduced by Senator Javits
(As modified by Senator Javits during hearings)—Continued

The benefits that *may* be provided under the the standard policy or other policies authorized under the bill include (to the extent they are not covered by the social security hospital benefits program) the following—

(1) Physicians', surgeons', dentists', and related services;
(2) Diagnostic care and laboratory and X-ray services;
(3) Prescribed drugs, eyeglasses, dentures, and prosthetic devices;
(4) Private duty nursing;
(5) Home health care;
(6) Inpatient hospital services;
(7) Skilled nursing home services.

Member carriers would be allowed to offer for sale, in place of the standard policy, one or more "alternative" policies which meet minimum approved standards requiring such policies to fulfill the same purpose and represent the same dollar value as the standard policy.

All premiums paid for standard and alternative policies would go into a "reserve fund" and all benefits and reasonable expenses of administering such policies would be paid from this fund.

Member carriers could also offer for sale supplementary health insurance policies to aged individuals at prices which allow for fair profits.

Under the rules of the association member carriers would be allowed to form regional divisions to confine their activities to a particular geographic area. Each division would have its own regional reserve fund which would serve the same purpose and be subject to the same requirements as the national reserve fund.

The association and each of its members would, with respect to the sale of standard or alternative policies, be exempt from—

(1) Regulation by a State or political subdivision;
(2) Federal or State income taxation;
(3) State taxes on policies or premiums;
(4) The provisions of the Sherman Act, the Clayton Act and the Federal Trade Commission Act. Operations exempted above would be subject to exclusive regulation by the

The CHAIRMAN. The first witness is the Secretary of Health, Education, and Welfare, Mr. Celebrezze.

Will you proceed, sir.

STATEMENT OF HON. ANTHONY J. CELEBREZZE, SECRETARY OF HEALTH, EDUCATION, AND WELFARE; ACCOMPANIED BY WILBUR J. COHEN, ASSISTANT SECRETARY; ROBERT M. BALL, COMMISSIONER OF SOCIAL SECURITY; ROBERT J. MYERS, CHIEF ACTUARY, SOCIAL SECURITY ADMINISTRATION; AND CHARLES E. HAWKINS, LEGISLATIVE REFERENCE OFFICER, WELFARE ADMINISTRATION

Secretary CELEBREZZE. Mr. Chairman and distinguished members of the committee, H.R. 11865, the Social Security Amendments of 1964 as passed by the House of Representatives, provides for certain changes in the benefits, coverage, and financing of the old-age, survivors, and disability insurance provisions of the social security program. I plan to summarize those provisions briefly and to submit for the record a more detailed statement on certain technical aspects of the bill.

In addition, I shall point out that H.R. 11865 is seriously lacking in the area of highest priority need. It fails completely to offer those past 65 an avenue through which they can afford and obtain adequate basic health insurance protection. It thus fails to come to grips with the gravest threat to financial security and peace of mind in old age.

What is needed to provide security in old age, in sickness as well as in health, is a three-pronged attack on the problem:

First and most urgent, hospital insurance for the aged should be provided under the social security program so that older people would be assured of being able to meet this major item of expensive health care in a way consistent with dignity and self-respect.

Second, with a substantial portion of their health needs provided for under social security, a high proportion of the aged will be able to supplement their social security protection through the purchase of private insurance covering physicians' services and other major medical-care costs.

Third, the provision of hospital insurance under social security will make better medical assistance programs possible under the Kerr-Mills program for those who do not have their medical needs met otherwise. This is true because the fiscal burden imposed on the States to provide medical care for the aged will be greatly reduced by hospital insurance under social security. Hospital insurance through social security would reduce the cost of current medical assistance payments for the aged by 40 percent.

This is the same three-pronged approach which has worked so successfully in the provision of retirement income in the United States: a contributory social insurance system covering just about everyone, with some 34,000 private plans and private savings and insurance building on this social security and, finally, underlying the whole effort, the last-resort program of old-age assistance for those whose needs are not met in other ways.

Before going further into a discussion of hospital insurance, I should like first to summarize the provisions of the bill.

THE BENEFIT INCREASE

The bill would provide for a 5-percent increase in the benefits payable to the people now on the benefit rolls and to those who will come on the rolls in the future, and would increase from $4,800 to $5,400 the amount of annual earnings that is counted for benefits and subject to contribution for the support of the program (the so-called earnings base). The long-range cost of the proposal is 0.42 percent of covered payroll.

For retired workers now on the benefit rolls who started to receive benefits at or after age 65, monthly payments would range from $42 to $133.40. The increases for retired workers will range from $1.60 (for a worker at the minimum benefit level who comes on the rolls at age 62 when the new rates become effective) to $6.40 (for a worker at the $400 average monthly earnings level who is over 65). For a wife, the increase will range from 80 cents per month at the comparable minimum level to $3.20 at the maximum. Where the sole survivor beneficiary is an aged widow, the increase for her would range from $2 to $5.30.

The $5,400 earnings base, which would go into effect in 1965, would increase benefits for those with earnings over $4,800 who retire in the future, and would ultimately result in a maximum benefit for the worker of $143.40, rather than the maximum benefit today or $127 as under present law.

The maximum on total benefits payable to a family would also, of course, be higher than under existing law. The maximum family benefit amounts would range from $63 at the lowest average monthly earnings level to $300 at the maximum average monthly earnings level—as against a range of $60 to $254 under present law.

The benefit increase provided in the bill would be effective for the second month following the month of enactment. The earnings base increase would be effective January 1, 1965.

SPECIAL TRANSITIONAL BENEFITS FOR PEOPLE NOW AT ADVANCED AGES

This special provision would grant benefits to certain people now in their seventies or older for a minimum of 3 quarters of coverage instead of a minimum of 6 quarters of coverage as in present law. Primary beneficiaries would receive $35 a month, the widows would receive the same amount and wives would receive $17.50. It is estimated that 400,000 people who have had some work covered by the program, or whose husbands have had such work, would be added to the rolls by this provision. The long-range cost of this proposal would be 0.01 percent of payroll.

BENEFITS FOR WIDOWS AT AGE 60

The bill includes a provision to make widow's benefits available at age 60, with the benefits of those widows who start receiving them before age 62 reduced to take account of the longer period over which they would be paid. An estimated 180,000 widows aged 60 or 61 on the effective date of the bill are expected to claim benefits during the first year of operation. Because the benefit amounts would be actuarially reduced, payment of the widow's benefits before age 62 would not increase the longrun cost of the program.

BENEFITS FOR CHILDREN ATTENDING SCHOOL AFTER ATTAINING AGE 18

Under the bill benefits would be payable to a child up through age 21 if he is attending school, rather than stopping at age 18 as under present law. Mother's benefits in such cases would not be payable.

This new provision provides for the payment of benefits to children through their attendance at high school, and for some or all of the period when they are going to college. An estimated 275,000 children aged 18 to 21 on the effective date of this provision are expected to claim benefits during the first year of operation. The proposal has a longrun cost of 0.10 percent of covered payroll.

THE COVERAGE PROVISIONS OF THE BILL

There are four changes that would be made by the coverage provisions of the bill that have more than technical significance. The bill would provide social security credits for tips received by employees in the course of their work. It would bring self-employed doctors of medicine under social security on the same basis as other self-employed people. The bill would make coverage available on a permissive basis to policemen and firemen under retirement systems in all States. It would also make a change in the provision in the law which permits farmers with low net earnings to report either actual net earnings or two-thirds of their first $1,800 of gross income. The House bill would raise the $1,800 figure to $2,400.

FINANCING

The changes made by the bill would be financed by increasing the maximum earnings base from $4,800 to $5,400, beginning January 1, 1965, and by a revised tax schedule. The last increase in the earnings base, to $4,800, was enacted in 1958 and was effective starting with 1959. If a $4,800 earnings base had been in effect in 1958, about 55 percent of regularly employed men would have had all their earnings taxed and credited toward benefits.

In comparison, if a $5,400 earnings base were effective this year, about 48 percent of regularly employed men would have had all of their earnings taxed and credited toward benefits. Thus, the increase to $5,400 is a rather conservative adjustment to the economic changes that have taken place since the last time the Congress made a change in this figure.

In addition to making higher benefits possible for people at average and above average earnings levels, an increase in the earnings base results in a decrease in the cost of the program expressed as a percentage of covered payrolls. Raising the earnings base results in a net saving to the program because the law provides benefits that are a higher percentage of earnings at lower earnings levels than at the higher levels, but the income is determined by a flat percentage tax. The proposed increase in the earnings base would produce a net income equivalent to 0.25 percent of taxable payroll. Similarly, an incidental effect of the extensions of coverage in the bill is to produce a net income of 0.03 percent of payroll.

The income from the higher earnings base and coverage extensions is not enough to finance the full cost of the higher benefits and other

improvements made by the House bill. The remainder of the cost would be met by a revised tax schedule. Under this schedule the contribution rates would increase more slowly and gradually than under present law, so that excessive accumulations of funds in the next several years, with possible depressing effects on the economy, would be avoided.

Under existing law, the tax rate for employers and employees would be increased one-half of 1 percent, from 3⅝ to 4⅛ in 1966 and again in 1968, when the ultimate rate of 4⅝ percent would become effective. Under the schedule in the bill the rate in 1965 would be 3.8 percent instead of 3⅝, in 1966 it would be 4 percent instead of 4⅛ and the rates would remain below those scheduled in present law until 1971. In 1971 the employee-employer rate would be 4.8 percent; that is, 0.175 percent higher than the 4⅝-percent ultimate rate under present law. Corresponding changes would be made in the tax rate for the self-employed so that it would continue to be 1½ times the rate paid by employees.

The bill would allocate to the disability insurance trust fund 0.15 percent of taxable wages and 0.1125 percent of taxable self-employment income more than is now allocated to it under existing law. This would bring the total allocation to the disability insurance trust fund to 0.65 percent of taxable wages and 0.4875 percent of taxable self-employment income for years beginning after 1964, and would bring this fund into almost exact actuarial balance (an imbalance of only 0.01 percent of taxable payroll) as contrasted with the present imbalance of 0.14 percent of taxable payroll.

An increase in the allocation to the disability insurance trust fund was included in the bill because disability insurance termination rates due to death and recovery have been lower than previously anticipated, with the result that the costs of the disability insurance part of the program have, since the addition of dependents' benefits and the elimination of the age 50 restriction, been somewhat higher than expected. This change in the allocation as between the two trust funds will not affect the actuarial balance of the whole program. It will, however, provide a more reasonable division of income between the old-age and survivors insurance trust fund and the disability insurance trust fund.

The present social security program is in close actuarial balance. The estimated imbalance of 0.24 percent of taxable payroll, 2.6 percent relative to the cost of the program, is well within any reasonable margin of safety, taking into account the longrun nature of the program and the nature of the long-range assumptions on which estimates are based. The changes made by the bill would reduce the small long-range imbalance still further to 0.19 percent—that is, 0.18 percent for the old-age and survivors insurance part of the program and 0.01 percent for the disability insurance part—this figure is to be compared with the imbalance of 0.30 percent that was considered acceptable by the trustees and the Congress when the 1961 amendments (the most recent amendments that had a cost effect) were enacted.

Taken separately, the disability insurance part of the system—as a result of the reallocation of contribution income made by the bill—is in almost exact actuarial balance, while the old-age and survivors' insurance part is within 2 percent relative to its total cost.

THE JOB LEFT UNDONE UNDER THE HOUSE BILL

As I indicated earlier, H.R. 11865 fails completely in providing for the highest priority need: hospital insurance protection under social security.

The reasons the administration favors hospital insurance for older people under social security and the supporting evidence for our position have been documented in detail—most recently before the House Committee on Ways and Means and the Subcommittee on the Health of the Elderly, a subcommittee of the Senate Special Committee on Aging. Testimony on this subject was also presented to this committee in 1960. The recently completed Social Security Administration survey of the aged verifies our previous conclusions, and I am attaching a statement of findings from this survey.

The problem is: People after 65 have need of much more medical care than people at younger ages.

Senator LONG. Might I just interrupt you there and say I do not see the attachment to which you make reference here, Mr. Secretary.

Secretary CELEBREZZE. Here it is, Senator.

(The material referred to was made a part of the files.)

Secretary CELEBREZZE. People after 65 have need of much more medical care than people at younger ages. They use, for example, three times as many hospitals days on the average. Yet the incomes that the aged have available to pay for this much larger amount of care are, on the average, only about one-half as large as the incomes of younger people. It is for this reason that any approach, such as most private insurance, that seeks to finance the high health costs of older people entirely out of their retirement income cannot do the job for the great majority of people over 65. Reasonably adequate health insurance for an aged couple (health insurance covering the cost of, say, one-half of their total medical bills) costs from over $400 to $550 a year when it is available. This represents one-sixth or more of the income of the average older couple and they just cannot afford it.

What is needed, and what the President has proposed, is a system under which workers will pay contributions during their productive years toward protection against the high health costs than can be expected to beset them in later years. Social security—and only social security—offers a ready-built, pay-while-working arrangement that can make hospital insurance in old age available to practically everybody.

With a social security hospital insurance program for the elderly in effect, private insurance would play an even more important role in protecting older persons than it does today. Having contributed toward their basic hospital insurance when they were working, older people would be in a position to take premiums many now pay for inadequate protection against hospital costs and apply them to insurance that would cover other health costs, such as physicians' care. Thus they would have, through a combination of public and private plans, a level of protection that only a very few of the aged can now afford.

While almost all of the aged will be able to stand on their own feet, as they strongly desire, when social security basic hospital insurance protection is made available, medical assistance for the aged and other public assistance programs would be available to serve as

a backstop to meet exceptional needs. As a matter of fact, with the large cost of hospital care for older people removed as a burden on the general taxpayer in the States, it would be possible to have more adequate medical assistance generally available.

Although relief and assistance are necessary as a backstop, I am opposed to putting our main reliance on medical aid programs which subject the aged to the humiliation of a test of need and which are a direct burden upon the general taxpayer. It is sound policy to provide that those who will benefit from medical protection should contribute directly to the cost of the benefit and have that protection as a matter of right.

It is now 29 years since the Congress of the United States made the basic decision to place primary reliance on a program of preventing poverty and dependency amoung our elderly citizens rather than merely relieving poverty, through assistance, after it occurs. This decision was strongly reaffirmed in 1950 when this committee was concerned about the fact that more older people were on public assistance rolls than were eligible for benefits under social security, and by the consequent drain on public revenues—Federal, State, and local—which was large and growing larger every day.

The report of the Senate Committee on Finance on the Social Security Amendments of 1950 stated as follows:

> Your committee's impelling concern in recommending passage of H.R. 6000, as revised, has been to take immediate, effective steps to cut down the need for further expansion of public assistance, particularly old-age assistance. Unless the insurance system is expanded and improved so that it in fact offers a basic security to retired persons and to survivors, there will be continual and nearly irrestistible pressure for putting more and more Federal funds into the less constructive assistance programs. We consider the assistance method to have serious disadvantages as a longrun approach to the Nation's social security problem. We believe that improvement of the American social security system should be in the direction of preventing dependency before it occurs, and of providing more effective income protection, free from the humiliation of a test of need. Accordingly your committee recommends action designed to immediately bolster and extend the system of old-age and survivors insurance * * * (May 17, 1950).

We face a situation today parallel to the one the committee faced in 1950. At that time, many older people had to go on public assistance to meet everyday living costs. Now we find that a growing proportion of people must turn to public assistance because they are not able to meet their health costs. Expenditures for medical care for people 65 and over under the assistance programs are running some $900 million a year, one-third of all the money being spent for public assistance for older people and the amount is growing. If reasonably adequate medical assistance for the needy aged were available throughout the United States it would cost, in the absence of hospital insurance under social security, at least $1.8 billion a year.

To avoid high costs to the general taxpayer at local, State, and Federal levels and to protect the dignity and independence of older people, we must once again place our main emphasis on social insurance rather than put more and more Federal funds into the Kerr-Mills program.

The provision of hospital insurance under social security has an importance that extends to all parts of the population. Not only will it provide protection with dignity for those who are now old, but it will also relieve those in the middle generation who frequently now

must divert savings and income from meeting the needs of their children to help pay for the medical care of stricken parents. Most important of all, the addition of this protection to our social security program would make a permanent contribution to the solution of the problem, with those now middle-aged and younger making current provision for the protection that they will need in later years.

Mr. Chairman and members of the committee, the need for hospital insurance under social security is most urgent. There are laws, with which you are all familiar, which provide for income-tax deductions for medical expenses that help those who are relatively well off, and there are laws on the books that help the very poor through public assistance. But there are no laws to help the great majority of older people who face the ever-present danger of high and unpredictable medical care costs. The problem is not one of only the very poor. It is unfortunately a problem facing just about all of our older citizens. I do not believe the aged should be asked to wait longer for this needed protection. I hope very much, therefore, that the Congress this year will make provision under social security for hospital insurance for older people.

(The statement previously referred to follows:)

ADDITIONAL INFORMATION ABOUT CERTAIN PROVISIONS OF H.R. 11865

COVERAGE OF TIPS

H.R. 11865 would provide social security credit for tips received by employees in the course of their work. This provision of the bill will improve the social security protection afforded to more than a million tipped workers and their families. Under present law their benefits do not reflect the level of living that they have been able to provide for themselves and their families.

The bill provides for coverage of tips as wages, with the employee being required to report his tips to his employer, and with a penalty being placed on the employee amounts of tips are excluded.

Under the House bill the employer would have no responsibility for trying to get employees to report their tips or for going out of his way to collect the employee's share of the tax. The employer would report tips for an employee and match the employee's social security tax only if the tips were reported to him in writing within 10 days after the end of the month in which the tips were received and if the employer could collect the employee's share of the tax by deducting it from the regular wages or other funds of the employee. It would be up to the employee to see that the employer got the money for these taxes if he did not already have it. The employer would never be required to pay the employee tax from his own funds, and his liability for the employer tax on tips the employee received in a month would end on the 10th day after the end of the month. The plan would require withholding for social security purposes only and not for income tax.

Provisions are included authorizing the employer to get employees' reports of tips more often than once a month to suit the employer's convenience, and there is specific authorization for the employer to withhold the employee tax on tips that may prove to be less than the $20 required in order for tips to be covered. Also, a provision is included that would enable the employer to treat tips as if they were paid to the employee on the date they are reported to the employer rather than on the date they were received by the employee.

The Committee on Ways and Means has indicated its intention that regulations and procedures to implement the provisions of the bill for covering tips are to be framed in such a way as to be the most help to employers in fitting the reporting of tips into their payroll operations. This might mean, for example, that where an employer had difficulty in fitting employee reports of tips into his normal operations he could, instead of getting a report of tips from the employee for each pay period, use an assumed amount of tips that would be the same for each pay period with a periodic adjustment based on the actual amount of tips reported

by the employee. Under this approach he would be required to make the adjustment to the amount the employee had reported to the employer only at the time of his regular social security report, which is made four times a year.

Coverage of doctors

The bill would bring about 170,000 self-employed doctors of medicine into the program on the same basis as other self-employed people. Doctors are the only professional group—except for Federal employees, they are practically the only group—whose earnings are not covered under social security.

More than half of the physicians in private practice today have some social security credits on the basis of work other than as a self-employed doctor or through military service.

The House committee report on the bill stated as follows:

"Large numbers of doctors have requested coverage. Your committee knows of no valid reason why this single professional group should continue to be excluded. It runs counter to the general view that coverage should be as universal as possible. There are no technical or administrative barriers to the coverage of self-employed doctors of medicine."

Policemen and firemen under retirement systems

At present only 19 States specifically listed in the Federal law—Alabama, California, Florida, Georgia, Hawaii, Kansas, Maine, Maryland, New York, North Carolina, North Dakota, Oregon, South Carolina, South Dakota, Tennessee, Texas, Vermont, Virginia, and Washington—may provide social security coverage for policemen and firemen who are under retirement systems. The bill would make coverage available on a permissive basis to policemen and firemen under retirement systems in all States. The bill itself would not cover a single policeman or fireman; it would just make such coverage possible.

H.R. 11865, in making social security coverage available to policemen and firemen in all States, would retain all of the safeguards of present law, and would add an additional safeguard. These safeguards assure that groups of policemen and firemen will not be brought under social security against their will.

Present law contains a declaration that it is the policy of the Congress that the protection afforded members of a State or local government retirement system should not be impaired as a result of the extension of social security coverage to members of the system. The specific safeguards of present law are concerned with the procedures which a State must follow in arranging coverage for persons whose position is under a State or local retirement system. Present law gives the States considerable latitude in the formation of groups to be brought under social security. This often permits persons who are likely to have similar needs and desires so far as benefit protection is concerned to be brought under coverage as a separate group. Where a retirement system covers employees of more than one governmental unit, the State may bring under coverage as a single group the employees of any one or more of the governmental units. Also, where policemen and firemen are in a retirement system with other classes of employees, the policemen or firemen (or both together) may be treated as if they were members of a separate retirement system. In order to provide an additional safeguard for policemen and firemen under retirement systems, the bill would amend this latter provision to make the provision mandatory rather than permissive. Thus policemen and firemen would have to be treated as if they were members of a separate retirement system, and would have to be covered separately, even in cases where they were actually in a retirement system with other employees.

There are basically two methods of covering policemen and firemen. Under one method of providing coverage, coverage is extended only if a majority of members vote in favor of coverage, and under the other method (now available in 18 States) coverage is extended to only those current members of the group who desire coverage, with all future members of the group being covered compulsory. Under the so-called referendum method, available to all States, all members of a retirement system group are covered upon a favorable vote by the majority of the members. The new safeguard provided by the bill would have the effect of requiring that only policemen and firemen could vote in any referendum to decide on coverage for them.

Three minor provisions relating to State and local government employees

1. In 1956 a provision was adopted to permit certain States specifically named in the law to bring into social security only those State and local government

employees under a retirement system who desired coverage. In order to minimize the adverse effect upon the social security trust funds which results from permitting employees to choose on an individual basis whether or not to come under social security, the law requires that where this procedure is used all future members of the group must be covered compulsorily. This procedure provided, for certain States, a method of coverage alternative to the referendum method, available to all States, under which all members of a retirement system group are covered upon a favorable vote by the majority of the members. Under the new method provided in 1956, coverage could be provided for only those who desired it, even in cases where a majority of the members of the group might not want coverage. In 1958 the Congress approved an amendment giving another opportunity to choose coverage to individuals who had originally decided against coverage when it was made available to them under this provision. The choice under this new opportunity had to be exercised within a specified time limit. In 1961 this time limit was extended through 1962. H.R. 11865 would give individuals who did not choose coverage under these earlier provisions an additional period, extending up until the end of 1965, to elect coverage.

2. The bill would add Alaska and Kentucky to the list of 18 States that may cover State and local government employees under the alternative coverage procedure discussed above.

3. The bill would permit the coverage of certain hospital employees in California who cannot now be covered. The amendments of 1960 permitted social security credit to be given for the earnings of certain hospital employees which had been reported in error to the Internal Revenue Service for the years 1957 through 1959, and provided future coverage for those employees in California for whom the erroneous reportings had been made. Under the bill, coverage would be made available to persons first employed by the hospital after 1959, who, since they were not in the group for whom erroneous reportings had been made, could not obtain coverage under the 1960 legislation.

Coverage of farmers' earnings

The last of the coverage changes made by the bill is a modification of the provisions under which farmers report earnings for social security purposes. When self-employed farmers were covered by the 1954 amendments, it was anticipated that some low-income farmers, who may have no income tax liability, would have difficulty in keeping records from which they could report their net earnings for social security purposes. Accordingly, a special provision was included in the law which now (after amendment in 1956) permits people with low net earnings from farm self-employment to report either actual net earnings in a year or two-thirds of their first $1,800 of gross income. The change now proposed by the House would raise the $1,800 figure to $2,400.

Automatic recomputation of benefits

Under the bill, provision is made for automatic annual recomputation of benefits to take account of earnings a beneficiary may have after he comes on the rolls. Under present law, benefit recomputations to take account of additional earnings generally are available only on application by the individual and can be made only if the individual had covered earnings of more than $1,200 in a calendar year after he became entitled to benefits.

Experience has shown that a large number of people who are eligible for higher benefits because of additional earnings fail to apply for them. With the improved automatic data processing system that is now used in the administration of the social security program, it is both feasible and administratively advantageous to handle these recomputations on an automatic basis.

The CHAIRMAN. Thank you, Mr. Secretary.

Now, Mr. Secretary, there are three bills before the committee: The House bill, the King-Anderson bill with some modifications reintroduced by Senator Gore as amendment 1178, and then the Javits bill reintroduced by Senator Javits as amendment 1163. Do you favor the House-passed bill (H.R. 1186)?

Secretary CELEBREZZE. I favor the King-Anderson bill.

The CHAIRMAN. You favor the King-Anderson bill (amendment 1178)?

Secretary CELEBREZZE. Yes.

The CHAIRMAN. Do you favor the King-Anderson bill on top of the House bill?

Secretary CELEBREZZE. I favor them both.

The CHAIRMAN. You favor both bills?

Secretary CELEBREZZE. I favor both. But if I had to make a choice, while I am for both an increase in benefits and hospital insurance, in my opinion hospital care for the aged is much more important at this particular time than a small increase in benefits.

I cannot get overly excited when you give some wives a benefit increase of 80 cents a month. I favor both the increase and the King-Anderson approach. But if you ask me pointblank, "If you cannot have both, which would you take?" I think that more benefits would result to people from hospital insurance than from the small increase in benefits.

The CHAIRMAN. In other words, it is clear that you favor the House bill as it now stands, and then you favor the passage of the King-Anderson bill as an amendment to the House bill?

Secretary CELEBREZZE. Let me put it this way: I prefer the hospital insurance for the aged, because I think it is of greater benefit to the and on top of that put the King-Anderson bill, then I would favor doing both. I say we need both a benefit increase and the hospital insurance. But if that is not possible, if this committee does not want to go that high in the tax structure, then my choice would be hospital insruance for the aged, because I think it is of greater benefit to the individual than the small increase that is provided for in the House bill.

The CHAIRMAN. But you favor the King-Anderson bill (amendment 1178)?

Secretary CELEBREZZE. Yes.

The CHAIRMAN. You favor the House bill.

Secretary CELEBREZZE. I favor the House bill if it is coupled with the King-Anderson bill.

The CHAIRMAN. You favor both of them?

Secretary CELEBREZZE. That is right.

The CHAIRMAN. Now, you are no doubt aware that Senator Ribicoff, a very distinguished member of this committee, when he was Secretary, stated that the limit that he thought should be established on the payroll tax was 10 percent. If you take both of these bills, it will be 10.4. However, you favor it, notwithstanding the fact that it exceeds the 10 percent that Senator Ribicoff, Secretary Ribicoff at that time, thought was the maximum tax that should be assessed?

Secretary CELEBREZZE. Well, of course, Senator Byrd, you don't have to increase the percentage above 10 percent. You can stay within the 10 percent and have both by merely increasing the wage base. I think it can be increased to $6,600 and it will cover both without increasing the tax above 5 percent. You can do it either way.

The CHAIRMAN. I think you have cleared my mind about your position: Namely, you want both bills.

Secretary CELEBREZZE. Yes.

The CHAIRMAN. And the ultimate cost will be 10.4 percent.

Secretary CELEBREZZE. Not necessarily, Senator. You can stay within the 5-percent limitation but increase the wage base. The wage base as recommended in the House bill would be $5,400. You can increase that and still stay within 10 percent.

I think Secretary Ribicoff at the time that he testified—he is here; he can correct me—said he thought that we should stay within the 10 percent, but he said nothing at all about the wage base.

Senator BENNETT. This is a case of six of one and half a dozen of the other. You do not increase your rate, but you increase the total take in dollars, and in that case the impact on the individual is increased, even though you may have theoretically stayed within the 10-percent percentage figure.

This seems to me to be a rationalization of the purest kind.

Secretary CELEBREZZE. No; you increase the benefits when you increase the wage base. Moreover, if you increase the wage base, you also increase——

Senator BENNETT. Well, here we have got a situation where we are breaking through the 10-percent ceiling, and you have done that by a proposal to increase benefits and add a new program. You say, "We'll solve that by increasing the wage base, so we won't have to increase the rates," and then you say, "When we increase the rates, we will increase the benefits," so that will take us through the ceiling again. You are just chasing your tail.

Secretary CELEBREZZE. There are many factors that must be taken into consideration. We are consistently diminishing the percentage of workers whose earnings are fully covered. In other words, when the social security program went into effect in 1935, we had a $3,000 wage base. That covered all the earnings of 94 percent of regularly employed men. We have consistently diminished that, until now, even with the $5,400, we are down to 48 percent.

The wage base that would be equivalent today to the $3,000 wage base of 1935 would be $12,500.

Another point is that when you talk about a 10-percent ceiling, the employer paying at the maximum corporation income tax rate pays out of pocket, under the new tax structure, only about 52 percent of the 5 percent—about 2.5 percent.

Actually, if you are figuring an out-of-pocket expense, the employer is only paying 2.5 percent, under the tax structure, and taking the rest as a business expense.

The CHAIRMAN. Do you favor the Javits bill also?

Secretary CELEBREZZE. There are two Javits bills. Are you referring to the original Javits bill or the one that was introduced recently? I haven't had an opportunity to examine the new bill in detail. The earlier Javits bill was almost parallel with the administration bill in its coverage of hospital and related benefits under social security but also included certain provisions to make it easier for insurance companies to work together on a national basis to develop and sell health insurance to the aged. We strongly favor the administration's version—the King-Anderson bill—rather than the new Javits version.

The CHAIRMAN. But you are not prepared to speak on the Javits bill, S. 2431, which I believe is the one he has modified and reintroduced as amendment No. 1163.

Secretary CELEBREZZE. The last one, the one that was just recently introduced? I haven't had an opportunity to examine it in detail. It was just introduced the other day, Senator. Mr. Ball may want to address himself to it.

The CHAIRMAN. You have not had any time to study the Javits bill, have you?

Secretary CELEBREZZE. No; I have not. Mr. Ball may be familiar with it. I have not had an opportunity to study it.

The CHAIRMAN. Mr. Ball, do you wish to express your opinion on the Javits bill, S. 2431, as modified in amendment No. 1163?

Mr. BALL. Mr. Chairman, as the Secretary said, our position would be first in favor of the cash benefits in the House bill, plus the benefits in the King-Anderson bill, with sufficient financing to cover them both, either through an increase in the contribution rate or a combination of an increase in the contribution rate and a further wage base increase.

The basic feature in the new Javits approach is to offer people over 65 an option for the election of hospital insurance in place of the cash benefit increases in the House bill. Although we believe that the way the Javits bill carries out this idea has some serious defects in it, the basic idea of an option in place of a cash benefit, although not as good as our first position, would certainly be preferable from our standpoint to the House bill alone. The idea of an option for hospital insurance, modified to make it more practical than it is in the Javits proposal, would be our second choice.

The CHAIRMAN. Then, you favor a part of the Javits amendment, you say?

Mr. BALL. It would come, Mr. Chairman, as a second choice, and it should be modified. The way the Javits amendment does it would not be, I think, acceptable to us.

The CHAIRMAN. Are you concerned about the fact that the staff says that the ultimate cost of the Gore amendment 1178 would increase the tax rate by 10.4 percent in 1971? In other words, do you agree with Senator Ribicoff that it should or should not exceed 10 percent?

Mr. BALL. Well, Mr. Chairman, speaking for myself, I don't believe that there is any magic in the figure of 10 percent that should detemine for all time into the future what the contribution rates in social security should be. There are many systems providing protection, such as the railroad retirement system and the civil service retirement system, that go beyond a 5-percent contribution rate on the employee. There is much to be said, however, in favor of some increase in the wage base instead of increases in the contribution rate. But to answer your question directly, it does not seem to me that there is an absolute ceiling for the long-range future exactly at 10 percent on this.

The CHAIRMAN. In other words, you are not disturbed if it goes over 10 percent? I think those who pay the tax would be disturbed. That is a very heavy tax. Now, is it not true that all of the medical care bills have required upward adjustment: the Forand bill, the Kennedy-Anderson amendment in 1960, the King-Anderson bill in 1962 and 1964? In other words, the history is that they have gone up above the estimates that were made at the time the legislation was proposed; is that not right?

Mr. BALL. Mr. Chairman, if it is agreeable to you, I would like to ask our chief actuary, Mr. Robert Myers, if he would comment on the basic conditions that have led to the revision in these cost estimates at this point. Would that be agreeable?

The CHAIRMAN. Well, let me ask you again about the King-Anderson bill as reintroduced by Senator Gore in amendment 1178 and the

House bill. You would favor those two bills, enacted together, without change?

Mr. BALL. That is, the benefit provisions of the King-Anderson bill added to the House bill with changes to provide for sufficient financing to cover the combined bills. You would have to change the financing.

The CHAIRMAN. And then, the Javits bill?

Mr. BALL. No; if that were done, Mr. Chiarman——

The CHAIRMAN. You would only favor the Javits bill as a single bill, is that it, or a part of H.R. 11865.

Mr. BALL. Well, the option approach that is in the Javits bill, Mr. Chairman, is clearly a second choice. You wouldn't have it in addition to the King-Anderson bill, but rather in place of it. The Javits bill in its present form, I think, would need rather substantial changes. I am only referring to the idea of an option.

The CHAIRMAN. Do you favor the optional feature?

Mr. BALL. As a second choice, Mr. Chairman. I think that hospital insurance for the aged is so important that if it were not possible in the time left this year to get agreement on the financing provisions that would be necessary to add the benefits of King-Anderson to the House bill, putting the two together, it would be much better than just passing a cash benefit increase to allow people to elect, instead of some of the cash, protection under hospital insurance. That is a second choice.

The CHAIRMAN. As far as the Gore amendment is concerned, you would be willing to take it just as it is?

Mr. BALL. The benefit provisions; yes, sir.

The CHAIRMAN. And then, you would put it on top of the other bill.

Now, do you think that there is any validity to the doctors' opposition to social security coverage as proposed under the House bill? In other words, should their wishes be followed by Congress?

Secretary CELEBREZZE. Mr. Chairman, the coverage of the doctors was included by the Ways and Means Committee. It was not an administration proposal, though we have no objection to it. The reason that the committee gave in their report for including the doctors was that about half of them are now covered, and that many of the communications of the committee—and I am relying upon the committee's statements—were from doctors who wanted to be included.

The CHAIRMAN. But you are indifferent as to whether the doctors go in or out?

Secretary CELEBREZZE. I think it is best to put them in.

The CHAIRMAN. If the majority of the doctors want to stay out and not get the benefits and pay in on it, do you think the committee would be justified in eliminating the coverage provision for doctors?

Secretary CELEBREZZE. Again, Mr. Chairman, this is a question of opinion. At the Ways and Means Committee, their information was that the majority of the doctors wanted to come in, and that is the reason they are included.

The CHAIRMAN. Going on the assumption that the majority don't want courage, what then?

Secretary CELEBREZZE. We have on the social security records now perhaps 100,000 physicians who have some coverage. For example,

there are doctors spending 1 hour a day in a plant, and for that work they are covered under social security. The feeling of the committee was, if you have that high a number, you might as well make it universal, since partial coverage creates certain inequities.

As I say, this was the recommendation of the committee and not of the administration.

The CHAIRMAN. You say the majority of them do want coverage?

Secretary CELEBREZZE. I believe that was the committee's opinion—that a majority of them wanted to be covered.

The CHAIRMAN. Senator Long?

Senator LONG. Mr. Secretary, you say quite a bit here about the desirability of covering people and providing for their needs on the basis of right rather than on the basis of need, charity, or whatever you want to call it. Why don't we simply blanket under social security those various people who are not covered by the social security system for the minimum amount of payment available under the system? I think it would be about $42.50 under this bill, wouldn't it? Why don't we simply blanket under this bill those people, from age 72, who are not covered and include them in the program? Financing is something else, but as a practical matter, leaving the financing aside, which is a detail which would have to be worked out, why don't we do that for those people? Aren't they generally a class that need it?

Secretary CELEBREZZE. One of the basic purposes of social security in addition to the humanitarian reason is that it reduces the cost against general revenues. If you blanket these people into the program it would be a charge against general revenues rather than a charge aaginst the specific individuals that contribute to the program.

Senator LONG. Let us just discuss that a moment.

Secretary CELEBREZZE. All right.

Senator LONG. Let us suppose that during my working years I had been a domestic servant or a waiter or a farm laborer not covered by social security, scratching out a living as best I could. Now, as a practical matter, would it not be correct to say that if I was able to buy an automobile or even so much as a suit of clothes, every time I bought one of those commodities, into the cost of that was figured the hidden cost of this social security program. If the manufacturer had added that on to his cost of manufacturing, and so had his competitor, and even the retailer had made that a part of his cost of doing business and put his markup on top of that to cover overhead and to allow for profit, then I would be paying part of the cost of the program. In the last analysis, would not I as a consumer have been one of those paying that tax?

I ask that question, based on the same theory I explained on the Senate floor no later than yesterday, or the day before yesterday, when we were talking about who pays for this tax on these foreign securities on which we just got through levying a tax. We say the incidence falls on the American buyer of that bond. He is the fellow against whom we have levied the tax, but the fellow who is really paying it is the foreigner who issues that bond, because the tax is going to reduce what he can make on the bond. He has to set it up for that, that net price, because of the tax.

Don't we have a similar situation here? We levy this tax, and certainly, as far as the employer is concerned, he is the one who pays

for it directly, but in the process passes the burden right on to the consumer, just as though it were a sales tax levied on the general public.

Secretary CELEBREZZE. Yes, in part, but that individual has not contributed any part of the social security tax. In other words, the covered worker is also paying the general tax on top of that. He is also paying part of the employer's tax if he buys the employer's product, naturally. On top of that, then, we get from him an additional social security tax, so that he is paying much more for his protection than an individual would pay who was blanketed in. There are hidden taxes on everything that we buy, of course. You can't get away from it.

The CHAIRMAN. We have Dunkards and Mennonites in the valley of Virginia who insist upon being strictly independent. In no way will they accept funds from the State or Federal Government.

Secretary CELEBREZZE. Yes; we have the same thing in Ohio among the Amish, and they have it in Pennsylvania, too.

The CHAIRMAN. There aren't many of that class of people left in this country, who won't accept benefits from the Government.

Secretary CELEBREZZE. But there is nothing to prevent them from accepting benefits or not accepting benefits. It is the tax that is compulsory.

The CHAIRMAN. They refused to pay the tax, they refused to accept the benefits, and then the Federal Government went in and sold their horses in order to collect the tax which they wouldn't pay. Do you think that was a fair action?

Secretary CELEBREZZE. I am familiar with the cases of selling the horses, and I certainly would not have sold the horses. That happened some time ago.

The CHAIRMAN. In other words, they wanted to be independent and not accept anything from the Government. I think they should have the right to do it. This is a free country, I think.

Secretary CELEBREZZE. Senator, you must agree with me that if all of us had an option as to whether we paid taxes or whether we did not, I am sure large numbers would choose not to pay the taxes. That is the problem we run into on this type of thing.

Senator LONG. Mr. Celebrezze, let me just discuss with you briefly the point you are making. You are saying you don't think we should do anything for a fellow under social security who, while he was paying that tax as a part of the cost of the product, was not contributing part of his pay into the fund. You are reluctant to try to do something for that person, who is among the most poor we have in this country and among those who need it the most; but on the other hand, you are coming in here and placing your first priority on assisting these people who have no need whatsoever to show, who because they were covered by social security during their working days and are presently retired. You would like to give them this expensive medicare benefit even if they don't need it. Even if they are well able to pay for it themselves, you would propose to take care of those people, take them and provide them medical care in a hospital, even though they have a family available to look after them, and the sickness might not be one that a family could not easily care for in the home. You would do that for them, even though here is someone else who needs it immeasurably more, and you wouldn't give him so much as a crust of bread on medicare.

How do you justify that position?

Secretary CELEBREZZE. Now, that isn't an accurate statement, because these people are covered under an assistance program in their State.

Senator LONG. Oh, yes, sir. You say they are covered under the general assistance programs.

Secretary CELEBREZZE. Yes, sir.

Senator LONG. But in some States, the requirements are such that if you have a relative who could help you, even though that relative will not help you, you can't get 5 cents from that State. And in some States, sir—and I am sure you know that—there is a requirement that before you can get the first nickel out of that State welfare agency, you have got to sign your little old home away so that when you die, the sheriff sells the home under the hammer and gets his money back.

Senator DOUGLAS. Will the Senator yield?

The Senator from Louisiana has just made a very eloquent case against Kerr-Mills.

Senator LONG. Let me say that we don't have that requirement in Louisiana. You may have it in Illinois, but in some States that is the case.

How do you justify saying that you should do nothing for these people who need it the worst, and recommend these big benefits for people who pay nothing for them, and have no real need of them?

Secretary CELEBREZZE. You were speaking about placing under the social security program people who have never paid social security taxes. Would you charge the cost of doing so against the trust fund? If you do, then you are going to throw the trust fund out of balance.

Senator LONG. Well, now, Mr. Secretary, you can do it one way or the other. But you have been changing the law to put additional people under it who have made some minor contribution to the trust fund already.

Secretary CELEBREZZE. Yes.

Senator LONG. And I would first like to bypass the question of how you raise the money for it and talk about whether it is right or wrong. I am talking about why don't we blanket under those programs those unfortunate people who are not covered by social security, who generally are the most in need of it of all. You present almost a full page here, talking about the desirability of these people getting some benefits as a matter of right rather than a matter of need and getting them under social security rather than public welfare. Why don't we just put them under social security?

Secretary CELEBREZZE. The King-Anderson bill does blanket them in for medical insurance.

Senator LONG. Some of these poor folks would be better off sick. They may starve between now and the time they become ill. Why don't we proceed to put them in at least for a minimum somewhere under this program? If you can't afford it at age 65, why not age 72, somewhere along that line?

Senator DOUGLAS. Would it irritate my dear colleague if I asked him to yield at this point?

Senator LONG. Let me just ask this question first.

Secretary CELEBREZZE. You want them blanketed in for cash and for health insurance. If this committee is willing to get the general tax structure to cover the cost, we will go along with it.

Senator LONG. I personally think that we should have something of that sort. Of course, it might come from the general revenues or come from the tax here, but it seems to me that we should have something along that line.

I want to ask another question on a different subject. Would you agree with me that, generally speaking, self-insurance is the cheapest kind of insurance that you can have? What I mean is this: Is it not cheaper to take the risk with regard to a matter where you can afford to take the risk than it is to buy insurance on it?

Secretary CELEBREZZE. I have always been one that liked to carry insurance, because there is nothing certain in life. I would not like to take the risk that my house wouldn't burn down. I pay insurance on it year after year.

Senator LONG. It seems to me, Mr. Secretary, one of the best contracts you could get, if you are in business, would be to insure the State capitol building of Louisiana, which is a stone and concrete and steel building, no wood in the structure whatever, against fire. So if I could get the contract or insure that building against burning down, that would be a profitable contract. And every time I look around, somebody is getting a contract to insure something of that sort. A lot of people insure against bridges falling in the river. I think out in Tacoma, Wash., a while ago, a bridge fell in Puget Sound, and then they discovered that the fellow who got the contract to insure the bridge just hadn't insured it. He thought no bridge would ever fall in the river; why take the insurance, anyway. But he made the commission on it, at least—not the commission, the fee. And I think he was rather hard to find after the bridge fell into the sound, because it was not anticipated.

Secretary CELEBREZZE. That is exactly my point. He gambled that it wouldn't happen, and it happened.

Senator LONG. But now, generally speaking, is it not cheaper for a State to be a self-insurer than it is for a State to take out insurance that something will happen?

Secretary CELEBREZZE. Yes, to a degree that you save a great deal of administrative cost.

Senator LONG. Well, how many Federal bridges do we insure? How many Federal buildings do we insure? Do you insure your building against fire?

Secretary CELEBREZZE. You will have to ask GSA on that. They handle all of that for me. I'll tell you, though, that the city hall in Cleveland is self-insured, and the airports.

Senator LONG. Self-insured?

Secretary CELEBREZZE. Yes.

Senator LONG. I think that the Federal Government is self-insured.

Secretary CELEBREZZE. Yes.

Senator LONG. If it is not a self-insurer, I would like to have the contract to insure this building against fire, because there is not much here that would burn.

Secretary CELEBREZZE. It gets pretty hot at times.

Senator LONG. The point I have in mind, Mr. Secretary, is, generally speaking, it is cheaper to be a self-insurer with regard to things that you could insure yourself against. I think even under this program, you are not proposing to insure a man against a common cold. He

can take that risk himself. You wouldn't insure him against a common cold; would you?

Secretary CELEBREZZE. It is a matter of degree. It is cheaper not to have insurance if nothing happens, but it is more expensive if something does happen. In other words, if I take out a policy on my home, as an example—if I take it out today and it burns tomorrow, I am way ahead. But if I pay for the insurance for the next 20 or 30 years, it would balance out.

Senator LONG. Here is the thought I had about this, Mr. Secretary. What I don't understand is why you don't try to shape the program on such a basis, in your recommendations, that it will cover those catastrophic situations where people are simply not able to meet the medical expenses, rather than those cases where the hospital bills are expected to run $100 or $200.

Secretary CELEBREZZE. We have done that to a considerable extent under the King-Anderson bill.

Senator LONG. Well, at one time you were leaving out the first 7 days.

Secretary CELEBREZZE. As an example, the highest cost to the States under Kerr-Mills—90 percent of the cost of Kerr-Mills is for hospital and nursing home care—that is, the tremendous, catastrophic sort of expenses.

What I suggested in my opening statement is that Kerr-Mills is financed from general funds. The percentages vary from State to State, and the coverage varies from State to State. What we said was, we would remove this cost of Kerr-Mills from the State to a great degree if we passed King-Anderson. We would release 40 percent of the funds that the States are now using, and the States themselves then would adopt better programs, perhaps, to take care of these other people and still stay within the same tax structure.

States and cities are having problems on their tax structure. I know from personal experience as a mayor that this is so. People are demanding more. We have got to do either one of two things, either not give it to them or get the revenue to do it. So we thought that since the highest cost under Kerr-Mills was for hospital and nursing home expenses, we should remove that cost from the States. They can be relieved of 40 percent of these costs and then can give better coverage under Kerr-Mills for other medical care.

You hit it right on the nose a minute ago when you said that Kerr-Mills varied in every State. They have relative responsibility provisions and they have other unrealistic provisions. The States themselves could take some initiative on these matters, provided we release some of these funds.

Senator LONG. One other item which is not covered in this bill. When the Kerr-Mills was enacted originally, I was successful in adding an amendment on the floor which would cause the Kerr-Mills program to apply to persons who were receiving care in mental institutions. Without my amendment people with mental sickness would not be eligible for any assistance under Kerr-Mills, and it looked like that would have gone back to the theory that historically you didn't treat mental people; you just locked them up like cattle somewhere, locked them up as criminals to separate them from society, and therefore if you had a medical program, you would not include mental illness under it.

I believe that the field of mental health is still probably the most neglected field. I would make the observation that we put a provision in the Kerr-Mills to help people who are generally sick with every other sickness except mental illness, but that the treatment must have tremendously improved, and the care, while on the other hand I think that this would continue to be a terribly neglected area.

I would like to ask you, Mr. Secretary, if you would give——

Secretary CELEBREZZE. You are aware, of course, of the mental health bill that was passed, under which we do a great deal of this now?

Senator LONG. You are doing some.

Secretary CELEBREZZE. You are absolutely right that the old theory was to put them in institutions and lock the door. But we have made great progress in the mental health field. As you remember, we had a committee appointed to suggest insurance for that sort of thing.

Senator LONG. Let us talk about the type of thing people don't even like to think about. The majority of those poor wretches that are locked up in those institutions will never come out of there. And that is the most expensive type of service, just to care for them and to treat them as though they are human beings rather than wild animals.

I wish you would take a look at those cost studies and advise me what it would cost to do something for those mental health cases, both in treatment and in care for these pitiful people who a lot of people would like to forget about.

There are a great many families bearing that cross, which don't like to talk about it. But it is a very pitiful situation to have someone in the family who suffers from mental sickness from which they will never recover. People bear that burden and don't talk about it, but I know that the help that would be made available to those people would be appreciated by the relatives perhaps as much as it would by the poor persons themselves.

I would appreciate it if you would get some studies together. I know you didn't come up here to testify about that today.

(The following memorandum was subsequently supplied:)

It is estimated that the elimination of the exclusion of inmates of mental and tuberculosis hospitals who are age 65 or over would increase total public assistance payments by about $271 million a year of which $150 million would be Federal funds. Of the $150 million, approximately $135 million would be for aged patients in mental hospitals and about $15 million for patients in institutions for tuberculosis.

The estimates include amounts that would be paid under both old-age assistance and medical assistance for the aged.

If persons under 65 in mental and tuberculosis hospitals were made eligible for aid to the permanently and totally disabled, a very large proportion of patients could be expected to qualify and the estimates of costs would be more than doubled.

Studies of the possibility of Federal participation in payments to patients in mental and tuberculosis hospitals have indicated that the Federal funds involved would probably in large part supplant existing State expenditures rather than provide additional or improved care for patients.

The CHAIRMAN. For the record, the Chair would like to state that as chairman of the committee, he has received 589 letters from doctors opposing coverage and 144 from doctors favoring coverage.

Secretary CELEBREZZE. That is, from your State of Virginia?

The CHAIRMAN. 589 opposing and 144 favoring it.

Senator SMATHERS. Are they limited to Virginia? Are those doctors limited to Virginia?

The CHAIRMAN. No they are from States other than Virginia. Practically all the Virginia doctors are opposed to it.

Senator WILLIAMS. Mr. Secretary, under this bill, when is the effective date of the first benefits?

Secretary CELEBREZZE. Under the bill, the effective date of the first benefits is 2 months after passage.

Senator WILLIAMS. That would be around October 3?

Secretary CELEBREZZE. It is the second month after enactment, depending upon when it is enacted.

Senator WILLIAMS. That is prior to the election, though.

Secretary CELEBREZZE. That effective date was a decision of the Ways and Means Committee.

Senator WILLIAMS. Well, I am asking you. Under the bill—it is your bill—when would it go into effect?

Secretary CELEBREZZE. No, it is not my bill. This is the bill that came out of the Ways and Means Committee.

Senator WILLIAMS. Do you oppose this bill?

Secretary CELEBREZZE. No.

Senator WILLIAMS. But you are recommending it?

Secretary CELEBREZZE. Well, we are back to the question again of Senator Byrd.

Senator WILLIAMS. Well, are you recommending the enactment of this bill or are you not?

Secretary CELEBREZZE. I am recommending the enactment of this bill if you attach to it the King-Anderson benefits.

Senator WILLIAMS. If we do not attach to it the King-Anderson bill, are you opposing the enactment of this bill?

Secretary CELEBREZZE. You are placing me in a difficult position.

Senator DOUGLAS. Would my colleague yield?

Senator WILLIAMS. No; I want him to answer the question, because after all, I think we should have the answer.

The CHAIRMAN. I would like to state that the Secretary came to see me in favor of the bill about a week ago.

Senator WILLIAMS. Well, I want the Secretary's answer on the record. Assuming that there are no provisions for medicare attached to this bill, are you for its enactment or against it?

The CHAIRMAN. Are you thinking?

Secretary CELEBREZZE. I am thinking. It is unusual for a Secretary to think, but I do that once in a while.

Senator DOUGLAS. Even more unusual for a Senator.

Secretary CELEBREZZE. I am unable to answer that question at this time, Senator.

Senator WILLIAMS. Well, now, I asked the question in all sincerity. Will you come back tomorrow and give us an answer to that, or will you come back and give us the answer in your official capacity prior to asking this committee to act on it because I think we should have your answer as to the administration's position.

Secretary CELEBREZZE. Am I to assume that you would pass the bill exactly the way it comes out from the House?

Senator WILLIAMS. Well, no, but subject to only minor changes.

Secretary CELEBREZZE. Well, then, I can't——

Senator WILLIAMS. But we have got to make up our mind. That determination must be reached, and the only way we could pass it would be to vote for it, and that is the only way you can get it passed. We would have to make the same decision we are asking you to make, whether to vote for it or against it, and I am asking you for your position and I would like you to answer. I won't press you now, although I will say that I am surprised that you don't know the answer to the question. But before we report this bill, I am going to ask the chairman to have you come back again and give us a flat statement of whether you are for or against the bill, assuming there are no amendments to it here in the Senate, or in this committee.

Secretary CELEBREZZE. I will answer it now. I have had time to think about it as we were talking.

If the Congress tells the American people that they don't want anything to do with hospital insurance for the aged, if that possibility is completely foreclosed from these 18 million people, then I have no alternative but to be for this bill.

The CHAIRMAN. Mr. Secretary, if you will permit me, you came to see me last week, did you not?

Secretary CELEBREZZE. Yes.

The CHAIRMAN. You spent about an hour in my office.

Secretary CELEBREZZE. Yes.

The CHAIRMAN. You said you favored this bill.

Secretary CELEBREZZE. Well, perhaps I created that impression. I was talking about hospital insurance for the aged, and I favor a hospital insurance——

The CHAIRMAN. I don't think you stated you favored every detail of it, but you recommended the passage by the Senate of the bill that was passed by the House.

Secretary CELEBREZZE. I am sorry if I created the impression, Senator, that I favored the bill without change.

The CHAIRMAN. I don't mean to say it was all your idea, but you certainly did not oppose the bill, did you?

Secretary CELEBREZZE. As a last resort, as I told Senator Williams—as a last resort, if there cannot be attached to it a hospital insurance program, which I think is the critical need, then of course I would have to favor the bill, because these people need something.

Senator WILLIAMS. And I understand that after about 10 minutes' consideration, you have finally decided that you are in favor of the bill as it passed the House of Representatives.

Secretary CELEBREZZE. Provided this Congress says pointblank, and this committee says pointblank, that there's no chance of getting hospital insurance for the aged.

Senator WILLIAMS. No proviso attached to it—because a committee couldn't possibly attach that provision. This Congress cannot bind the next Congress. Presumably, even if we do not attach the amendment this year, that could be back for consideration next year. So, therefore, it is utterly impossible for either any Member of Congress or any member of the executive to say what in the future may happen. So you get back to the question of what you are going to do at this immediate time.

Again, to make sure there is no misunderstanding, assuming this bill is being voted on in the form in which it came over from the

House, without any further amendments, is the administration for the bill or against it?

Secretary CELEBREZZE. I stand on my previous answer to you, Senator, and I don't know what else I can say.

Senator DOUGLAS. Mr. Chairman?

Senator WILLIAMS. As I understand your previous answer, it was you are for the bill?

Secretary CELEBREZZE. Provided that every attempt has been made to attach hospital insurance to it, and you say to me that that is not possible, and then you say, "Do you favor anything for these people?" I would, of course, say that I do. That is my position.

Senator WILLIAMS. Well, presumably, the King-Anderson bill will be offered, it will be voted on, it will be accepted or rejected, and I am proceeding on the premise that it is going through those stages and that it is ready for a vote in the Senate—on the bill as it came over from the House—and whether the administration wants it passed in that form or not.

Secretary CELEBREZZE. Now, I think we are defining the issues a little more clearly. If the King-Anderson or some other bill dealing with hospital insurance is voted down by the Senate, of course, I would be for this bill.

Senator RIBICOFF. Mr. Chairman, will the Senator——

Senator DOUGLAS. Mr. Chairman, the Senator from Delaware has been pressing the witness pretty closely. I wonder if he would answer a question I would propound to him.

Senator WILLIAMS. I would be glad to answer, but after all, this is the Secretary's day. This bill has been before the Congress for some time, and recognizing that——

Senator DOUGLAS. There is something in the Senator's interesting line of questioning which leads me to seek clarification as to what his position would be.

Apparently, he complained that the increase in benefits would take effect the first of October, a month before election. I am going to ask him if he will make a statement: If he would propose to postpone the amendments going into effect until the first of the year, I would be very glad to support him.

Senator WILLIAMS. Sure. Will you support it?

Senator DOUGLAS. But he should propose that first.

Would it be your intention to propose that they be postponed until the first of the year?

Senator WILLIAMS. I offered an amendment to the last social security bill that was on the eve of an election, to make both the benefits and the tax effective the same date, and it was rejected. I don't recall just how you voted.

But the point I am making here is, would the administration recommend that the effective date of the tax and the benefits both be as of the same date?

Secretary CELEBREZZE. The administration has no objection. If you want to make them both effective January 1, I have no objection.

Senator WILLIAMS. You believe the administration would have no objection to making them both effective on the same date? Would you recommend such a procedure?

Secretary CELEBREEZE. I wouldn't recommend it, for this reason: I think that these people need this money as soon as they can possibly get it.

Senator WILLIAMS. Well, what about the tax?

Secretary CELEBREZZE. But while we ought to give it to them at the earliest possible time, if you feel there is any political consideration, it is entirely satisfactory to make it January 1.

Senator WILLIAMS. I am not suggesting there is any political consideration in this. But would you object to the tax being advanced to the effective date of the benefits?

Secretary CELEBREZZE. I am informed by the experts that you cannot do that.

Senator DOUGLAS. Mr. Chairman, if the Senator from Delaware will act as a trailblazer, I will be very glad to be a humble follower in his footsteps.

Senator WILLIAMS. I will gladly accept the proxy of the Senator from Illinois and cast his votes on this bill, and I would be far more confident in what would happen than if he were casting his own vote.

Senator RIBICOFF. Will the Senator yield for a question on the line he has been pursuing?

Senator WILLIAMS. Sure.

I might say, though, I was asking this question in all seriousness, because there are a lot of suggestions made about the political significance, in having the effective date of the benefits prior to the election, and the tax take effect afterward. I don't mind saying very clearly that I think that both should be effective the same date. And if a Member of Congress wants to go home and boast of the benefits he is giving someone, he should also go home and say, "Here is the tax and cost for it."

I yield to the Senator from Connecticut.

Senator LONG. Would the Senator yield to me?

Senator WILLIAMS. Senator Ribicoff was first.

Senator RIBICOFF. In reply to Senator Williams, you made the statement that if you couldn't have a medical care proposal, you would be for the Mills bill. What would the significance of the passage of the Mills bill be on the future prospects for medicare for the next 10 years?

Secretary CELEBREZZE. In my opinion, if you passed the Mills bill and kept to the idea of not going above the 10 percent, then you will have difficulty getting medical care for the aged and staying within the 10 percent.

Senator RIBICOFF. Therefore, you have made a point of concession here, haven't you, Mr. Secretary by practically foreclosing out medicare for the foreseeable future by the acceptance of a bill which doesn't include medicare, and yet under your own testimony, it doesn't actually go to the basic needs of the people over 65.

Secretary CELEBREZZE. No. Unless, Senator Ribicoff, you are willing to go to a higher wage base.

Senator RIBICOFF. Well, we have to deal with practicalities. Can't you get the basic benefits of the Mills bill and get medicare on the freedom-of-choice basis?

Secretary CELEBREZZE. Yes. You can incorporate part of the Mills bill and part of the hospital insurance bill.

But my response to Senator Williams, so that I can keep the record clear, Senator, was in the setting that you don't have a choice of a combination, but just have a choice of this or nothing.

Senator RIBICOFF. Don't you, then, actually face a situation where the administration may have to make that choice? I think the question put by Senator Williams was pertinent and proper to be put by him, and the decision is weighted with great significance. Isn't it true that what the Mills bill has actually done is, basically, to use up the most precious part of what is left in the social security possibilities? In other words, from now on we are dealing with the most valuable and precious one-tenth of 1 percent, because we are going so high in social security taxes. Isn't that correct?

Secretary CELEBREZZE. It is still possible under the Mills bill to come within your limitation of 10 percent and have hospital care attached to it. There is a possibility of joining the two bills together. You can reduce the benefits, of course or raise the wage base.

Senator RIBICOFF. I understand that, and I have a proposal that at the proper time I believe can accomplish that. But that isn't what I am aiming at in this series of questions. Senator Williams elicited a response that becomes very, very important to the ultimate decision, because the Mills bill, in raising the wage base from $4,800 to $5,400 has taken a jump that is reasonable, taking into consideration the general wage scales in the United States today. It has also gone up to 9.6 percent, going very close to the line of 10 percent.

To take the King-Anderson on top of the Mills bill would mean raising the wage base to $6,600. May I say to you in all deference that I don't think that the taxpayers of this country nor the Congress of the United States want to the wage base raised to $6,600. Yet I do believe the people want medicare.

Now, we are faced with a choice, and that choice has been put to you by Senator Williams. I think it was a very proper question for Senator Williams to ask from where he sits, and I think it has to be very carefully considered by you before you answer, because should the Mills bill be adopted, I would make the prediction that for the next 10 years there would be no such thing as medicare in the United States, which would be a great tragedy to the 18 million people over 65 who desperately need health care for the aged.

Senator WILLIAMS. I thank the Senator from Connecticut for his observations, and I might say that that is the basis of my question and the reason that I was pressing for an answer. I did feel that this was a question which the administration had to face, and I thought it was one to which this committee and the Congress was entitled to an answer.

As I understand it, the King-Anderson bill added to this bill would add another eight-tenths of a percent increase in the tax, and it would bring the wage tax to 10.4 percent. And I understand that even you have recognized that 10 percent is the ceiling.

Now, I am asking this further question——

Secretary CELEBREZZE. I have never stated that 10 percent was the ceiling. We naturally want to keep the tax rate as low as we can, consistent with meeting the needs of the people, but I said repeatedly that I can't sit here and make a commitment for the future as to whether the rate should go above 10 percent.

Senator WILLIAMS. I appreciate that.

Secretary CELEBREZZE. But we are trying to keep the rate down and accomplish our purpose within a reasonable means.

Senator WILLIAMS. Others want to ask questions, and I just have one other question.

In your testimony, you are recommending the adoption of the King-Anderson bill here today. Are you recommending that as a substitution for the House bill or an addition to the House bill?

Secretary CELEBREZZE. I am recommending it as either a substitution or an addition. We would go along with either.

Senator WILLIAMS. Which would you prefer?

Secretary CELEBREZZE. If I had a choice between the King-Anderson bill and the House bill, I would choose without any hesitance whatsoever the King-Anderson bill.

Senator WILLIAMS. Well, which would you prefer that this committee accept: the King-Anderson bill as a substitution, which would thereby hold it below the 10 percent, or would you prefer that this bill be passed out with the King-Anderson bill as an addition to the House bill?

Secretary CELEBREZZE. I would prefer that it be passed out as an addition to the King-Anderson bill.

Senator WILLIAMS. That would have been the last question. Do you think that the Kerr-Mills bill has been a success?

Secretary CELEBREZZE. The Kerr-Mills program has been a success within limitations, Senator Williams. Not all States have it, as you know. And as I say, the States are now getting to the position where it is becoming rather expensive.

As I said in my opening statement, Kerr-Mills has its proper place, but it is no substitute for hospital insurance for the aged.

Senator WILLIAMS. I appreciate that, but I just wanted to establish for the record that you are not advocating the repeal of the Kerr-Mills bill.

Secretary CELEBREZZE. No, I am not advocating that. As a matter of fact, in my opening statement, I think I said that the King-Anderson bill would relieve 40 percent of the medical assistance cost to the States, which they could use to beef up the Kerr-Mills programs.

The CHAIRMAN. Senator Smathers?

Senator SMATHERS. Mr. Chairman, I wonder if I might pass temporarily. I have not had an opportunity to read the statement of the Secretary.

The CHAIRMAN. The Senator from Illinois?

Senator DOUGLAS. Thank you very much, Mr. Chairman.

Mr. Secretary, I am very glad you are taking the position that you are taking on health care for the aged. I noticed that in the text you refer to this as hospital insurance, yet you also endorse the King-Anderson bill.

Now, the King-Anderson bill, of course, is broader than mere hospital insurance. It includes nursing home care and some form of nursing in the home. Do you stand on this—on nursing care in the home and nursing homes?

Secretary CELEBREZZE. Yes, we stand on that.

Senator DOUGLAS. Let me say for the record that I very frankly think that nursing home care and practical nursing in the home may be more important than hospital care itself, because we do not want the hospitals to become warehouses for the senile aged. I have always felt that possibly the King-Anderson bill did not have sufficient stress

on these two features: nursing home care and practical nursing in the home, and perhaps had a little too much stress on hospital care.

What is your estimate on the cost of this whole program? Eight-tenths of 1 percent?

Secretary CELEBREZZE. Eighty-five hundredths of 1 percent.

Senator DOUGLAS. 0.85. Five-sixths of 1 percent. On a base of how much?

Secretary CELEBREZZE. The wage base?

Senator DOUGLAS. Yes.

Secretary CELEBREZZE. A wage base of $5,400.

Senator DOUGLAS. $5,400?

Secretary CELEBREZZE. Yes.

Senator DOUGLAS. How much protection could you give for four-tenths of 1 percent; that is, above the present maximum which will be 9.6 percent. For four-tenths of 1 percent, how much protection could you give.

Secretary CELEBREZZE. I will refer that question to Mr. Myers, the actuary, who has the figures on it.

Mr. MYERS. Senator Douglas, if you had available only four-tenths of 1 percent of payroll—that is, for the employer and employee combined—it would necessarily have to be a very limited program of hospital benefits.

Senator DOUGLAS. I understand. The question is, how limited?

Mr. MYERS. As compared to, say, hospitalization for a 45-day maximum with no deductible——

Senator DOUGLAS. Well, the King-Anderson bill has 90 days with 9 days for deductible at $10 each.

Mr. MYERS. A 9-day-deductible, the Senator said?

Senator DOUGLAS. Yes.

Mr. MYERS. Of course, depending on how much deductible was included, it could vary considerably.

Now, first, if I could give a set of provisions without a deductible, then I would give it with a deductible. If you had no deductible at all, you could hardly have a program of more than a maximum of just 10 days for four-tenths of 1 percent of payroll. You would have to put in some deductible to have a more meaningful maximum duration.

With the $5,400 base, you could have a program—and you realize there are many combinations——

Senator DOUGLAS. Yes.

Mr. MYERS. One combination would be a 30-day maximum duration with a 6-day deductible.

Senator DOUGLAS. What about nursing home care?

Mr. MYERS. A limited nursing home provision as in the King-Anderson bill doesn't add too much more cost. So that by cutting, say, the 30-day maximum to a 25-day maximum, you could have a certain amount of nursing home care.

Senator DOUGLAS. Then, I take it what you are saying is that a full King-Anderson program would require here that the rates go up to 10.4 or that the base be increased. If the base were raised to $6,600 this could be done at approximately 10 percent?

Mr. MYERS. That is correct, Senator.

Senator DOUGLAS. If the base were raised to $6,000, what would be the cost?

Mr. MYERS. Well, with a base of $6,000 and using up to the full 10 percent of the combined employer-employee rate, you could have a program, for example, of 30-day maximum with a 2-day deductible, and with some nursing home benefits.

Senator DOUGLAS. What about practical nursing?

Mr. MYERS. Or home health services. I don't know whether they would be practical nurses, or registered nurses.

Senator DOUGLAS. They don't have to be registered nurses to be effective. They could be under the supervision of nurses, but the nursing would not have to be done by registered nurses. That is pretty expensive.

Mr. BALL. Senator, could I point out one thing on the wage base that you are exploring?

One possibility is that you might put in a $6,000 wage base for 1965 right away, which actually is the amount that would be needed if one were to restore the situation that existed in 1958, the last time the Congress acted, and then taking into account the trend of wages

Senator DOUGLAS. There has been an increase of roughly 25 percent in wages since that time.

Mr. BALL. And if you made a projection on wages, $6,600 would be the comparable figure in a few years. If the law were to provide later for $6,600, not right away, but in a few years when wages would have risen to that level—that two-step approach, with contribution rates of 5 and 5, or a combined rate of 10 percent these, together, are sufficient to support the benefits of the King-Anderson bill.

Senator DOUGLAS. I don't want to steal Senator Ribicoff's thunder, but it is well known that he has informally made a suggestion, not as an alternative to King-Anderson, but as a second line of defense for King-Anderson—namely, to give to the insured person the choice as to whether they will take the increase in benefits or accept some form of hospital and nursing care. I take it that you said that was your second choice also, Mr. Secretary?

Secretary CELEBREZZE. Yes, sir.

Senator DOUGLAS. Have you worked out cost figures for such a limited plan, assuming a maximum of, say, 60 days of hospital care and a corresponding cut in nursing care, home service care?

Secretary CELEBREZZE. We can work those figures up for you. We don't have them available right now.

Senator DOUGLAS. And you will work in cooperation with Senator Ribicoff?

Secretary CELEBREZZE. Yes, we'll be happy to.

Senator DOUGLAS. This would give freedom of choice to the individual as to how they wished to take their benefits, whether in cash or in hospital and nursing care.

Secretary CELEBREZZE. Yes. The individual could determine whether he wanted to take the cash or be covered under the hospital care provisions of the act. He would have a choice.

Senator DOUGLAS. This is a question which perhaps might more properly come from Senator Ribicoff. I hope you will forgive me.

Senator RIBICOFF. I am delighted that you have entered this discussion, Senator.

Senator DOUGLAS. At what point in an insured person's life would he exercise this choice?

Senator RIBICOFF. Sixty-five.

Secretary CELEBREZZE. Sixty-five.

Senator DOUGLAS. Sixty-five? Could the choice be revoked or altered after 65?

Senator RIBICOFF. It has to be at 65 once and for all. He couldn't change it.

Senator DOUGLAS. It would simplify administration very much.

Senator RIBICOFF. Yes, it would.

I think, to keep the record clear on this, since you brought it up—and if I may proceed, Mr. Chairman—it is not my intention to offer my proposal at this time because I am basically for the King-Anderson bill and shall fully support it on the floor. However, should the King-Anderson bill run into difficulty, then in all fairness and candor, I would say to you, Mr. Chairman, that I would offer my proposal as a second line of defense, because I am deeply concerned as indicated by the line of questioning with the Secretary as a result of Senator Williams' proposal, that should the Mills bill become the law of this land, then for all practical purposes, for the next decade, we would not have medicare. Personally, I think medicare is so important that this fight must be made, and we should not use up the precious balance of what we have left, and I say that we can use it in a very, very tight tax situation.

As I told the committee, I have this proposal, but I would not offer it now because I am for King-Anderson and will only offer it if King-Anderson does not prevail on the floor of the Senate.

Senator SMATHERS. Would the Senator mind if I asked him a question?

Senator RIBICOFF. Please do so.

Senator SMATHERS. In the light of what the Senator has said, presuming that the King-Anderson bill, as you express it, ran into trouble on the floor and was not adopted, and thereafter the Ribicoff amendment ran into trouble on the floor and was not adopted, would your position then be that you would oppose the Mills bill?

Senator RIBICOFF. Yes, I would. I think the Mills bill gives the old people of this country a "mess of pottage." I think the Mills bill is a snare and a delusion. I think it is a tragedy to use up these precious few pennies that we have to give an aged woman 80 cents a month, and I think the American people must be alerted to what they are using up out of the precious resources of the social security tax base.

I was disappointed in the Secretary's proposal, or in his answer because, contrary to the Secretary's position, I would oppose the Mills bill if the Mills bill was all that we had. I think that we must make a fight to save these precious few pennies for health care for the aged under social security.

Senator DOUGLAS. I would like to make just one other comment and get the Secretary's opinion on it, and that is about nomenclature.

The term "Medicare," I think, was attached to the bill when it was sponsored by Representative Forand. Up to that time is it not true that the bill included not only hospital nursing care but medical and surgical care?

Secretary CELEBREZZE. Just surgical care.

Mr. COHEN. Only surgical care.

Senator DOUGLAS. Only surgical care, not medical care.

But it did have an element of doctors' services and, therefore, could properly have been called medicare.

Now, the King-Anderson bill has been stripped of surgical care. In the interests of correct understanding, wouldn't it be correct to refer to it as "health care for the aged" or "hospital and nursing care for the aged," so that we will not overstate our case?

Secretary CELEBREZZE. That is right. We don't call it "medicare," we call it "hospital insurance for the aged."

Senator DOUGLAS. But it includes nursing home care and home nursing as well.

Secretary CELEBREZZE. Yes; and the King-Anderson includes home care as well, yes.

Mr. BALL. I think, Senator Douglas, that the term "hospital" is used simply because the hospital benefit is the central benefit, and in the King-Anderson benefit provisions the other benefits are less expensive substitutes for hospital care. But perhaps the name ought to be longer to make sure that people understood that there was nursing home care in it, too.

Senator DOUGLAS. I would use "hospital and nursing care for the aged."

Also, I wondered if you would comment about this observation of mine, that there may be an undue concentration upon hospital care in the bill. Hospital care, of course, is the most expensive form of care that there is, but nursing home care is less expensive, and practical nursing in the home is still less expensive. There are a great many aged people who are somewhat incapacitated, semisenile. To put them in hospitals, although they may prefer to be there, is a very expensive proceeding. In many cases, they could be taken care of in their own home with a practical nurse under skilled supervision coming in once a day, to get them through the day.

I wondered if these gentlemen would be willing to comment on the emphasis within the proposed system. Should there be more in the direction of nursing home care and practical nursing in the home as compared to hospital care. Have you thought of that at all?

Mr. BALL. I think, Senator, that the reason that the hospital benefit was the one that was selected was really because of the same line of reasoning that Senator Long was questioning us about earlier, and that is that the people who have a heavy medical cost to bear in a given year that they can't absorb into their regular budget—as self-insurers, you might say—are usually the people who have a spell of hospitalization.

I might just give you a few figures on that for the record, Senator. If you take couples in the United States over 65, those who have no hospital experience during a given year have, on the average, total medical costs of $233. But if they have a spell of hospitalization, then the average for them for all of their medical care is $1,220, of which about half is the actual hospital expense.

Comparable figures for single people are, if they are not in a hospital, $131, and if they go to a hospital, $1,038.

So the main philosophy, in this package of proposals was to select the situations in which people would have big and unpredictable expenses and then cover a major part of those expenses.

Senator DOUGLAS. In other words, this more closely approached the catastrophic situations?

Secretary CELEBREZZE. Yes.

Senator DOUGLAS. Well, this is perhaps a matter for administration. But I was distressed in going over the estimated costs of King-Anderson to find that so small a fraction, a very small fraction, of the total cost was allowed for nursing in the home. Could not the administration of this measure be directed to hurry the exit of people from hospitals into nursing homes, and from nursing homes into practical nursing. This is the tendency in hospital administration now. In the old days, people used to go to the hospital and stay a long time. Now the effort is made to get them out of the hospital as quickly as possible.

But the exit is delayed, of course, in the case of hospitals that would like to hold on to them because they are paying guests.

Mr. COHEN. Senator, I think we had the same colloquy when you were here a couple of years ago. In the meantime, of course, the administration did send up a proposal, which has now passed both Houses, to increase Hill-Burton grants toward long-term care facilities by $30 million. In other words, we found it necessary, in order to accomplish the purpose, to build more of these facilities, because obviously you can't use the services if you don't have the facilities.

Senator DOUGLAS. I know. But then, you have got to have some means of paying for the care for the people in the nursing homes.

Mr. COHEN. That is correct.

We do have provision for nursing home care, as we pointed out in the bill. We agree with the objective that you have in mind, and we have tried in the interim to provide more facilities and to increase provision for visiting nurse services in the bill.

Senator DOUGLAS. Well, I am still somewhat appalled by the distribution of costs within the King-Anderson system, that is all.

Mr. COHEN. I would say one other thing: Of course, there still is not an adequate amount of home nursing services available in the United States.

Senator DOUGLAS. But if you provide the financing for it, you will get the services provided.

Now, one of the things which developed, of course, in the war, was that you could take unskilled youngsters and make them into hospital orderlies in a relatively short period of time. They would operate under the direction of registered nurses, but the registered nurses themselves would do very little actual nursing. The corpsman, in effect, would do the major portion of the physical work, but under skilled supervision.

I think you can take a large number of women and makes them nurses' assistants, and this would be must less costly than if you tried registered nurses doing all of the work.

Mr. COHEN. That is correct. And we have, for instance, for the vocational education bill, attempted to expand the whole training of practical nurses, which I think fits into your idea.

I think there are two parts to the problem. There is a provision for the education and training of the manpower and womanpower necessary, and then a financing arrangement to pay for the services, which is, in principle, embodied in the bill.

Senator DOUGLAS. I don't think you have made enough allowance, if I may say so, in the allocations for either nursing homes or nursing

in the home. I would be willing to see the hospital provisions cut down and funds thrown over to the other two branches of the system.

That is all, Mr. Chairman. Thank you.

The CHAIRMAN. Senator Carlson?

Senator CARLSON. Mr. Secretary, 29 years ago, in 1935, I was a member of the House of Representatives, and we passed the original Social Security Act. I well remember some of the debates and I remember the $3,000 base figure.

I have followed with great interest the program as it has gone through these years, and I think for the record we ought to have the various basis for the number of increases during these past years, for the increase in rates and also the increase in benefits. I think it would be helpful for the record when we get into it. I am sure you can supply it.

Secretary CELEBREZZE. Yes; we will supply it for the record.

(The following pamphlet was subsequently supplied by the Secretary:)

THE HISTORY OF THE SOCIAL SECURITY CONTRIBUTION RATES AND THE LIMIT ON TAXABLE ANNUAL EARNINGS

The Social Security Act of 1935 fixed the contribution rates for employees and their employers at 1 percent each on taxable wages for the calendar years 1937–39, and scheduled the rates to increase by steps to 3 percent each in 1949. However, subsequent acts of Congress extended the 1-percent rates through calendar year 1949. On January 1, 1950, the rates rose to 1½ percent each for employees and employers, as provided by the Social Security Act Amendments of 1947. In accordance with the Social Security Act Amendments of 1950, the 1½-percent rates remained in effect through calendar year 1953, and, on January 1, 1954, rose to 2 percent each for employees and employers. These rates remained in effect through December 31, 1956. In accordance with the Social Security Amendments of 1956, the 2-percent rates rose to 2¼ percent each on January 1, 1957, and remained in effect through calendar year 1958. On January 1, 1959, the rates rose to 2½ percent each, and on January 1, 1960, to 3 percent each, as provided by the Social Security Amendments of 1958. These rates remained in effect through December 31, 1961. In accordance with the Social Security Amendments of 1961, the 3-percent rates rose, on January 1, 1962, to 3⅛ percent each for employees and employers, and on January 1, 1963, to 3⅝ percent each. Beginning January 1, 1951—the effective date of extension of coverage to self-employed persons—the rates of tax on self-employment income have been equal to 1½ times the corresponding employee rates, except that beginning in 1962 the resulting rates for the self-employed are rounded to the nearest 10th of 1 percent. The tax rates that have been in effect since 1937 and the maximum amount of annual earnings to which the rates applied are shown in the following table:

Calendar years	Maximum taxable amount of annual earnings	Contribution schedule (percent of taxable earnings)	
		Employees and employers, each	Self-employed
1937–49	$3,000	1	.....
1950	3,000	1½	.....
1951–53	3,600	1½	2¼
1954	3,600	2	3
1955–56	4,200	2	3
1957–58	4,200	2¼	3⅜
1959	4,800	2½	3¾
1960–61	4,800	3	4½
1962	4,800	3⅛	4⅞
1963	4,800	3⅝	5⅛

If H.R. 11865 is enacted the following changes will be made in the maximum taxable amount and in the contribution schedule:

Calendar years	Maximum taxable amount of annual earnings		Contribution schedule (percent of taxable earnings)			
			Employees and employers, each		Self-employed	
	Present law	H.R. 11865	Present law	H.R. 11865	Present law	H.R. 11865
1965	$4,800	$5,400	3.625	3.8	5.4	5.7
1966–67	4,800	5,400	4.125	4.0	6.2	6.0
1968–70	4,800	5,400	4.625	4.5	6.9	6.8
1971	4,800	5,400	4.625	4.8	6.9	7.2

Senator CARLSON. Then I heard you this morning begin to talk about $6,600, and I also heard you mention 10 percent, that it might be a maximum, which I would be hopeful would be the maximum, but I am not that optimistic in this program.

Secretary CELEBREZZE. Let me make my position clear on the 10 percent. I have never said that there was anything magic about 10 percent. I said it is desirable in all tax bills to keep tax rates as low as possible, but I see nothing magic in 10 percent. That is a question for the Congress to determine at a particular time. Today, we may believe that 10 percent is an awfully high figure, but conditions may change in the next decade or the next 20 years, and you have to make a judgment at that particular time with existing conditions.

That is why it is difficult to predict sometimes. You don't know what all the conditions are going to be when you are called upon to make a decision.

Senator CARLSON. Well, I share your views regarding that. I hope it is 10 percent, myself, but I don't have much faith it is going to be 10 percent and that the base pay will be $5,400 if we go through and continue to expand this program.

I would also like to have placed in the record the tax rates proposed in the medical care for the aged amendments, compared with the present law, and showing the rates for 1965, which go up to 1971. Under the present law, in 1971, the employee and employer tax rate would be 4.625 each; this rate in the House bill would be 4.8 in 1971. Under the Gore amendment, which is the King-Anderson bill, it would be 5.2; and under the Javits amendment, 5.005. I would like to have this table placed in the record as a part of the other requests made, as to what has been happening to the program.

(The tax rates table referred to follows:)

Tax rates proposed in medical care for the aged amendments for both employees and employers

[In percent]

	Present law	House bill, H.R. 11865	Gore amendment No. 1178	Javits amendment No. 1163
1965	3.625	3.8	4.2	4.005
1966–67	4.125	4.0	4.4	4.205
1968–70	4.625	4.5	4.9	4.705
1971	4.625	4.8	5.2	5.005

Senator CARLSON. I am interested in your proposal, that Senator Long went into. You are opening up a field here, are you not, that is going to be new in this program when you take in those people 70 years old and older by really reducing the coverage required?

Secretary CELEBREZZE. That again was included by the House Ways and Means Committee. The committee voted to put that in.

Senator CARLSON. Did the Department recommend this?

Secretary CELEBREZZE. No, the Department did not recommend it, but when it was voted in, we didn't oppose it.

Senator CARLSON. You are not opposed to it now, if we include it?

Secretary CELEBREZZE. No.

Senator CARLSON. It is an interesting suggestion, and I can see great possibilities. I share the views of Senator Long.

Secretary CELEBREZZE. I can defend the position of the committee more in this instance than I could defend Senator Long's proposal, because these individuals have been covered. They all have had some social security coverage. They didn't have six quarters, but some had five, some had four and some had three, and the Ways and Means Committee drew the line there; they said anybody in this age group with three quarters of coverage should get benefits. Senator Long would give people that don't have any coverage, any quarters of coverage, the benefits. So there is a distinction between the two.

Senator CARLSON. This is very true. There is a distinction but isn't the next logical step to include them?

Senator BENNETT. You would make it covered with two quarters of coverage, one quarter of coverage, and then 24 hours of coverage, so that there is a token obedience to the principle established in the law. But we have already passed the point where——

Secretary CELEBREZZE. Except that in the long run you are getting almost complete coverage under the social security program for years ahead, so that almost everyone will have contributed to the program long enough to be insured even when the requirement becomes 10 years of coverage.

Senator CARLSON. It seems to me that is an argument why they should be included, because that group of people is gradually going out, and they are folks who had no opportunity to get under the social security program. I am thinking of the self-employed. I am thinking of people in agriculture. They contribute to the cost of these programs indirectly. This is not just a tax burden on the employer and employee. It is a burden on the consumers in this country. It seems to me that——

Secretary CELEBREZZE. Most of these people that you are referring to are under some sort of State program. The moneys to pay benefits to them would have to come out of general revenue funds: they couldn't come out of social security trust funds. So in most instances what you would be doing is substituting Federal funds for State funds, since many of them are drawing some sort of assistance under a State plan.

Mr. BALL. Senator, you might want for the record some figures to illustrate what the Secretary was just saying. The effectiveness of social security coverage now among the aged has gone so far that the group we are talking about has gotten smaller and smaller. We are now dealing with a problem of from 1¾ to 2 million people, depending

upon just what group you would blanket in. Within the group 800,000 to 900,000 are receiving old-age assistance from the States. Blanketing in at the minimum social security benefit would not remove very many of those people from the assistance roles. We estimate maybe 180,000 might actually be removed. Most of them would be just getting their money partly from one source and partly from another, and still would have to be on State old-age assistance, and would have partly shifted their source of support from the Federal-State program to an entirely general revenue program of the Federal Government.

What I am trying to say is that the situation has changed quite a lot since the old days, in this issue of blanketing in. I think there was perhaps more merit to the idea at an earlier stage and that now we are getting to a very diminishing situation.

Senator CARLSON. Now, you are going to put 400,000 in that that would qualify under this proposal.

Mr. BALL. The three-quarters provision: yes.

Senator CARLSON. That is right; 400,000.

Mr. BALL. As the Secretary said, we didn't really recommend that, although we are not opposing it.

Senator CARLSON. Now, I notice if it passed it would cost 0.01 percent—I don't know too much about percentages. How much is that in dollars?

Mr. BALL. $160 million in the first year.

There is another aspect, Senator, that I think you might want to keep in mind in relation to any blanketing-in proposal, and that is that what the House provided is a transitional provision. The idea was that these older people are in the situation that they are in because their occupations, or their husbands' occupations, weren't under social security soon enough. But they are a disappearing group. The provision wasn't made a permanent provision, and it would wash out after a time.

Senator CARLSON. Of course, when we orginially put them in, we put them in whether they had any coverage or not, I mean any contribution. We blanketed in a great many of them at the beginning of this program.

Mr. BALL. No. Senator. People have always had to have some coverage under social security, to get benefits. The minimum has been a year and a half—six quarters.

Senator CARLSON. Now, this 400,000 is going to cost $160 million. How many others would there be eligible if we just took all of them in, say, 1 million—was the figure?

Mr. COHEN. Senator, I would like to point out that what the Ways and Means Committee did on this amendment was to say that anybody who did have some quarters of coverage could be brought in because their benefits could reasonably be financed out of the regular social security income. They did not vote to broaden it to people who had no quarters of coverage, because our recommendation was that benefits for those people had to come out of general revenues.

I think that is the biggest distinction here, as the Secretary said. People who have some quarters of coverage, these people with three, four and five, could be brought under and the cost of their benefits would be met out of the social security taxes. If you go further and extend it to people who have no quarters of coverage—who never have

contributed anything—then logically you would have to pay that cost out of general revenues.

Senator CARLSON. I can see it is opening up a great field, and I am not going to complain about this particular section, because I think there is some merit to it. But is is just another case of where we are adding to this burden, and now we are talking about putting the King-Anderson bill on this particular House bill and would the Secretary believe that we could limit these payments in the future under the King-Anderson bill so that we could still stay under the 10 percent, if we should decide to do it?

Secretary CELEBREZZE. That is difficult for me to say, Senator. There's some leveling off of possible costs and other factors involved that you would have to take into consideration. I think where we went wrong in the past is meeting the cost more by increasing the percentage in the tax rates rather than keeping a balance between that and increasing the wage base.

When you voted for the $3,000 base back in 1935, you were covering all the wages of 94 percent of regularly employed men. Under $5,400, we would be down to about 48 percent. If you had a parallel situation today to what $3,000 was in 1935, you would be at $12,500. I am not recommending $12,500, but only saying that $3,000 in 1935 would be parallel to $12,500 today.

But the policy has been to raise the rates and let the wage base diminish in effectiveness.

Senator CARLSON. Would you repeat that again? Did I understand you to say that $3,000 in 1935 is the equivalent of $12,000?

Secretary CELEBREZZE. $3,000 in 1935 covered 94 percent of the workers. Today, to keep the same ratio——

Senator DOUGLAS. You mean the wages, don't you?

Secretary CELEBREZZE. Yes, I mean the wages of 94 percent of the workers.

Senator CARLSON. Mr. Secretary, in your appearance before the House Ways and Means Committee, did you express as strongly your desire for the King-Anderson bill as you have here this morning?

Secretary CELEBREZZE. I have made 20 or 22 appearances before the Ways and Means Committee—executive sessions, and we were very strong for the King-Anderson bill. On the other hand, we did go into many other aspects.

Senator CARLSON. The committee, however, did not approve your recommendation, did they?

Secretary CELEBREZZE. The committee did not vote on either the King-Anderson proposal or on changes in the Kerr-Mills program.

Senator DOUGLAS. Would my good friend from Kansas permit an observation?

It is my understanding that the King-Anderson was only turned down by a vote of 13 to 12.

Mr. COHEN. No, there was no vote.

Secretary CELEBREZZE. There was no vote on the King-Anderson bill at all.

Senator DOUGLAS. Well, I understand there was a poll and the result was 13 to 12, a very narrow margin.

Senator RIBICOFF. Would Senator Carlson yield?

Just to keep the record straight, to go back to the interchange you had with Senator Williams and myself and now Senator Carlson:

The so-called Mills bill that is now before the Senate was not presented as an administration measure; is that correct?

Secretary CELEBREZZE. Yes, that is correct. The bill is what the committee came out with.

Senator RIBICOFF. Now, the administration went before the Ways and Means Committee with the health care for the aged bill, the King-Anderson bill, correct?

Secretary CELEBREZZE. Yes. We testified before the Ways and Means Committee, Senator, on the King-Anderson bill, and the Ways and Means Committee then went into executive session. I am sure you are all familiar with executive sessions where we confer and go over many things. Part of the time we conferred about the King-Anderson bill and, part of the time the Kerr-Mills program, and part of the time an increase in benefits.

Senator RIBICOFF. How long a time did you occupy discussing health care for the aged under social security in all the proceedings before the Ways and Means Committee?

Secretary CELEBREZZE. I'd say two-thirds of the time.

Senator RIBICOFF. Well, in days or weeks, how much time did that cover?

Secretary CELEBREZZE. Well, there were 23 separate sessions, executive sessions. Aside from the public hearings, and I think that in most of the sessions, Senator, we would touch on health insurance and also touch on other aspects of the bill.

Senator RIBICOFF. Out of those 23 days, when did it finally dawn upon you that you weren't going to get health care for the aged at all, but get what we now have before us? When did you conclude that?

Secretary CELEBREZZE. That is a difficult question. I haven't had as much experience as you have had.

As I said, the committee did not vote on it, and the King-Anderson bill is still pending, as are the improvements to the Kerr-Mills program that were before the committee. I think it is obvious by this time that the committee is not going to report out the King-Anderson proposal.

Senator RIBICOFF. Were you surprised with the bill that did come out as a substitute for the King-Anderson?

Secretary CELEBREZZE. Yes. I would say that I was not only surprised; I was very much disappointed when they didn't come out with—if not the total program of the King-Anderson bill, some sort of a hospital insurance program.

Senator RIBICOFF. In other words, all the hearings were based on King-Anderson or some form of hospital insurance. This was the whole thrust of the hearings that were taking place before the Ways and Means Committee?

Secretary CELEBREZZE. Not all the executive sessions were devoted exclusively to hospital insurance. We went into benefit increases. In other words, we were there in the capacity to answer questions for the committee and be as helpful as we could to the committee on whatever questions they asked us.

Senator RIBICOFF. Then, for all practical purposes, what we have before us is neither Johnson's baby or Celebrezze's baby.

Secretary CELEBREZZE. No. This is the committee's baby. I will stop at that point.

Senator WILLIAMS. But you have adopted it now. I understand you are willing to adopt it as your own child: is that correct?

Secretary CELEBREZZE. Let no one make any mistake about it—I am strongly and urgently for some kind of health insurance for the aged.

Senator CARLSON. Mr. Secretary, as one member of this committee, I want to get on the record, too, as being very strong for health care of the aged. I wouldn't want the record to indicate any other way. I have some questions as to different programs that will be presented and have been presented and, particularly, the King-Anderson bill which we have had before this committee at some length, 2 years ago. I think we ought to get into the record what the King-Anderson bill actually does.

There has been a lot of information put out in this country to our elderly people that it takes care of doctors' bills, any doctor's services, it takes care of hospital care and nursing care, drugs, and many other things; that, in fact, it is an all-inclusive program. Now, that is not correct, is it?

Secretary CELEBREZZE. Not at all.

Senator CARLSON. I would like to have the record show just exactly what an individual can expect past 65 in the King-Anderson bill. If you have it in mind now, I would like to have the record absolutely clear on it, so that when someone walks into my office and talks to me about it and says, "Well, if you had passed that bill, I wouldn't have to pay my doctor bills."

Secretary CELEBREZZE. There are four types of benefits under the King-Anderson bill, all relating to hospital and nursing homes and home care, and outpatient diagnostic services. There is nothing in the King-Anderson bill which would pay private doctors' bills. As a matter of fact, under the King-Anderson bill the Government would furnish no services; it would just pay the cost. You could go to whatever hospital you want to go to. You could choose whatever doctor you want to choose. The bill is limited to hospital and the services I mentioned and would not meet the medical doctors' bills or surgical expenses.

I think there has been a great deal of confusion on that, but there has also been a great deal of confusion caused by the other side, who go about the country telling doctors that the Government is going to tell them who they can treat and who they can't treat. That is a falsehood.

Senator WILLIAMS. Mr. Secretary, for the record, would you supply for the record in as clear and concise a manner as possible, the things that the King-Anderson bill would not do, as well as the things which it would do? I think it would be very helpful to a lot of people to understand it.

Secretary CELEBREZZE. We have that available. We will supply it for the record.

(The description of the so-called King-Anderson bill referred to follows:)

DESCRIPTION OF "HOSPITAL INSURANCE ACT OF 1963" S. 880

PROHIBITION AGAINST ANY FEDERAL INTERFERENCE

The bill specifically prohibits the Federal Government from exercising supervision or control over the practice of medicine, the manner in which medical services are provided and the administration or operation of medical facilities.

FREE CHOICE BY PATIENT GUARANTEED

The bill specifically provides that a beneficiary may receive services from any participating provider of his own choice.

ELIGIBILITY

The proposal is limited to coverage of the aged because the aged as a group have low incomes and high medical care expenses. Moreover, they are at a period in life where their incomes and assets are more likely to go down than up. Their income is, on the average, about half that of those under 65; at the same time they require three times the hospital care of younger people. Furthermore, since most aged people are not employed they have in general no opportunity to obtain economical group insurance. The individual or nongroup health insurance that may be available to them is often twice as expensive for the same benefits—because of higher acquisition cost, premium collection cost, and other administrative costs—as group insurance would be.

Under the bill, hospital insurance protection would be provided for all people who are aged 65 and over and entitled to monthly old-age or survivors insurance benefits or to benefits under the Railroad Retirement Act. An individual would be eligible for hospital insurance protection at age 65 even through his monthly cash benefits are being withheld because of earnings from work. In addition, protection would be provided, under a special provision of the plan, to many people aged 65 and over who are not eligible for benefits under the social security or railroad retirement systems.

Almost all of the more than 18 million people who will be age 65 and over in January 1965 would be protected under the proposal. The few not protected under the legislation would consist for the most part of retired Federal civilian employees, who have their own health insurance program, and aliens with relatively short residence in the United States. Of the people protected under the proposal, about 15¾ million would be covered as persons eligible under the old-age and survivors insurance or railroad retirement programs and about 2¼ million would be protected under the special provision.

Under the special provision, aged people who are not insured for cash benefits under the social security or railroad retirement systems would be deemed insured for hospital and related benefits only. Uninsured people who reach age 65 in 1967 would be deemed to be insured for hospital benefits if they had earned as few as 6 quarters of coverage in covered work at any time—10 fewer quarters of coverage than men of this age need to qualify for cash social security benefits.

For people who reach age 65 in each of the succeeding years, the number of quarters of coverage needed to be insured for hospital insurance protection would increase by 3 each year. Thus the provision would not apply to women who reach age 65 in 1971 (or later) and men who reach age 65 in 1972 (or later), since in those years the number of quarters that would be required to qualify for hospital benefits would be the same or greater than the number required for social security cash benefits.

The cost of the coverage for aged persons who do not meet the regular insured status requirement of the social security law would be met from general revenues. Thus, the provision of the same hospital benefits for persons who are not fully insured under the social security system would not be inconsistent with the principles upon which the system is based. Funds obtained through the application of social security contributions would be used only to pay benefits of those who have contributed over a sufficient length of time to acquire insured status, and over the long run only persons who make significant contributions would be eligible for benefits.

BENEFITS PROVIDED

The bill would provide payments for inpatient hospital services, followup care in a hospital-affiliated skilled nursing facility, certain organized home health agency services and hospital outpatient diagnostic services.

Inpatient hospital services were selected as the point of concentration in the bill because of the great financial strain placed on people who must go to the hospital. Medical expenses for aged people who are hospitalized in a year are about five times greater than the annual medical bills of aged people who are not hospitalized, and hospital costs account for the major portion of the difference between the health bills of the hospitalized aged and those not hospitalized. Further, the occurrence of hospitalization one or more times in old age is to be

expected. It is estimated that 9 out of every 10 people who reach age 65 will be hospitalized at least once before they die; 2 out of 3 will be hospitalized 2 or more times. Another reason for placing primary emphasis on protection against the cost of hospital care is that hospital insurance is the part of the protection against health costs on which there is the most experience in this country—through Blue Cross and other Government programs—with the result that adequate models for administration are available.

BENEFICIARY OPTION

Under the bill, payment would be made for up to 90 days of inpatient hospital services, subject to a deductible amount of $10 a day for up to 9 days (with a minimum of $20), unless the beneficiary exercises his option to receive inpatient hospital benefits for either (1) up to 45 days with no deductible or (2) up to 180 days with a deductible amount equal to the average daily cost of 2½ days of hospital care.

The provision under which each beneficiary could choose among three alternative hospital benefit plans enables the beneficiary to select the plan which he thinks is best suited to his needs.

SERVICES FOR WHICH PAYMENT WOULD BE MADE

Hospital services

The proposed inpatient hospital benefits would (except for the deductible amount applicable under two of the beneficiary options) generally cover the full cost of all hospital services and supplies of the kind ordinarily furnished by the hospital which are necessary in the care and treatment of its patient. The full coverage follows the recommendations of the Commission on Financing of Hospital Care and other expert groups studying hospital insurance. As hospitals acquire new equipment, adopt new health practices, and improve their services and techniques, the additional operating costs resulting from such changes would automatically be covered under the proposal without need for modification. Thus, coverage would always be up to date. Furthermore, this built-in responsiveness to changing medical practices and needs would provide assurance that the program would provide the proper financial underpinning to improvements in care.

Skilled nursing facility services

The bill would provide payments for the cost of hospital-affiliated skilled nursing facility services in cases where a hospital inpatient is transferred to such a facility to continue to receive professionally supervised skilled nursing care (while under the care of a physician) needed in connection with a condition for which he had been hospitalized. The requirement that the patient have been transferred from a hospital is one of the measures included in the bill to limit the payment of nursing home benefits to persons who may reasonably be presumed to require continuing skilled nursing care and for whom the nursing facility provides an alternative to continued hospitalization.

Home health care services

Payments would be made for visiting nurse services and for other related home health services when furnished by a public or nonprofit agency in accordance with a plan for the patient's care that is established and periodically reviewed by a physician. Since the nature and extent of the care a patient would receive would be planned by a physician, medical supervision of the home health services furnished by paramedical personnel—such as nurses or physical therapists—would be assured.

Outpatient diagnostic services

In the case of outpatient hospital diagnostic services, payment could generally be made for any tests and related services that are customarily furnished by a hospital to its outpatients for the purpose of diagnostic study. Payment would only be made for the more expensive diagnostic procedures because a $20 deductible amount would be applied for each 30-day period during which diagnostic services are furnished.

Patient's need and economy served

The bill provides payments for skilled nursing facility care, home health agency services and hospital outpatient diagnostic studies in order to promote

the economical use of hospital inpatient services. In doing so, the proposed legislation would support the efforts of the health professions to limit the use of hospital beds to the acutely ill who need intensive care and to make more efficient use of other health care facilities. Moreover, coverage of these services is consistent with the recommendations made by authorities who have studied the causes and effects of improper utilization of hospital care. For example, the availability of protection against the costs of outpatient hospital diagnostic tests would avoid providing an incentive to use inpatient hospital services in order to obtain coverage of the cost of diagnostic services. The availability of this protection would also give support to preventive medicine by meeting part of the costs of expensive procedures that are essential in the early detection of disease.

INCLUDED AND EXCLUDED SERVICES

Under the bill, payment would be limited to health services which are essential elements of the services provided by hospitals. Since the primary purpose of the proposal is to cover hospital costs and a major reason for the coverage of other services is to provide economical substitutes for hospitalization, the proposed legislation is framed to permit payment for skilled nursing facility, home health, and hospital outpatient diagnostic services only to the extent that they could be paid for if furnished to a hospital inpatient. Thus the outer limits on what the proposed program would pay for are set by the scope of inpatient hospital services for which payment could be made. Services covered outside the hospital are more limited than those in the hospital. Following is a description of the various services for which payment would be made under the bill.

Room and board

Payments would be made for room and board in hospital and skilled nursing facility accommodations. Generally speaking, accommodations for which payment would be made would consist of rooms containing from two to four beds. Covered accommodations are described by number of beds, rather than the frequently used designation of "semiprivate." The differences that exist among hospitals in the use of the term "semiprivate" would create an undesirable lack of uniformity of benefits provided.

Payments could also be made for more expensive accommodations where their use is medically indicated. Where private accommodations are furnished at the patient's request, the payments that would be made would be the equivalent of the reasonable cost of accommodations containing two to four beds. Room and board would not, of course, be paid for where the beneficiary is receiving care under a home health plan.

Nursing services

Payments would cover all hospital nursing costs, but not private duty nursing. Private duty nursing would not be paid for since it can be expected that the nursing services regularly provided by hospitals and skilled nursing facilities which would participate in the program would almost always adequately meet the nursing needs of their patients.

Payments for home health services would only cover part-time or intermittent nursing care such as that provided by visiting nurses. Where more or less continuing skilled nursing care is needed, an institutional setting is more economical and generally more suitable.

Physicians' services

The cost of physicians' services would not be paid for under the proposal except for the services of hospital interns and residents in training, and for the professional component of certain specified ancillary hospital services described below under "Other health services."

The bill would cover the cost of the services that hospital interns and residents in training furnish but only while they are participants in teaching programs that are approved by the American Medical Association's Council on Medical Education and Hospitals. This coverage of the services of interns and residents is in agreement with the generally accepted principle of hospital payment that third parties should contribute a fair share toward the hospital costs—in large part consisting of educational costs—of interns and residents.

Drugs

Under the bill, payment could be made for drugs furnished to hospital and skilled nursing facility patients for their use while inpatients. The bill would provide payment for drugs which are approved by the hospital's pharmacy com-

mittee (or its equivalent) or which are listed in the "United States Pharmacopoeia," "National Formulary," "New and Non-Official Drugs," or "Accepted Dental Remedies." A hospital's drugs must, of course, meet the standards established by these formularies in order for the hospital to be accredited by the Joint Commission on Accreditation. Assurance of satisfactory control over drugs in nursing facilities is provided through the requirement that the nursing facility-hospital affiliation agreement include provision for standards on use of drugs.

The drugs prescribed for a patient as part of his home health care would not be paid for under the proposed program. The decision to exclude the cost of drugs from home health service payments is part of the more basic decision not to provide coverage of drug and other outpatient therapeutic costs under the program. The coverage of drugs outside the institutional setting would, of course, add greatly to the cost of the program and would present exceedingly difficult problems in limiting payment to needed drugs and covering the payment of a multitude of small bills without excessively cumbersome and expensive administraton.

Supplies and appliances

Under the proposal, payment would be made for supplies and appliances so long as they are a necessary part of the covered health services a patient receives. For example, the use of a wheelchair, crutches, or prosthetic appliances could be paid for as part of hospital, nursing facility, or home health services but payments would not be made for the patient's use of these items upon discharge from the institution or upon completion of the home health plan. Extra items, supplied at the request of the patient for his convenience, such as telephones in hospitals, would not be paid for.

Medical social services

Payments would cover the cost of the medical social services customarily furnished in a hospital, as well as such services furnished in a skilled nursing facility or as part of a home health plan. Such services often perform the important function for the aged of facilitating a return to normal life at home.

Other health services

Payment would be made for the various ancillary services customarily furnished as a part of hospital care, including various laboratory services and X-ray services and use of hospital equipment and personnel. Among the covered services would also be physical, occupational, and speech therapy. Payment for ancillary services would cover the costs of services rendered by physicians in four specialty fields—anesthesiology, radiology, pathology, and physiatry—where the physician furnishes his services to an inpatient as an employee of the hospital or where he furnishes them under an arrangement with the hospital which specifies that payment to the hospital for the services he performs discharges all liability for payment for the services. Thus, whether the services of any particular specialist are covered would depend entirely upon the arrangement between the physician and the hospital. The chart below lists the specific kinds of hospital and related care for which payments could be made and those which would not be covered.

LIMITATIONS ON PAYMENT

The bill includes a number of limitations on the payment of hospital and related benefits, primarily because of considerations of cost and priorities of need.

The deductible provisions and the other limitations on inpatient hospital and skilled nursing home payments would be applied on a "benefit period" basis. In general, the "benefit period" would coincide with the beneficiary's episode of illness. Under the proposal, the benefit period would begin with the first day in which the patient receives inpatient hospital services for which payments could be made and would end after the close of a 90-day period during which he was neither an inpatient in a hospital nor a skilled nursing home; the 90 days need not be consecutive, but they must fall within a period of not more than 180 consecutive days. This limitation is designed to provide a cutoff point in the payment of benefits for persons who are more or less continuously institutionalized persons without, however, denying payment for persons who suffer repeated episodes of serious illness.

Health services and supplies that could be paid for under the Hospital Insurance Act of 1963

	Inpatient hospital benefits	Skilled nursing facility benefits	Outpatient hospital diagnostic benefits	Home health agency benefits
Room and board	Coverage limited to bed and board in a 2 to 4 bedroom or in more expensive accommodations where medically required.		Not applicable	Not covered.
General duty nursing services	Covered (benefits would not cover private duty nursing)		Not applicable	Coverage limited to part time or intermittent nursing care.
Physicians' services	Not covered except where furnished by an intern or resident-in-training in the course of an AMA approved teaching program, or where the services are in the field of pathology, radiology, anesthesiology, and physical medicine and are rendered through the hospital. Services furnished in a nursing facility by interns and residents-in-training under an AMA approved teaching program of the hospital with which the nursing facility is affiliated would be covered.			Not covered except where furnished by an intern or resident in the course of an AMA approved hospital teaching program.
Physical, occupational, and speech therapy	Covered		Not applicable	Covered.
Medical social services	Covered		Not applicable	Covered.
Drugs	Covered		Not applicable (except as needed for diagnostic study).	Not covered.
Other services and supplies necessary to the health of the patient	Covered if the hospital customarily furnishes them to its patients.	Covered if generally provided by skilled nursing facilities.	Covered if customarily furnished by the hospital to outpatients for the purpose of diagnostic study.	Medical supplies (other than drugs) and the use of appliances are covered. Also, to the extent permitted by regulations, part time or intermittent services of a home health aid would be covered.

Duration of benefits

The maximum number of days of inpatient hospital care for which payment could be made during a benefit period would be 45, 90, or 180 days, depending on the combination of duration and deductible selected by the beneficiary. Since some patients need extended skilled nursing care after hospitalization, a maximum of 180 days of skilled nursing care is provided for each benefit period.

Under the proposal, as many as 240 home health visits could be paid for in a calendar year. The limitation placed on the payment of home health benefits is written in terms of "visits" rather than "days." Unlike the institutionalized patient, people receiving home health services do not receive health care on a full-time basis. Home health services involve periodic visits to the patient's home by therapists, nurses, and other professional personnel. The amount of home health service which is covered would be unaffected by whether a variety of services is offered on the same day or different days.

Deductible provisions

Beneficiaries who prefer "first-dollar" coverage could obtain such coverage by electing the 45-day option with no deductible. Those who would rather have protection against the cost of more extended stays and could budget for a modest deductible could choose the 90-day option or the 180-day option. Under the 90-day option the deductible amount would be $10 a day for up to 9 days (with a minimum of $20); under the 180-day option the deductible amount would be the average daily cost of 2½ days of hospital care.

A deductible amount of $20 is also applied against payments for diagnostic services furnished within a 30-day period primarily to reduce costs and to avoid processing a large volume of small claims. Thus, the program provides protection against the cost of the more expensive procedures—not only the single expensive test but the series of tests in which costs add up to large amounts.

CONDITIONS FOR PARTICIPATION OF PROVIDERS OF HEALTH SERVICES

One of the keys to determining the nature of the health services which would be paid for under the proposal is the type of institution which may participate in the program. Therefore, the question as to what, for purposes of the proposed program, is a hospital, a skilled nursing facility, or a home health agency is of considerable significance. There are no universally accepted definitions of the various health facilities. The type of institution providing health services on which there is closest agreement on definition is, of course, the hospital. The definition of a health institution includes within it elements related to the quality and adequacy of the services which the institution provides. For example, one of the conditions an institution must meet to satisfy the American Hospital Association requirements for listing as a hospital—the same condition which would have to be met before an institution could participate under the program—is provision of 24-hour nursing service rendered or supervised by registered professional nurses. This is one of the characteristics that differentiates a hospital from other institutions; in addition, of course, an institution which does not meet this condition cannot offer adequate services as a hospital.

The bill therefore spells out the conditions that an institution must meet in order to participate in the program. These conditions offer some assurance that participating institutions have the facilities necessary for the provision of adequate care. Also, the inclusion of these conditions is a precautionary measure designed to prevent the program from having the effect of undercutting the efforts of the various professional accrediting organizations sponsored by the medical and hospital associations, Blue Cross plans, and State agencies to improve the quality of care in hospitals and nursing homes. To provide payments to institutions for services of quality lower than are now generally acceptable might provide an incentive to create low-quality institutions as well as an inducement for existing facilities to strive less hard to meet the requirements of other programs.

Specific conditions for participation of hospitals

An institution, to meet the definition of a hospital, must (*a*) be primarily engaged in providing diagnostic and therapeutic services or rehabilitation services, (*b*) maintain clinical records, (*c*) have bylaws in effect for its medical staff, (*d*) provide 24-hour nursing service rendered or supervised by registered professional nurses, (*e*) have in effect a hospital utilization review plan, and (*f*) be licensed or approved under the applicable local law. In addition, the

institution must meet certain health and safety requirements to be established by the Secretary of Health, Education, and Welfare.

These specified conditions provide a basic definition of a hospital and embody minimum requirements of safety, sanitation, and quality. As such, they are fully in accord with the established principles and objectives of professional hospital organizations. The requirement that there be bylaws in effect for the hospital's medical staff—included at the specific suggestion of representatives of the American Hospital Association—is intended to assure that the hospital's staff of physicians would be organized in the professionally acceptable manner characteristic of most hospitals. Such a requirement would encourage the fullest contribution by medical staff to the operation of the hospital and to the quality of medical services furnished by the individual staff members.

Under the bill, hospitals accredited by the Joint Commission on Accreditation of Hospitals would be conclusively presumed to meet all the statutory conditions for participation, save that for utilization review. However, in the event the Joint Commission adopts a requirement for utilization review accredited hospitals could be presumed to meet all the statutory conditions. Linking the conditions for participation to the requirements of the Joint Commission provides assurance that only professionally established conditions would have to be met by providers of health services which seek to participate in the program.

Health and safety standards

Under the bill, the Secretary of HEW would have the authority to prescribe conditions in addition to those specifically listed (only, however, in the case of hospitals, to the extent that these conditions have been incorporated into the requirements of the Joint Commission on Accreditation of Hospitals) where such additional conditions are found to be necessary in the interest of the health and safety of beneficiaries. This authority is proposed because it would be inappropriate and unnecessary to include in a Federal law all of the precautions against fire hazards, contagion, etc., which should be required of institutions to make them safe. Payment for services in institutions where there are fire and health hazards could seriously undermine the efforts of State health departments and professional groups to eliminate dangerous conditions in health care institutions.

States could require higher standards

The national minimum conditions for participation by providers of health services could vary for different areas and classes of institutions. If a State decided, for example, that all nursing facilities within its jurisdiction should satisfy higher requirements than are stipulated for use generally in all States and requested that certain specified higher requirements be applied with respect to institutions within its jurisdiction, the Secretary of HEW would have the authority to apply these State rules in the Federal program. Thus the Federal program could support the States in their efforts to improve conditions in institutions. In no event, however, could the conditions for participation of hospitals go beyond those required for accreditation by the Joint Commission of Accreditation of Hospitals.

The States would have the function of applying the requirements for participation in the Federal program to the institutions within their jurisdictions. In this way, too, the States would have the opportunity to coordinate their current efforts in appraising the quality of institutions with functions which would be performed under the proposal.

The conditions for participation were framed so that medically supervised rehabilitation facilities could qualify either as hospitals or nursing facilities. Some rehabilitation facilities are for all intents and purposes hospitals and in fact some are licensed as hospitals. Others are more like skilled nursing facilities than hospitals in the extent of their medical supervision, staffing, and scope of service. An institution of either type, which conducts a program of rehabilitating disabled people, could participate in the program by meeting the conditions specified in the bill for a hospital or a nursing facility.

Mental and tuberculosis hospitals excluded

Under the bill, institutions providing care primarily for mental or tuberculosis patients are excluded from participation. The main reason for this exclusion is that most of these hospitals are public institutions and are supported by public funds. Nor did it seem reasonable to cover private but not public institutions. It should be kept in mind that the care provided by general hospitals to persons

afflicted with mental disease or tuberculosis would be included. If a patient in a mental or tuberculosis institution were to go to a general hospital to receive care, the care would be paid for under the program.

Requirement for review of utilization of services

The hospital utilization review plan required for participation in the program must provide for a review of admissions, length of stays, and the medical necessity for services provided as well as the efficient use of services and facilities. Such a review of each admission of a beneficiary must be made within 1 week following the 21st day of each period of continuous hospitalization, and subsequently at such intervals as may be specified in regulations. In the event of an unfavorable finding the review group must notify the attending physician of its findings and provide an opportunity for consultation between the committee and the physician. The utilization review plan of a hospital would also be extended to include review of admissions and length of stays in a skilled nursing facility which is affiliated or under common control with the hospital.

These provisions with respect to utilization review mechanisms follow the kind of recommendations for utilization review that have been made by private study groups, State medical societies, and State agencies. The utilization review requirement in the bill provides that not only would hospital staff reviews meet the requirement but other physician review arrangements outside the hospital would be acceptable for purposes of the program as well. Furthermore, if and when the Joint Commission includes a utilization review requirement for accreditation, accreditation by the Joint Commission could be accepted by the Secretary as sufficient evidence that the provider meet the requirements of the law.

Conditions for participation of nursing facilities

To meet the definition of a "skilled nursing facility" an institution (or a distinct part of an institution) must, in addition to being affiliated or under common control with a participating hospital, (*a*) primarily provide skilled nursing care for patients requiring planned medical or nursing care, or rehabilitation services, (*b*) have medical policies established by a professional group (including one or more physicians and one or more registered professional nurses) with a requirement that each patient be under a physician's care, (*c*) be under a physician's or registered nurse's supervision, (*d*) maintain clinical records, (*e*) provide 24-hour nursing services rendered or supervised by a registered professional nurse, (*f*) operate under the utilization review plan of the hospital with which it is affiliated, and (*g*) be licensed or otherwise be approved as required under applicable local law. Nursing facilities must also meet such conditions essential to health and safety as may be found necessary. Some institutions operating as nursing facilities are not engaged primarily in the furnishing of skilled nursing care for patients who require planned medical or nursing care but rather furnish primarily personal care.

As in the case of hospitals, these conditions describe the essential elements necessary for an institutional setting in which adequate skilled nursing services are provided. Generally, institutions which provide skilled nursing services to patients who require continuing planned nursing care would be able to meet these conditions. While many existing nursing facilities could not meet these conditions because they generally provide, exclusively or primarily, domiciliary or custodial care and not skilled nursing care, the proposal would encourage such facilities to take the necessary steps to qualify.

Hospital affiliation requirement

The requirement of hospital affiliation—intended to provide assurance that payment would be made only to skilled nursing facilities having adequate medical supervision—will serve to encourage facilities to enter into arrangements which many experts in health care believe will have (and where attempted have had) success in improving the quality of their services. A facility would be deemed to be affiliated with a hospital if, by reason of a written agreement, (*a*) the facility operates under standards, with respect to its skilled nursing services, clinical records and use of drugs, which are jointly established by the hospital and the facility, (*b*) arrangements exist for timely transfer of patients, and (*c*) the hospital's utilization review plan applies in all respects to the services furnished by the facility.

The Secretary is required to study, after consultation with appropriate professional organizations, ways of increasing the availability of skilled nursing

facility care. On the basis of such study, the Secretary may authorize the participation of facilities which, though not affiliated with hospitals, operate under conditions assuring the provision of a good quality of care, provided such action does not create (or increase) an actuarial imbalance in the trust fund.

Conditions for participation of home health agencies

To meet the definition of a home health agency an organization must (*a*) be a public agency or a nonprofit organization exempt from Federal taxation under section 501 of the Internal Revenue Code of 1954, (*b*) be primarily engaged in providing skilled nursing or other therapeutic services, (*c*) have medical policies established by a professional group (including one or more physicians and one or more registered professional nurses), (*d*) maintain clinical records, and (*e*) be licensed or approved under applicable local law. As in the case of hospitals and nursing homes, home health agencies would also have to meet further conditions to the extent they are found necessary in the interest of the health and safety of the patients.

Home health services covered

The conditions for participation of home health agencies are designed primarily to provide assurance that agencies participating in the program are basically suppliers of health services. The bill would cover visiting nurse organizations as well as agencies specifically established to provide a wide range of organized home health services. The provision of services under such agencies is now only in the initial stage of development. The services covered are based on the practices of the agencies now in existence which furnish a broad range of organized home health services which may be used as a substitute for continued hospital care. These agencies, while few and generally of recent origin, have established excellent records of operation so that it seems reasonable to expect new providers of services to adopt the pattern of organization found successful thus far. These home health service agencies offer primarily visiting nurse services but many offer other therapeutic services.

PAYMENT TO PROVIDERS

Under the bill, the provisions for paying for covered services follow the recommendations of the American Hospital Association—that is, payments to providers of service would be made on the basis of the reasonable cost of services furnished. The Secretary would be authorized to develop a method or methods of determining costs and to provide for payment on a per diem, per unit, per capita, or other basis, as most appropriate under the circumstances. The principles for reimbursing hospitals developed by the American Hospital Association provide a basis for determining how costs should be computed. However, since the elements of cost are, to some extent, different for different types of providers of health services—for example, hospitals as contrasted to skilled nursing facilities—a number of alternative methods of computing costs are permitted so that variations in practices may be taken into account. In computing reimbursement on a "reasonable cost" basis, the program would be following practices with respect to reasonable cost reimbursement already well established and accepted by hospitals in their dealings with other Federal and State programs and with Blue Cross.

EXCLUSION OF FEDERAL HOSPITALS

No payment would be made to a Federal hospital, except for emergency services, unless it is providing services to the public generally as a community hospital—a rare situation, but the exclusion of such institutions would be a hardship to beneficiaries in the localities involved. Also, payment would not be made to any provider for services it is obligated to render at public expense under Federal law or contract. The purpose of this exclusion is to assure that Federal hospitals would not be used to furnish care under the program as well as to avoid payment for services which are furnished under other Government programs to veterans, military personnel, etc. Furthermore, this exclusion would have the effect of reducing future need for Federal hospitals for veterans and retired members of the Armed Forces and place more emphasis on the use of voluntary hospitals for their care.

EMERGENCY SERVICES

Payment could be made to nonparticipating hospitals for emergency inpatient hospital services—or emergency outpatient diagnostic service—if the hospital agrees not to make any charges to the beneficiary with respect to the emergency services for which payment is provided. The proposal does not cover use of the emergency ward for outpatient purposes except where the diagnostic service provision, subject to the $20 deductible, applies.

AGREEMENTS BY PROVIDERS

Any eligible provider may participate in the proposed program if it files an agreement not to charge any beneficiary for covered services and to make adequate provision for refund of erroneous charges. Of course, a provider could bill a beneficiary for the amount of the deductible, and for the portion of the charge for expensive accommodations or services supplied at the patient's request and not paid for under the proposal.

An agreement may be terminated by either the provider of service or the Secretary of HEW. The Secretary may terminate an agreement only if the provider (*a*) does not comply with the provisions of law or the agreement, (*b*) is no longer eligible to participate, or (*c*) fails to provide data to determine benefit eligibility or costs of services, or refuses access to financial records for verification of bills.

ADMINISTRATION

As in the case of other benefits under the social security system, overall responsibility for administration of the hospital and related benefits would rest with the Secretary of Health, Education, and Welfare. Similar responsibility for railroad retirement annuitants rests with the Railroad Retirement Board. Agreements by hospitals and other providers with the Secretary would be made on behalf of both the Secretary and the Board.

The bill provides for the establishment of an Advisory Council to advise the Secretary on administrative policy matters. The Advisory Council, appointed by the Secretary, would consist of a chairman and 13 members who are not otherwise employees of the Federal Government. To assure representation of the health professions, four or more members of the Advisory Council would be persons outstanding in hospital or other health activities.

The Secretary would also be required to consult with appropriate State agencies, national and State associations of providers of services, and recognized national accrediting bodies. These efforts would be especially oriented to the development of policies, operational procedures, and administrative arrangements of mutual satisfaction to all parties interested in the program. This consultation at the local and national level would also provide additional assurance that varying conditions of local and national significance are taken into account.

ROLE OF THE STATES

Under the bill the Secretary is authorized to use State agencies to perform certain administrative functions. It is expected that the Secretary would exercise this authority fully, and it is believed that all States would be willing and able to assume these responsibilities. State agencies would be used in—

(*a*) Determining whether and certifying to the Secretary that a provider meets conditions for participation in the program; and

(*b*) Rendering consultative services to providers to assist them in meeting the conditions for participation, in establishing and maintaining necessary fiscal records, and in providing information necessary to derive operating costs so as to determine amounts to be paid for the provider's services.

State agencies would be reimbursed for the costs of activities they perform in the program. As in the cooperative arrangements with State agencies in the social security disability program, reimbursement to State agencies for hospital insurance benefits activities would meet the agency's related costs of administrative overhead as well as of staff. In recognition of the need for coordination of the various programs in the States that have to do with payment for health care, quality of care, and the distribution of health services and facilities, the Federal Government would pay a fair share of the State agency's costs attributable to planning and other efforts directed toward the coordination of the agency's activities under the proposed program.

What is contemplated in administration of the insurance program is a Federal-State relationship under which each governmental entity performs those functions for which it is best equipped and most appropriately suited. State governments license health facilities and State public health authorities generally inspect these facilities to determine whether they are conforming with the requirements of the State licensure law. In addition, State programs purchase care from providers of health services. On the basis of experience and function, State agencies would assist the Federal Government in determining which providers of health services conform to prescribed conditions for participation. Furthermore, where an institution or organization that has not yet qualified needs consultative services in order to determine what steps may be appropriately taken to permit qualification, such consultative services would be furnished by the State health or other appropriate State agency. Other types of consultative services closely related to conditions of the hospital benefits program or similarly related to State programs and requirements should logically be provided for or coordinated in the State agency. There may, of course, be situations where a State is unwilling or unable to perform some or all of these certifications and consultative services. In any such situation, the Secretary will have to make other provisions to carry on these activities.

ROLE OF PRIVATE ORGANIZATIONS

The bill would provide the opportunity for considerable participation by private organizations in the administration of the program. Groups of providers, or associations of providers on behalf of their members, would be permitted to designate a private organization to act as an intermediary between themselves and the Federal Government. The designated organization would determine the amounts of payments due upon presentation of provider bills and make such payments. In addition, such organizations could be authorized, to the extent the Secretary considers it advantageous, to perform other related functions such as auditing provider records and assisting in the application of utilization safeguards. Such activities are likely to prove advantageous where private organizations have developed experience and skill in these activities. The Government would provide advances of funds to such organizations for purposes of benefit payments and as a working fund for administrative expenses, subject to account and settlement on a cost-incurred basis.

The principal advantage hospitals and other providers of services would find in an arrangement of this sort would be that the policies and procedures of the Federal program would be applied by the same private organizations which administer the existing health insurance programs from which providers now receive payments. The participation of Blue Cross plans and similar third-party organizations would have advantages that go beyond the benefits derived from their experience in dealing with various types of providers of services. Such private organizations, serving as intermediaries between the Government and the providers, would reduce the concern expressed by some people that the Federal Government might try to interfere in hospital affairs.

OPTION TO INDIVIDUAL TO OBTAIN PRIVATE INSURANCE

A guiding principle in the formulation of the program is the desirability of encouraging private insurance to play the same complementary role to hospital insurance for the aged under social security that it has played under the retirement, death, and disability benefit provisions of the social security program. It was in part because of this principle that the decision was made to provide a program oriented toward meeting only the major costs of hospitalization. It was assumed that with social security providing basic protection of this form beneficiaries would obtain additional private supplementary protection and private carriers would seek to provide such protection. While the hospital insurance portection that would be provided by social security would be significant and substantial, it would not cover all of the health costs that are capable of being insured against.

Under the bill, therefore, the Secretary would be required to consult with and furnish assistance to providers of services, private insurance carriers, State agencies, and other appropriate private and public organizations in order to encourage and help them to develop and make generally available to the aged supplementary private insurance protection.

SEPARATE TRUST FUND

Under the proposal there would be a separate trust fund for the hospital insurance program, in addition to the present old-age and survivors insurance trust fund and the disability insurance trust fund. Under the proposed law, hospital insurance benefits could be paid only from the hospital insurance trust fund, just as under present law disability insurance benefits can be paid only from the disability insurance trust fund. Payments made on behalf of persons who are not eligible for social security or railroad retirement benefits would not be made from the trust fund but directly from general revenue of the Treasury.

EFFECTIVE DATES

Benefits would be payable for covered hospital and related health services furnished after January 1, 1965, except for skilled nursing facility services, for which the effective date would be July 1, 1965.

The CHAIRMAN. Senator Hartke?

Senator HARTKE. Mr. Mayor—I call you "Mayor" because I am a mayor, too, I think that is a higher title than "Senator" at the moment. At least, as one that is real close to the people, you have had a chance to be close to the situation.

Let me ask you: About 20 million people would be covered by the bill, right?

Secretary CELEBREZZE. That is right, roughly; 19½ million.

Senator HARTKE. Are these people at the present time receiving the dollar benefit that they received, say, at the time that the last increase went into effect as a result of the increased cost of living—for getting the bill? At the present time, are these recipients receiving the same dollars in purchasing power that they were receiving at the time of the last increase?

Secretary CELEBREZZE. No.

Senator HARTKE. So, there isn't any question about it that there is a need someplace along the line here for some type of adjustment for benefits; isn't that true?

Secretary CELEBREZZE. That is true.

Senator HARTKE. My son told me, when I explained to him what the maximums were under this new bill, he said, "my goodness, is that all?"

Frankly, this is not a great bounty for any individual even under the best of circumstances under the new bill; isn't that true?

Secretary CELEBREZZE. That is true. It is our contention that you would be doing much more at this time by passing a hospital insurance bill rather than a benefit increase, because, as the Senator says, you can't get excited over someone receiving 80 cents a month more.

Senator HARTKE. But that is not true, either. That is in it, but the higher percentage increase does really make a material difference in the total amount of benefits that go to some of these people. That is the other end of the totem pole.

Secretary CELEBREZZE. There is a range from 80 cents to $6.40 a month.

Senator HARTKE. So, it is no more fair to say 80 cents than it is to say that this provides everybody with $6.40 increase.

Secretary CELEBREZZE. The point I was trying to make is that many of these people would be much better off with hospital insurance, because of their hospital costs, than with even the $6.40.

Senator HARTKE. But these people, if they are going to have to make a choice between this bill and no hospital insurance and no

increase—and this would be as a practical mayor, the approach as I would look at it for my people——

Secretary CELEBREZZE. That is the position Senator Williams put me in.

Senator HARTKE. I am not trying to put you in any position. I am looking at it from my position as a sponsor of the King-Anderson bill and as a man who voted for the King-Anderson bill in the Senate. I think that in all good conscience, any person who looked at the legislative situation at the moment would have to conclude that in controversy over this, the net result probably is going to be no increase and no hospital care either.

Secretary CELEBREZZE. That is why, although my position is that I prefer a hospital program, if the alternative were to be for this bill or nothing at all, I would have to go along with the bill.

Senator RIBICOFF. If the Senator would yield, I can assure the Senator from Indiana there is going to be plenty of controversy on this bill when it gets to the floor.

Senator HARTKE. Well, let me say to my dear friend from Connecticut, I have no fear of controversy. I have been involved with that before, and that is certainly one of the things that makes life interesting.

I am not talking about controversies; I am talking about benefits. And the ultimate benefit to these 19½ million people is placed in jeopardy if we are involved in a situation which prolongs the debate to the extent that nothing is passed. Is that true? Isn't that what the position of the Department is? You have said you have a choice, at this time, as to whether you are going to be able to obtain medicare or hospital care, or whatever you want to call it, or these increased benefits. You have said with great reluctance that you are willing to take the benefits as the only thing that is available at the moment.

Secretary CELEBREZZE. I would rather take the benefits than nothing at all; that is right.

Senator HARTKE. In the long run, do you feel in good conscience, as some people assert, that these benefits will forever and a day terminate the possibility of hospital care for the aged?

Secretary CELEBREZZE. No; I can't in good conscience say that, because, as I said, I don't know what any congressional body is going to do. The point that we tried to make is that if there is a determination to draw the line at 10 percent, then, to some degree, by passing the Mills bill and using most of the 10 percent for that purpose, you make it more difficult to get hospital insurance. You would have to raise the wage base or go above 10 percent.

Senator HARTKE. But this assumes a basic situation which is not, in fact, true: That is, that there is a limit of 10 percent, that Congress is going to hold to 10 percent, or that Congress is not going to give thought to some other approach on this matter.

Secretary CELEBREZZE. That is true.

Senator HARTKE. But are you in favor of this bill as it is presently drafted?

Secretary CELEBREZZE. Senator Hartke, let me again state my position. I am strongly in favor of the King-Anderson bill—in lieu, if necessary, of this bill. If we don't have the King-Anderson bill, I am strongly in favor of some other form of workable hospital insurance

for the aged. If we can't have the King-Anderson bill, then I would favor a plan for a choice by the individual, so that he could have either cash benefits or hospital insurance. That is what I favor.

Senator HARTKE. Are there any provisions of the bill that you are opposed to?

Secretary CELEBREZZE. I am not opposed to it. This is not, as you know, the administration's bill; this is a committee bill.

Senator HARTKE. I understand that.

Secretary CELEBREZZE. There were never any public hearings on this bill in the House.

Senator WILLIAMS. Would the Senator yield?

Senator HARTKE. Yes.

Senator WILLIAMS. Before the Senator came in, I think the Secretary, in answer to a similar question, stated that in the event there were no amendments attached to this bill, which would incorporate medicare in any form—in other words, if the bill was being considered as it is, that he would still favor the bill as it passed the House, if that was necessary.

Now, I think I am stating this correctly, am I not?

Secretary CELEBREZZE. Yes; I think so, with one exception. I think I said that if the Senate of the United States has an opportunity to vote on the King-Anderson bill and they turn it down and they have an opportunity to vote on the Ribicoff amendment and they vote it down—if they vote against hospital insurance for the aged in any form, then I am willing to accept this bill.

Senator DOUGLAS. As a very last resort.

Secretary CELEBREZZE. As a last resort, yes.

Senator HARTKE. Mr. Secretary, I know some people may be playing games. I am not playing games with these people, and I think they have a real situation. One of the provisions in the bill, and I know it had not been made public, is a provision for benefits for children attending school after attaining age 18. It had not been publicized and I wrote to the Agency and brought this to their attention, and they said they had been studying it, and it was then brought out in the open at that time.

I certainly am in favor of these benefits for these people, and I have some amendments which I hope may be adopted. But I have also talked to some members of the Ways and Means Committee, and I think that you are playing hob with some benefits to people which can't be realized, with a situation that appears to me to be a legislative impossibility. That is why I think it is rather dangerous to jeopardize the benefits of those people.

Secretary CELEBREZZE. Senator, I have been in legislative bodies, and I have never known anything to be a legislative impossibility. There is always a possibility.

Senator HARTKE. Let's say, probability. How's that?

Secretary CELEBREZZE. The point I was trying to make to this committee, and in my opening statement, is that the most critical need at this time is hospital insurance for the aged. That is the most critical need, and we are not meeting the most critical need.

Now, you can give them 5 percent in increased benefits, but that is not the critical need, as it exists at this particular time.

Senator HARTKE. Is it the Secretary's position that it weakens the ultimate argument for meeting this critical need by refusing to give these people the benefits? In other words, by holding them in a position in which they are so desperate on this thing that ultimately you drive the Congress to obtaining this result? Is that your position?

Secretary CELEBREZZE. No. It is my position that if you are going to hold the combined tax rate within a 10-percent limit, the closer you get to the 10 percent by making other changes, the more you diminish your opportunity of getting hospital insurance.

Senator HARTKE. I think I was here when the first 10-percent limitation was discussed, and there is nothing in the law that talks about any 10-percent limitation.

Secretary CELEBREZZE. That is true.

Senator HARTKE. This is a barrier which has been established as a sort of a blind to keep you from seeing what the ultimate possibilities are; isn't that true?

Secretary CELEBREZZE. As Secretary of Health, Education, and Welfare, I appear before committees, and particularly chairmen of committees, and I have got to be realistic in my attitude. The attitude of the House Ways and Means Committee, I think, is that they do not want to go above 10 percent.

Senator HARTKE. And also the attitude of the Ways and Means Committee is that they are not going to approve any medical care proposition this year. Isn't that pretty generally considered to be true?

Secretary CELEBREZZE. The chairman said it was pending.

Senator HARTKE. Mr. Secretary, I am not trying to drive a hard bargain, but the truth is, you have been willing to assume the 10 percent in the discussion as something to be dealt with. Isn't it just as much a fact that at the moment the Ways and Means Committee is just plain not going to act on medicare in this session?

Secretary CELEBREZZE. I think it is reasonable to come to that conclusion.

Senator HARTKE. I think that is fair.

Secretary CELEBREZZE. But the point I am trying to make, and I don't think we are too far apart, is about your saying that regardless of what happens, we ought to have this benefit increase.

Senator HARTKE. That is right.

Secretary CELEBREZZE. I am saying to you that what we ought to do is to exert all our efforts at this time to get at the critical need, which is hospital insurance for the aged: and after we have exerted all those efforts, and if the only choice then is nothing or an increase to these people, I think it is logical to take the increase.

Senator HARTKE. I think we tried this last year and failed to pass it in the Senate. I think if a count were made at the moment it would indicate we could possibly pass it in the Senate by a narrow margin now. I think this is a fair interpretation. But if we do pass it in the Senate and send it to the House and run into a roadblock, what is the advantage to the 19½ million people, if that increase in benefits does not reach them?

Senator DOUGLAS. Would my good friend permit me to reply to that?

Senator HARTKE. Certainly.

Senator DOUGLAS. I would say that a 13-to-12 margin is a very narrow one, and we need only convert 1 of the 13, and it is transformed into a 13-to-12 margin the other way. I would not accept the 13-to-12 poll as being unalterable and final.

Excuse me. I thought perhaps I could say that and the Secretary couldn't.

Senator HARTKE. I am talking to the members of the House Ways and Means Committee, and I don't think there is a chance of their doing it.

I hope we can proceed with this bill which I think provides minimum benefits to people who are entitled to it. I hope that we can then proceed to come to some solution of this critical problem, which I guarantee I would be more than glad to work on with the Department because I helped to work out the details of the King-Anderson bill at its original inception. I sat there in that drafting. I don't think too many other Senators did.

But I think it is foolhardy for us to try to do something which appears to have no chance of success.

I would like to say this on the blanketing-in provision, just to make it clear. I think it is a good provision, and I think that in the ultimate end—you talk about the redistribution of costs—one of the real critical problems in most of the communities in my home State is the question of property tax for taking care of medical bills for these people who are not under social security. These people are going to have to meet this problem; those who are not covered with social security benefits will have to be taken care of.

As I understand you, by 1985, for all practical purposes there will be no people outside the coverage; is that it?

Secretary CELEBREZZE. I think we will hit the saturation point by that time.

That was one of the points I was trying to make, again, in my opening statement, Senator Hartke. The local communities are hard pressed for money, and by adopting some sort of a hospital insurance program, we can release 40 percent of the funds some of these communities are now spending under the Kerr-Mills program.

Senator HARTKE. I am not objecting to that. I am quite in sympathy. But I think that the Secretary is realistic enough to know his own mind, to know what he has to do, and if you want to drive a hard bargain, I think we can sit here and drive a hard bargain, or we can sit here and try to do something for these people. I, personally, am on the side of trying to take care of those who are alive this year, and I am willing to work next year——

Secretary CELEBREZZE. I am interested in keeping them alive a little while longer under proper medical care.

The CHAIRMAN. We will have to recess until 10 a.m. tomorrow.

Mr. Secretary, we would like to have you come back again for further questioning at that time.

(Whereupon, the committee adjourned at 12:40 p.m. to reconvene at 10 a.m. on Friday, August 7, 1964.)

SOCIAL SECURITY; MEDICAL CARE FOR THE AGED AMENDMENTS

FRIDAY, AUGUST 7, 1964

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

The committee met, pursuant to recess, at 10 a.m., in room 2221, New Senate Office Building, Senator Paul H. Douglas, presiding.

Present: Senators Long, Douglas, Ribicoff, Williams, Carlson, Bennett, Curtis, Morton, and Dirksen.

Also present: Elizabeth B. Springer, chief clerk; and Fred Arner and Helen Livingston, of the Education and Public Welfare Division, Legislative Reference Service, Library of Congress.

Senator DOUGLAS. The committee will come to order.

I believe we stopped yesterday with Senator Carlson.

Do you have any further questions?

Senator CARLSON. Not this morning.

Senator DOUGLAS. Senator Curtis?

Senator CURTIS. Mr. Secretary, you have given us helpful information. I have a few questions and I will try to be as concise as I can.

Referring primarily to your support of the King-Anderson bill, what would the King-Anderson bill do in the way of hospital or medical care for the people over 65?

Just a nutshell statement as we start today's proceedings.

STATMENT OF HON. ANTHONY J. CELEBREZZE, SECRETARY OF HEALTH, EDUCATION, AND WELFARE; ACCOMPANIED BY WILBUR J. COHEN, ASSISTANT SECRETARY; ROBERT M. BALL, COMMISSIONER OF SOCIAL SECURITY; ROBERT J. MYERS, CHIEF ACTUARY, SOCIAL SECURITY ADMINISTRATION; AND CHARLES E. HAWKINS, LEGISLATIVE REFERENCE OFFICER, WELFARE ADMINISTRATION

Secretary CELEBREZZE. Under the King-Anderson bill, Senator, the proposed program would provide for, in a nutshell, the following benefits: It would provide one, for the payment of hospital bills. Each person would have one of three choices under the King-Anderson bill. He could elect to take 90 days of hospitalization, at a cost to him of $10 a day for the first 9 days, with a minimum cost of $20, or he could elect to take 45 days——

Senator CURTIS. What is this about $10 and $20?

Secretary CELEBREZZE. A deductible of $10 a day up to a maximum of $90, with a minimum deductible of $20.

In other words, if you go to a hospital and stay 4 days, you would have to pay $40 of your hospital bill. If you stayed there 1 day or 2 days you would have to pay $20 out of your own pocket. That is the 90-day option.

Senator WILLIAMS. That is, the party would have to pay that.

Senator CURTIS. If you stayed the full 90 days what would happen?

Secretary CELEBREZZE. If he stayed the full 90 days, the patient himself would pay $90.

Senator CURTIS. A dollar a day?

Secretary CELEBREZZE. $10 for the first 9 days. After that there is no deductible.

Senator CURTIS. I see.

Secretary CELEBREZZE. Or he could elect, under the King-Anderson bill, to take 45 days with no deductible.

That is your second option.

Senator CURTIS. Go ahead.

Secretary CELEBREZZE. Or he could elect to take 180 days of hospital care and pay the national average cost for two and a half days of hospital care.

In other words, if the national average was $40 per day, the patient would be charged two and a half times the $40 or $100.

The bill provides also, in addition to this, for payment for up to 180 days of skilled nursing home care following discharge from the hospital, and payment of costs above the first $20 for outpatient dignostic services furnished within any 30-day period.

In addition, it provides for payments for up to 240 visits a year by a visiting nurse or other health worker in the patient's own home.

The hospital payments would cover the cost of all services in semi-private accommodations, and drugs and supplies customarily, and we emphasize "customarily," furnished for the care of patients in a hospital or skilled nursing facility.

No payment would be made for services of personal physicians or private duty nurses, or for luxury items furnished at the request of the patient.

Senator CURTIS. How about a special prescription requested by the doctor in attendance?

Secretary CELEBREZZE. That would be taken care of.

Senator CURTIS. Is that customarily done by hospitals?

Secretary CELEBREZZE. I think in most cases it is the customary procedure of a hospital to furnish the medicine to the patient that the doctor recommends.

Senator CURTIS. If the doctor orders the securing of a medical prescription for a patient, either in a pharmacy which happened to be located in a hospital or elsewhere, the hospital pays that without adding it onto the patient's bill?

Secretary CELEBREZZE. It is added onto the bill.

Senator CURTIS. Well, then, what would you do about it?

Secretary CELEBREZZE. We would pay for it.

Senator CURTIS. So you would pay for all drugs and prescriptions that the hospital added onto the bill?

Secretary CELEBREZZE. We would, in general, follow the same pattern as the Blue Cross now follows in paying the hospital bills.

Perhaps I can give you a list, Senator, of what is not covered.

Senator CURTIS. Go ahead with your thumbnail sketch.

Secretary CELEBREZZE. Those are the benefits that are provided under the King-Anderson bill.

Senator CURTIS. How often can you get those benefits? If you are hospitalized in January, and consume your election, and then are hospitalized for another illness, another attack in the fall of that same year do you start all over again?

Secretary CELEBREZZE. It isn't on a calendar-year basis, as you know, Senator; it is on a benefit-year basis.

Senator CURTIS. I see.

Secretary CELEBREZZE. You are entitled to 90 days of hospitalization under one option. At the end of that 90-day period, if you have exhausted the option, then there is a period of 90 days during which you must be out of the hospital, and then your benefit period starts again.

Senator CURTIS. If you elected the longest period of 240 days?

Secretary CELEBREZZE. The longest period is 180 of hospitalization.

Senator CURTIS. 180 days?

Secretary CELEBREZZE. It is 240 home visits.

Senator CURTIS. Well, all right.

One hundred and eighty days, what does the patient pay if he takes that election?

Secretary CELEBREZZE. He pays 2½ times the national average for daily hospital costs.

Senator CURTIS. How many times can he take that 180 days in a benefit year?

Secretary CELEBREZZE. Well, he can take it once in a benefit year. You have 180 days, and then you have a waiting period of 90 days without hospitalization within a 180-day period and that consumes a whole year.

Senator CURTIS. What happens to the man who goes to the hospital for 3 or 4 days once and then never has to go again? If his election is proper you take care of the whole thing?

Secretary CELEBREZZE. His benefits are cumulative. That is, he is entitled to 180 days of hospital care within a benefit year under this option so he can go in for 2 days and come out and go back for 5 days and come out, until he has exhausted his 180 days or a new benefit year starts.

Senator CURTIS. Suppose he just goes in 3 days and doesn't come back for years, it pays the whole bill?

Secretary CELEBREZZE. Well, if he has elected to take the 45 days then he pays no part of the bill. If he has elected to take the 90 days then he pays the $10 per day up to a maximum of $90, so if he is in there for 2 days he would pay a minimum of $20; for 3 days, $30.

Senator CURTIS. Does it pay anything for surgery?

Secretary CELEBREZZE. No; there is no provision in the King-Anderson bill either for surgery or for physician's services.

Mr. BALL. It would pay for the use of the operating room, Senator.

Senator CURTIS. It would pay for the use of the operating room?

Mr. BALL. Yes, sir.

Senator CURTIS. But it would not pay for the doctor's calls at the hospital?

Mr. BALL. No.

Secretary CELEBREZZE. No.

Senator CURTIS. Would it pay for the doctor's calls at a patient's home if he wanted to stay home without going to the hospital?

Secretary CELEBREZZE. No. The King-Anderson bill has nothing whatsoever to do with the costs of private physicians' services.

Senator CURTIS. Does it pay dental bills?

Secretary CELEBREZZE. No.

Senator CURTIS. Does it pay the bill of a person who goes to the doctor's office?

Secretary CELEBREZZE. No.

Senator CURTIS. Would it pay for the prescriptions under any of these circumstances?

Secretary CELEBREZZE. No.

Senator CURTIS. Will it pay for glasses?

Secretary CELEBREZZE. No.

Senator CURTIS. Will it pay for insulin?

Secretary CELEBREZZE. Insulin? In a hospital?

Mr. BALL. Yes; in a hospital or skilled nursing home.

Secretary CELEBREZZE. But not out of a hospital or a skilled nursing home.

Senator CURTIS. You say it will pay for the prescriptions if you get the hospital to add it onto the bill.

Mr. BALL. Senator, just as under the majority of Blue Cross contracts, while the patient is an inpatient in the hospital or in a nursing home, if the doctor writes a prescription and the drug comes from the hospital's own pharmacy, the charge for it becomes part of the hospital charge, and, as usually under Blue Cross, this program would pay for the drugs.

Senator CURTIS. Does this bill——

Mr. BALL. But not for a prescription if you are at home.

Senator CURTIS. Does this bill by its language tie its benefits to Blue Cross?

Mr. BALL. No, Senator; I was just making a comparison.

Senator CURTIS. What does it say about prescriptions in the hospital?

Mr. BALL. It says that it will pay for drugs and biologicals included in several official listings, or approved by the pharmacy and drugs therapeutics committee of the medical staff of the hospital, and it will pay for them only while the person is in a hospital or a skilled nursing home.

Senator CURTIS. I may be wrong, but I had the impression from our previous hearings that actual prescriptions written out for the individual patient were not regarded as drugs customarily furnished by a hospital.

Mr. BALL. Well, the bill specifically provides on page 12 for such coverage, Senator.

Senator CURTIS. Would you read the language into the record at this place?

Mr. BALL. This is the definition of drugs and biologicals:

Subsection (e). The term "drugs" and the term "biologicals," except for purposes of subsection (c) (5) of this section include only such drugs and biologicals, respectively, as are included in the United States Pharmacopoeia, National Formulary, New or Non-Official Drugs, or Accepted Dental Remedies,

or are approved by the pharmacy and drug therapeutics committee (or equivalant committee) of the medical staff of the hospital furnishing such drugs or biologicals (or of the hospital with which the skilled nursing facility furnishing such drugs or biologicals is affiliated or is under common control).

Senator CURTIS. Didn't you say something earlier that you furnish such drugs as are customarily furnished by the hospital?

Mr. BALL. That is on page 8, Senator. The connecting point here is a description of "inpatient hospital services."

What I read earlier was the definition of drugs.

Senator CURTIS. Yes.

Mr. BALL. Now in section 1703, subsection (a), the definition of "inpatient hospital services," we have this:

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

And the pertinent point about drugs comes in paragraph 2:

Such nursing services and other related services, such use of hospital facilities, and such medical social services as are customarily furnished by the hospital for the care and treatment of inpatients and such drugs, biologicals, supplies, appliances, and equipment for use in the hospital as are customarily furnished by such hospital for the care and treatment of inpatients.

Senator CURTIS. Well, now, "as customarily furnished"; does that mean as are customarily furnished by paying the daily rate in the hospital and not a separate addition to your bill?

Mr. BALL. I believe, Senator, it would mean as customarily furnished in either way, by a separate addition to the bill as well as in the daily rate. It does not have to be included in the daily hospital rate as long as the hospital provides it.

Senator CURTIS. I would like to know the name of a hospital that customarily provides expensive medicines to their patients.

Mr. BALL. Well, practically all of them do, Senator, but they charge for them, of course.

Senator CURTIS. And so we have this conclusion, if they can put it on the hospital bill it is taken care of.

Mr. BALL. Yes, Senator. If it is furnished by the hospital.

Senator CURTIS. Furnished by the hospital doesn't mean procured by the hospital. To me furnished by the hospital means something that is part of your daily rate in the hospital. I am afraid that the pronouncements you have here is a new departure, a new concept.

Mr. BALL. Senator, I think I might expand on that a little bit, because it is not only drugs that are involved in this concept, but some other things, too.

The hospital may——

Senator CARLSON. Will you yield at that point?

Mr. BALL. What is that?

Senator CARLSON. Will you yield at that point?

Mr. BALL. Certainly, Senator.

Senator CARLSON. My thought is what you are trying to tell us is if you need castor oil if you get castor oil in the hospital, that is part of the regular operations of a hospital.

Mr. BALL. Right.

Seantor CURTIS. Suppose it is a prescription that costs $9 or $10 to fill. If you can induce the hospital to put it on the bill, it is taken care of?

Mr. BALL. Well, Senator, I don't think it is a matter of inducing the hospital to put it on the bill. I think that if it is customary for this particular hospital to handle drugs for inpatients in this way, then it would be on the bill and it would be paid for, and my point is that that is true not only of this bill but this is the way hospital insurance such as Blue Cross now operates. The way the bill——

Senator CURTIS. I wonder about that. I wonder if a great city hospital that has a pharmacy as part of the hospital, provides more expensive prescriptions than a rural hospital where the doctors calls on the patient in the hospital, and writes out a prescription and somebody has to go down to the villeage drugstore to get it. I don't want to take too much time on this point but I am unclear about what is customary.

Secretary CELEBREZZE. The basic philosophy, Senator Curtis, behind this was that we didn't want to change any of the procedures that are customarily followed by any particular hospitals.

In other words, we didn't want to be in a position where either the agent of the hospital or the Government—as you know, an agent can be appointed under the King-Anderson bill; the hospital doesn't have to deal directly with the Federal Government—would be in a position to tell the hospital how to run its business, and that is why we used the word "customarily." So that may vary from hospital to hospital.

Senator CURTIS. If what you say is true, then an aged person who has to take a very expensive prescription, and I am not passing on the point whether the prescription is overpriced or not, I think there is a strong case made for the wonderful advance in the research that drug companies have to do so I am not passing on that. But if he can be well and happy and stay with his loved ones by going to the doctor's office to be checked on a bit, and the doctor writes the prescription, even though the medicine is expensive, he gets nothing under King-Anderson, but if he goes to the hospital, where he doesn't want to go, the prescription will be paid for.

Is that correct?

Secretary CELEBREZZE. That is the same as Blue Cross now. Blue Cross generally operates in exactly the same way.

Mr. BALL. Except, Senator, this patient——

Senator CURTIS. I will have Blue Cross submit a statement. I am surprised. (A representative of Blue Association appears as witness on Wednesday, August 12, 1964.)

Secretary CELEBREZZE. Senator, if you want to amend the bill to include that, to broaden the benefits, why——

Senator CURTIS. No, I just think that we ought to know what the bill provides. My basic opposition to the bill is very fundamental. I do not believe in taxing the young and the able-bodied and the middle-aged people who are buying their homes, educating their children, paying their taxes, and paying their own medical bills, to pay the hospital bill of somebody who just happens to be over 65 if that person is far more able to pay the bill than the individual you are taxing.

I know all the problems of some sort of an income test, I think we are doing pretty well under Kerr-Mills.

Secretary CELEBREZZE. Kerr-Mills is——

Senator CURTIS. But I think everyone who is politically astute knows that if you once start this thing of taxing people to pay hospital

bills for somebody who doesn't need it, the age is going to be lowered to pay the hospital bill of somebody who does need it, that medicines are going to be added and house calls are going to be added and surgery is going to be added and what you are here advocating today is the beginning of national medicine.

Secretary CELEBREZZE. No, no, I disagree with that. But I want to get back to the other points.

I see no distinction between your point and the effect of private insurance in certain instances. I continue to pay on my policy, for example, my automobile policy for years and years and years. I don't get any benefits from it. I am paying for protection in the event I get in an accident. Someone else who is carrying the same policy will get in an accident and some of my premium money is going to pay off his bill.

That is the basis of insurance. I don't know how you can get around this.

Senator CURTIS. You are tying this to social security.

Secretary CELEBREZZE. Well, the court has called social security——

Senator CURTIS. No, social security has no connection with ordinary insurance. It has been a fraud to say so.

Secretary CELEBREZZE. No.

Senator CURTIS. But few people have their houses burn down.

Secretary CELEBREZZE. If you want to say the Supreme Court in calling it social insurance is a fraud.

Senator CURTIS. Well, it didn't.

Secretary CELEBREZZE. But the Court did say it was social insurance.

Senator CURTIS. No, no. I know about that.

Secretary CELEBREZZE. All right.

Senator CURTIS. A lot of people go through life and do not have a car accident. A lot of them go through life and their houses don't burn down. Everybody or substantially everybody either gets old or leaves dependents, and social security is not insurance in the sense that everybody shares a risk that might come to a few people.

Mr. COHEN. That is not a necessary part of insurance, Senator.

Senator CURTIS. I don't want to get sidetracked on this but when the Supreme Court ruled on the Social Security Act, the Social Security Administration specifically argued that it wasn't insurance, and within hours after the Court approved it as a taxing and a benefit plan they announced that it was insurance, but that is a matter of semantics I am not concerned about.

Mr. BALL. Senator, just for the correction of the record, I think it might be desirable to have in it what the Supreme Court said on the question of whether the social security system is insurance. With the permission of the committee, could I read the paragraph?

Senator CURTIS. Yes.

Mr. BALL. The Supreme Court of the United States in the case of *Flemming* v. *Nestor* said:

> The social security system may be accurately described as a form of social insurance, enacted pursuant to Congress' power to "spend money in the aid of the general welfare." * * *.

Now, related to this general discussion, the committee might be interested in the fact that the article on insurance in the Encyclopedia Britannica states:

* * * The modern institution of insurance is divided into the two broad categories of voluntary or commercial insurance and compulsory or social insurance, both relying on the same basic principles. * * *

Of course, there are significant differences. But they share certain common basic principles.

Senator CURTIS. Well, I won't go into that. It is a matter of semantics.

Now, what other things does the King-Anderson bill not provide?

Mr. BALL. Senator, would it be possible, before going to that to go back to your earlier point in order to make something clear about that illustration of the individual who did not get his prescription paid for because he stayed at home and went to the doctor's office.

Senator CURTIS. Yes.

Mr. BALL. And your point that if he went to the hospital he could get it paid for. I would just like to make sure that it is clear that he could get into the hospital only if the doctor indicated that it was medically necessary for him to be in a hospital, and that if he could be cared for elsewhere he wouldn't be in the hospital, and that the bill requires also that there be review of hospital admissions by a utilization committee, so a person who does not need hospitalization couldn't be put in a hospital just to get a prescription paid for.

Senator CURTIS. Well, my observation of old people is that they want to stay well so they don't have to go to the hospital.

Mr. BALL. Yes, sir.

Senator CURTIS. And that includes the poor and the near poor as well as everybody else.

Now, the Secretary was about to say what other things it does not provide.

Secretary CELEBREZZE. It does not provide for private accommodations in the hospital. These are excluded. The extra costs of private accommodations are excluded unless the accommodations are medically necessary.

Physicians' or surgeons' services are excluded except where customarily paid for in the same way a hospital service, and then only in the fields of pathology, radiology, physical medicine, rehabilitation, anesthesiology, and the services of interns or residents-in-training. Private duty nursing care, items not customarily furnished by the hospital to its inpatents, and items for use at home after discharge. These are exclusions related to the inpatient hospital services.

Now, the following skilled nursing facilities services are not covered. We exclude all that I have mentioned as applying to hospitals, and add to that services not specifically defined as covered if they are not generally provided by skilled nursing facilities.

Under the home health services the following items are not covered, again excluding the same items excluded as hospital inpatient services, and in addition anything more than part-time care, drugs, and biologicals. This is in a home. Such part-time or intermittent services by home health aids as is not covered by the regulations, and any services not specifically listed as being covered.

Now the exclusions for the outpatient diagnostic services: those not customarily furnished by the hospital or by others through arrangements made with it to its outpatients for the purpose of diagnostic study.

These are the exclusions under the King-Anderson bill.

Senator CURTIS. I believe I understood you to say that when the patient elects he can get three different categories of treatment. Can he change his election?

Secretary CELEBREZZE. No. Once he makes his election it is a firm election. Otherwise you would get into the basis where the individual will change to what is most advantageous from time to time. For example, after he has made his election for 45 days he feels he needs 90 days and changes it would just be administratively impossible and, of course, costly.

So once the election is made——

Senator CURTIS. Once in a lifetime.

Secretary CELEBREZZE. Yes, sir.

Within the limitation that unless Congress in future years changes it.

Senator CURTIS. But he is entitled to whatever election he chooses to use that once every benefit year?

Secretary CELEBREZZE. Benefit period, that is right.

Senator CURTIS. What happens to the individual who takes the 45-day election and a catastrophic illness strikes and he spends the last 10 years in the hospital assuming he were 65?

Secretary CELEBREZZE. You are now speaking about a minute fraction of cases, if any, because 45 days on the average covers about 92 percent of all hospital stays. I emphasized yesterday with your particular thought in mind that a three-pronged approach is necessary. Hospital insurance under social security will not cover it all. The private sector would be able to come up with a policy to give extra protection. The third prong then, of course, is that if we went to hospital insurance under social security you would relieve the States of about 40 percent of their costs under Kerr-Mills and the States could then liberalize their Kerr-Mills provisions to take care of unusual cases.

In your example he will have exhausted all his benefits and if he doesn't have a private policy or after he has exhausted it, then he would have to revert back to Kerr-Mills.

Senator CURTIS. By relieving you mean they could transfer——

Secretary CELEBREZZE. Well, 40 percent of the State costs are now for hospital care under the Kerr-Mills—actually 90 percent of all costs are for hospital care and nursing home care, but with the adoption of hospital insurance under social security we would relieve the State obligation of about 40 percent of the costs.

We then say to the State, "Without increasing your costs at this time, take about 40 percent and liberalize your Kerr-Mills provisions."

Senator CURTIS. Now, in answer to my question, under the King-Anderson bill as written now and as you propose, what would it do for the individual who is hit by a catastrophic illness and goes to the hospital for his last 10 years, assuming he was 65 when he went there so he was eligible.

Of course, after the Congress meets a few times and faces a few other elections that 65 will be reduced considerably, but for the present, at 65 years of age he has a catastrophic illness and his last 10 years is in the hospital, he has made the 45-day election.

Now, what will it do for him?

Secretary CELEBREZZE. It would do for him what is defined as under any private insurance policy.

Once you have exhausted your benefits the payments terminate.

Senator CURTIS. What are the benefits that he will exhaust?

Secretary CELEBREZZE. Well, let's assume he has chosen 45 days with no deduction he would get 45 days in the hospital, he would then have a 90-day waiting period, in which no benefits——

Mr. BALL. Senator, are you talking about a case where the individual stays in the hospital continuously for 10 years?

Senator CURTIS. Yes.

Mr. BALL. Stays in the hospital for 10 years. Then he, of course, would get only the 45 days because a new benefit year requires that he be out of hospital.

Senator CURTIS. He has got to get out.

Mr. BALL. Yes; that is what starts a new benefit period.

Senator CURTIS. Suppose they load him in an ambulance and get him out for a week?

Secretary CELEBREZZE. He has to be out for 90 days. If he has exhausted his 45 days, if that is his election. Let me explain it so we all understand. He has to go out of the hospital for 90 days. At the end of 90 days he can come back because of his new benefit period, so he can get 45 more days. He has to leave again for 90 days to start a new benefit period.

If he has chosen the other method, the 90 days, he could stay in 90 days and then leave for 90 days and then would be eligible again for 90 more days.

Senator CURTIS. I am talking about the real unfortunate person who goes to the hospital and stays and stays and stays, no escape from it, he loses his home, his family exhausted their resources, and the like. I am talking about the individual who should have first claim on a public plan. He stays there 10 years, that is 3,650 days. You would take care of him 45 days, and he would be right back where he was for 3,605.

Secretary CELEBREZZE. I don't think there are hardly any such cases. I think when you say stays in the hospital for 10 years, what they do is transfer him to a skilled nursing home which is provided for also under King-Anderson.

I don't recall of anyone ever staying in a hospital for 10 years.

Senator CURTIS. I have in mind a cancer patient or two who have gone through a series of operations. I have in mind one lady who spent the last 5 or 6 years in the hospital. I know of another individual, her husband is dead, she has no children, and she actually needs hospital care because her paralysis is so great that she is, I think according to everybody's standards, required to have hospitalization.

Now, suppose she only lives 3 years, three times 365 are 1,095 days. If her election had been 45 days, that person suffering from catastrophic illness would still be right back where they were for 1,050 days out of 1,095.

And those are the cases that should have first claim on some level of government because the sickness will wipe them out. I talked to a man back home a few weeks before he died, who had had cancer for 3 or 4 years. He said, "Well, my time is short now: But I have been cleaned out." And the proponents of King-Anderson have capitalized on that. They have cited those cases and they say, "Vote for the President's medical care plan, hospital care plan."

My point is, it wouldn't do anything for him.

Secretary CELEBREZZE. No; I think that is the wrong approach, too. What you are saying to us now is that the King-Anderson bill doesn't go far enough. We have to be realistic in the cost factor in any insurance program.

Now, what you are referring to, these people are transferred. They don't stay in the hospital, they are transferred to chronic nursing homes.

Now, let's assume that the individual is in the position that you said. He has exhausted his 45 days. He could pick up his intermittent period under the Kerr-Mills Act, paid out of general obligation funds.

Senator CURTIS. After his own resources are gone.

Secretary CELEBREZZE. Yes; after his own resources are largely gone.

Senator CURTIS. Kerr-Mills is a pretty good law. It puts its benefits where the needs are.

Mr. COHEN. But, Senator, the point the Secretary is making—if you pass the King-Anderson and relieve 40 percent of the financial obligation that the States have now for hospital care, they could amend Kerr-Mills and liberalize it so that people could have even more resources retained and you could take care of this indefinite hospitalization.

Even Kerr-Mills does not do what you—take care of the kinds of cases that you talk about now because of the financial limitation on States. But with the passage of King-Anderson they could take care of this small number.

Senator CURTIS. What do you mean financial limitations of the State. Is there any Federal law to prevent them from doing it?

Secretary CELEBREZZE. But there are State matching funds needed and you have only 33 States that have Kerr-Mills in operation. They have all kinds of limitations. There are practically no two States that have all of the same benefits.

Senator CURTIS. Now, we have talked about the elderly person who wants to stay out of the hospital and wants to go to the doctor's office to get some medicine and so on, so he can remain with his family, and also about the catastrophic case.

Now, I want to ask you, do you have to be retired to receive the benefits of Kerr-Mills?

Secretary CELEBREZZE. No. They start at age 65.

Mr. COHEN. You meant King-Anderson?

Senator CURTIS. King-Anderson.

Secretary CELEBREZZE. No; it starts at age 65.

Senator CURTIS. You don't have to retire. Is there any income limit?

Secretary CELEBREZZE. No.

Senator CURTIS. Any property limit?

Secretary CELEBREZZE. No. It works the same as an insurance policy.

Senator CURTIS. Well now, suppose I had a lawyer friend who is worth millions of dollars. He hits 65, he is still in his prime. That is one profession where the longer you stay in the income curve goes up, if you are a good one, and he has the highest income in his life.

Are you going to raise the social security taxes on the 20-year-olds and the 30-year-olds who are raising families and educating the children and paying their own medical bills, to pay my lawyer friends hospital bill?

Secretary CELEBREZZE. Well now, Senator, of course, you are picking the extreme case. But let's get back to the 20-year-old and the 30-year-old and the 40-year-old.

Senator CURTIS. Well, first answer my question.

Are you going——

Secretary CELEBREZZE. The answer is "Yes, he would be covered." You are picking an extreme case. You brought in the 20-year-old and the 30-year-old and the 40-year-old. There isn't anyone who knows at age 20 whether he is going to be a millionaire or pauper at age 65. There isn't anyone who is 40 who knows whether he is going to be a millionaire or a pauper at 65. You are buying protection the same as you do when you buy a private insurance policy and you are paying toward the cost of it.

Senator CURTIS. Oh, no. Oh, no.

Secretary CELEBREZZE. Why, of course, you are.

Senator CURTIS. His money isn't going into a fund to be accumulated with compound interest and protected by a reserve as an insurance company, not at all. He is being taxed in 1965 to pay for public expenditures in 1965 and if he is alive at 65 or whatever the retirement age is in 1995, why, he will be dependent on taxing the producers then.

Secretary CELEBREZZE. What you are arguing against is not the King-Anderson bill, you are arguing against the total social security program because that applies as much to the total program.

Senator CURTIS. I am not arguing against it. I am contending that all this sham and talk, and likening it to insurance is deceptive to the people.

What you have is a taxing program to tax the producers to pay a social benefit. I agree with that, but I think it should be called what it is.

Mr. BALL. Could I make the point——

Senator CURTIS. Yes.

Mr. BALL (continuing). That the elimination of the people who are at work from the plan, or, to go at it another way, the elimination of those who had significant income, would reduce the contribution rate for the plan by only 0.02 percent of payroll.

In other words, this is a very small group that we are speaking about here among the aged, and philosophically, it isn't that we would have any objection to a retirement provision in the plan any more than in social security, but it has seemed technically just about impossible to work out, and the group is a relatively small one and it is not expensive to pay them.

Senator CURTIS. You may know about the philosophical side. I happen to know about the political side. And you cannot——

Mr. BALL. I said we would have no objection to a retirement test if it were workable.

Senator CURTIS. You cannot tax the young and the middle aged and the people who are raising their children and paying their taxes, and paying for their education, providing their own medical and hospital bills if they are paid, if taxed, to pay a hospital bill of somebody of wealth and great income who doesn't need it just because they happen to be 65, then someone over on the Senate floor or the House floor offers a proposal to lower the age or to add this or that because there are x dollars in the funds, they think, and they are giving this money away to people of great wealth who do not need it.

Mr. COHEN. But, Senator——

Senator CURTIS. You have headed toward a program where the program is doing it all.

Secretary CELEBREZZE. Suppose we talk about the other 96 percent, the ordinary people on this program, rather than stressing the wealthy 4 percent or so.

It seems to me if there is a 96-percent need, that offsets the 4 percent who don't need it. You are giving us the extreme case. Now, I know young people. They have told me they are willing to pay for this. I know people and many of us know people—perhaps members of this committee—who have had to pick up hospital bills for their parents at the same time that they are trying to send their children to college. Sometimes the question becomes, "Do I give my parents this hospital care and take away from my child's education," and, of course, the decision is always that you are going to give the medical care to your parents.

Now, if the individual, while he was working, could have been contributing something to a program which would have lifted this tremendous cost from his children's shoulders, he would have been happy to do it, and I say to you that the majority, the vast majority of the young people that I talk to are willing to pay the small sum now, not only for their own future protection but to protect their parents now.

Now, it is possible—I can cite you a case of a married couple that have four aged parents, and I can cite you a case where these four people got sick, they needed hospital care and they had to sell their home, I am talking about the youngsters now, they had to sell their home, they had to mortgage themselves to the hilt.

If you had some kind of a social security program——

Senator CURTIS. They wouldn't have had to if the Kerr-Mills law had been made available to them.

Secretary CELEBREZZE. They might, because under the Kerr-Mills law some States have relative responsibility, and the children have to assume the obligation if they can before the State will assume it under the Kerr-Mills. That is one difficulty with Kerr-Mills; the States have so many limitations. Some States have assessments against property that can be recovered after death.

Senator CURTIS. But the States can correct that if they want to.

Secretary CELEBREZZE. Yes, but the States, Senator Curtis—and I work closely with the States, I have them in my office all the time, in

this Department of Health, Education, and Welfare—the States are straining for financial assistance. They say, "That is fine. You on the Federal level say to me, if you will do such and such the Federal Government will give 50 percent." Then they say to me the same thing that I used to say as mayor of Cleveland: "How do I get the 50 percent on the local level when I am taxing my people to the hilt now and they won't pass any more levies?" The States are faced with that problem.

Senator CURTIS. We have to choose between priorities.

The Government can't take care of everything under the sun.

Senator WILLIAMS. Will the Senator yield?

Senator CURTIS. But that leads to the philosophy the Federal Government can reach up in the air and get it. They either get it by printing money, inflating the currency, or by taxes.

Secretary CELEBREZZE. Senator Curtis, what I am trying to convey is a basic philosophy: Instead of increasing our general-revenue commitments—Kerr-Mills and these other assistance programs are paid out of general revenues—I am saying to you, let's come up with a plan where the individual himself can contribute to the benefits he is going to receive in the long run and let us take this burden off the backs of the State, let's take this burden out of the general-revenue classification.

In other words, if I am going to receive medical benefits, let me contribute during my working years toward those benefits. That relieves the obligation on the general funds of the State and Federal Governments.

Senator CURTIS. Before pursuing that idea I will yield to Senator Williams.

Senator WILLIAMS. I want to thank the Secretary for citing a specific example of how this would work because we can all understand the case better when we cite a specific case.

Now, would you furnish for the committee, and we will keep the name in confidence, the specific case to which you referred where the individual had to sell his home. We would like to have the specific case, the total amount of his hospitalization, the time in which it took place, along with the amount which he would have collected under this bill had it been effective at that time. And to what extent this would have minimized his danger of having to lose his home.

Senator CURTIS. You want that submitted off the record?

Senator WILLIAMS. Off the record.

Secretary CELEBREZZE. I will have to ask permission of the individual, that is why I didn't use names.

Senator WILLIAMS. We only want the names—we assure you that the committee will keep that in strict confidence, the name, because I respect that but I think we can follow through better and understand this better if we follow through a specific case, and you have just cited a rather heartbreaking case and I would like to know to what extent this would have minimized this particular individual's difficulties.

Secretary CELEBREZZE. I can cite you another case that was just published recently and that was the case of Postmaster General Gronouski and the bill he had to pay for his parent. That was in the newspapers.

Senator WILLIAMS. I am not concerned with the Postmaster General. He is being paid enough and he should be able to take care of his own parents. I am just concerned about this case, and this is what we are dealing with and I would ask you to cite that and if you wish to include this other case, as many other cases as you can but I want them cited for the committee's record with the name and address of the individual, the hospital he attended and all of the details involved.

Now, I assure you that the committee will accept that in confidence, but I think we can understand it better and I don't want it furnished for the official record.

I appreciate the Senator's yielding.

Senator CURTIS. I want to ask you this, you talked about a contribution, and I am aware that Congress was induced to strike out the word "tax" and put in "contribution." But if you get what you are advocating here, the House bill, and King-Anderson what will be the contribution or tax rate, say, in 1971?

Secretary CELEBREZZE. Under the Gore bill it would be 5.2 percent of covered payrolls.

Senator CURTIS. 5.2, a total or on each?

Secretary CELEBREZZE. On each.

Senator CURTIS. 5.2 and on the self-employed?

Secretary CELEBREZZE. 7.8 percent.

Senator CURTIS. Self-employed 7.8. My farmers are all self-employed. What will be the base on which you applied that?

Secretary CELEBREZZE. Under the Gore bill it is $5,400.

Senator CURTIS. $5,400.

Secretary CELEBREZZE. So that we can keep our figures straight, the Gore bill is in addition to the House bill.

Senator CURTIS. Yes, that is what I am asking about.

Mr. BALL. What figure did you want?

Senator CURTIS. I want to know what a farmer would be paying.

Mr. BALL. In 1971, at 7.8 percent on $5,400, he would be paying at that time a total under the Gore bill of $421.20. That is to be compared with the bill that is before the committee as passed by the House, that does not have hospital insurance in it, of $388.80. In other words, adding hospital insurance would cost the self-employed, at the ultimate rate for the maximum earner, $32.40 a year.

Senator BENNETT. Will you give me that top figure again, 400 and what?

Mr. BALL. $421.20 a year. This is the man who earns $5,400.

Senator BENNETT. Yes, that is right.

Mr. BALL. And that, the House bill, without hospital is $388.80, the difference being $32.40 which comes about by the addition of the benefit provisions of King-Anderson in the Gore bill.

Senator BENNETT. Will the Senator yield?

Mr. Chairman, I have been interested in the area into which the Senator from Nebraska has now moved, and in preparation I have had prepared for the record a statement showing the changes that will occur under H.R. 11865 between now and 1971 as these various changes come into effect, and I would like to offer this schedule for the record which shows that in 1971 the social security tax on the self-employed individual will be $388.80, the figures to which you have referred. It also shows a corresponding column which shows that if that individual

is a man with a wife, is self-employed and has two children, and earns $5,400, taking the standard deduction, his income tax will in 1971, assuming no changes in income tax rates, will be $354. We have now boosted the social security tax above the income tax. That break comes in 1968.

Senator CURTIS. That is without King-Anderson.

Senator BENNETT. It is without King-Anderson. If you are going to add $32 on top of these figures that break will come in 1966, 2 years from now. We will have boosted social security tax above that individual's income tax, and I think we have come, with this bill, and at this time, to a point of great decision. Are we going from here on out to have a social security system which costs an individual at the maximum base covered by the system, more than it costs him to support his share of the cost of our Government? Now we have been gradually coming up to this time during recent years. When we pass this bill we will have reached it. If we add King-Anderson we will cross that rubicon 2 years from now.

(The information referred to follows:)

MEMORANDUM

To: Senator.
From: Ralph.
Date: August 6, 1964.
Re comparison of income tax and social security taxes for a self-employed person.

The following assumptions were made in computing the income tax figures:
1. The family consists of man, wife, and two children.
2. Man and wife file a joint return.
3. They take a standard deduction.
4. They are both under age 65.
5. They earn $5,400.

	Existing law		H.R. 11865		Income tax amount
	Social security tax	Rate	Social security tax	Rate	
1963					$492
1964	$259.20	5.4	$259.20	5.4	395
1965	259.20	5.4	307.80	5.7	354
1966	297.60	6.2	324.00	6.0	354
1967	297.60	6.2	324.00	6.0	354
1968	331.20	6.9	367.00	6.8	354
1969	331.20	6.9	367.00	6.8	354
1970	331.20	6.9	367.00	6.8	354
1971	331.20	6.9	388.80	7.2	354

NOTE.—Average income figures:
1. Arithmetic mean average, 1963, for the total labor force, $6,115.
2. Median family income, 1963, $6,249.
3. Per capita income, 1963, $2,443.

Senator WILLIAMS. Will the Senator yield?

Senator BENNETT. Yes.

Senator WILLIAMS. That is assuming we elect the Presidents to come without boosting this social security.

Senator BENNETT. That is assuming no changes either in the income tax or the social security tax.

Senator WILLIAMS. Benefits.

Senator CURTIS. May I ask on what do you base any such assumption? When King-Anderson was debated on the Senate floor last

time, Senator Gore, who now offers this, made the flat statement that this was but a beginning. It doesn't take care of catastrophic cases. It doesn't take care of a lot of things.

Now, upon what basis do you assume that between now and 1971 the Congress won't add to it?

Senator BENNETT. May I answer that question?

This is, of course, a completely hypothetical situation, but when we look back 10 years, we discover these interesting figures.

Since 1952, we have increased the dollar benefits of social security at the maximum end of 257 percent.

Senator DOUGLAS. Would the Senator permit me to make a comment?

Senator BENNETT. May I finish my figures?

Senator DOUGLAS. Surely.

Senator BENNETT. And at the minimum end by 150 percent in the last 12 years.

And we have increased the base by 50 percent. So if you look forward 10 years, based on our experience of the last 10 years, you can realize that we are looking forward to substantial increases in rates, substantial increases in base; and the third point that I want to make is today we are bumping our head against the mythical 10-percent ceiling.

Now, I will be happy to yield.

Senator DOUGLAS. Is it not also true that during this period the average earnings of the persons covered have also increased, and, since the contributions from these groups exceed the obligations in the form of benefits, that, therefore, this has largely counterbalanced the increase in average benefits?

I would like to ask Mr. Myers that question.

Senator BENNETT. May I put two more figures in in response to your question before Mr. Myers replies?

Senator DOUGLAS. Surely.

Senator BENNETT. In 1963, the mean average for the labor force, and they are the ones who pay social security, was $6,115, and we are up to $5,400. The median family income for 1963 was $6,249. So we haven't got very far to go before we are bumping our head against both the mean and median average income of the labor force, the employed income.

Senator DOUGLAS. Well, Senator, what I was referring to was not a comparison of the present maximum base with present earnings but what has happened to the average earnings over a period of time.

It has been this increase in average earnings and, therefore a greater volume of contributions than benefits, which has enabled us to increase the scale of benefits and keep the reserve fund from being unduly depleted.

And I would like, if I may, to ask the actuary to make a comment on this general statement.

Senator BENNETT. I would like to have those figures.

Mr. MYERS. Senator Douglas, you are quite correct.

In the past, in fact over the lifetime of the system, the average earnings of all male workers covered by the system—whether they are full time or part time—has risen from a little less than $1,000 a year in the late 1930's to somewhere around $4,000 now.

Senator DOUGLAS. Quadrupled. The earnings have quadrupled.

Mr. MYERS. That is correct. Looking at it another way, comparing, say, 1951 when coverage was expanded rather broadly with the present time, the total earnings of all persons who are in covered employment, whether these earnings are taxed or whether they are over the earnings limit, has doubled from $148 billion in 1951 to $306 billion in 1963.

Senator DOUGLAS. What has happened to the average earnings?

Mr. MYERS. In those 12 years from 1951 to 1963, there, of course, have been more people with earnings because of the growing population and the labor force, but the average earnings have probably risen about 75 percent.

Senator DOUGLAS. Is it not true that because of this increase in earnings at a given benefit rate that you tend to collect more in contributions than you pay out in benefits, assuming the rate of benefit is kept constant?

Mr. MYERS. Yes, sir; that is correct. That is one of the features of the cash benefits of the OASDI system. Because of the weighted benefit formula, as the Senator knows, a larger proportion of benefits is derived from the lowest part of the earnings rather than on the upper part.

Therefore, as earnings rise, the benefit liability does not rise as rapidly, and this gives some savings to the system which, of course, have been recognized in the actuarial cost estimates and which have been utilized in the past, in part, to liberalize the system.

Senator DOUGLAS. If the Senator will permit me to ask another question: Is it not true in every estimate which you have previously made on costs you have assumed that average earnings remain constant?

Mr. MYERS. Yes; that is correct.

Senator DOUGLAS. This is one of your actuarial constants, so to speak, that you used. Is it not true that in practice the average earnings have risen?

Mr. MYERS. Yes; that is correct.

Senator DOUGLAS. And this has provided a margin of safety which has permitted the benefit scales to be increased?

Mr. MYERS. That is correct; yes.

Senator DOUGLAS. Judging the future by the past, unless there is a catastrophe, do you expect this tendency to stop with the year 1964?

Mr. MYERS. No, Senator, I think that it is very, very likely that earnings will continue to rise in the future, and such trend will generate this, you might say, profit to the system—or reduction in cost to the system; but it also has seemed to me to be appropriate actuarial procedure to make estimates for the present law using present earnings levels.

Senator DOUGLAS. I understand. I think you are a very cautious, very conservative actuary. I simply want to point out that there is a margin of safety which is not included in the set of current statistics which helps to explain why the benefits could have been increased in the past without depleting the reserve.

Senator CURTIS. Now, I yield to Senator Dirksen.

Senator DIRKSEN. Well, Mr. Myers, I assume that all these percentages and figures are based upon present hospital costs, are they not?

Mr. MYERS. In the cost estimates that we have currently been quoting for the King-Anderson bill, and for similar proposals, at least following the discussion with the House Ways and Means Committee, the assumptions have been that the hospital costs have been based both on what we project that they would be in 1965, plus an allowance that in the future hospital costs will rise more rapidly than wages for about the next 5 or 6 years, with perhaps a 10-percent differential, and that after then we assume that if wages go up, hospital costs will go up at the same rate.

Senator DIRKSEN. Isn't it true, as a matter of fact, that hospital costs have followed an almost precise pattern, and have risen 3 to 4 percent every year?

Mr. MYERS. Senator Dirksen, in the past 10 years hospital costs have risen at a rate of about 7 percent a year, and wages——

Senator DIRKSEN. Every year?

Mr. MYERS. An average of 7 percent a year, some years a little more, some years a little less.

For example, in 1963 the increase was 5.6 percent. At the same time, over this roughly 10-year period, earnings in covered employment have increased about 4 percent a year. So there has been this gap of 3 percent a year, and in the estimates that are currently being made, we assume that this gap continues until 1965, but that after 1965 it gradually closes, so that by perhaps 1970, wages and hospital costs are assumed to increase at the same rate in the future.

Senator DIRKSEN. Why do you make that assumption?

Mr. MYERS. Well, Senator, it seems reasonable that at some point in the future hospital costs can't keep rising more rapidly than wages because after a while the costs of a day in the hospital would be far more than anybody could possibly pay.

The reason for the gap in the past has been, at least in part, that hospital wages have been relatively low; and this difference has been diminished, and there have been other factors of this sort, so that, in the long run, we feel that it is a reasonable assumption that hospital costs and wages will have to move together.

Now, whether 5 or 6 years will be when the gap will be closed or not, I don't know. But in discussions with the Ways and Means Committee we developed this assumption, and I have based the estimates on it.

Senator DIRKSEN. Yes; but, Mr. Myers, what you are saying here is that history rises to smite one in the face with its own figures. That there is between wages and hospital costs a gap of 3 to 4 percent. You are hoping that somehow by some miracle that is going to close in the future.

Now, I would just like to know what the basis of it is for that assumption or hope, if that has been the pattern over a period of years. It looks to me like its knocks Senator Douglas' case right out of court by what has been happening over the years and those costs are going to increase and what you will be up against is either an increase in the contributions or an increase in the base to which it applies and, of course, that was discussed by the Secretary yesterday when he was speculating with some figures in the neighborhood of $6,000, $6,600.

Mr. MYERS. I would agree——

Senator DIRKSEN. I just want to know. It just looks to me like you are catching up with yourself in a circle that has come full tilt. And what we are up against here is the constantly rising increase in the contribution or the base in order to offset that gap. You hope that that gap will close. Is there anything on which you can predicate that hope?

Mr. MYERS. I think there are some things, Senator Dirksen—of course, nobody can know precisely about this over the short range but, of course, over many, many years in the future, this gap has to close.

But even over the short range, the increase in hospital costs in 1962 was 5.3 percent; in 1963 it was 5.6 percent, but in the early 1950's it was as much as 7 or 8 percent a year.

So, this differential has been coming down some.

Then, too, there is the fact that prices of other things, as you know, have not risen as fast as wages, and it seems, I think, reasonable to assume that this rise we have been experiencing in hospital costs which is more rapid than wages eventually has to wear itself off.

Senator DIRKSEN. Could you put in the record a table—of course it is sheer estimate—covering the next 10 years on the assumption that that gap is not going to close, and what we have to do if the gap doesn't close?

Mr. MYERS. Yes. I have made estimates on that base. I made them when we had our long sessions with the Ways and Means Committee. They said, "Let's make the estimates on different assumptions." The original assumptions that I used were ones that I thought reasonable, but they said, as you have said, "Suppose this 3-percent differential goes on for a full 10 years without grading down from 3 percent to zero in 5 or 6 years." This assumption would increase the cost of any hospital benefits proposals by about 20 percent.

So, that, for example, instead of an additional 0.80 to 0.85 percent of taxable payroll for the King-Anderson bill if it were added to the Mills bill, you would need perhaps 1 percent.

Senator DIRKSEN. I think it would be most informative if you could prepare such a table on the assumption that the history pattern will continue and that the gap will not close and then indicate what we have to do about the contributions as well as the base.

Mr. MYERS. You can do either way. You can finance it by the tax base or you can finance it by the earnings rate.

Senator DIRKSEN. Either one or both.

Mr. BALL. Senator, could I make one additional point here?

Senator DIRKSEN. Yes.

Mr. BALL. And that is that these estimates being long-range estimates over really the indefinite future, I think it might be important to bring out that the assumption that on indefinitely, 50 and 75 years from now, prices of hospitals are going to continue to rise just as fast as wages do, has a very conservative element in it.

It allows for very big increases in hospital pricing, and even if in the short run prices should outrun wages for a few more years than Mr. Myers has assumed here, there is, in my judgment, a considerable likelihood that over the long run there would be an offsetting factor where later on wages might run higher than price increases, and then you would still have a valid estimate here.

Senator DIRKSEN. I think, frankly, it is a little astonishing that you haven't done a little more to inform the Congress and the country as to these rising hospital costs. Hospital workers are organized today, they bargain collectively and, of course, these costs have gone up and, as Mr. Myers so well said, the pattern shows that they have gone up 7 percent a year.

Mr. BALL. His cost estimates allow for it.

Senator DIRKSEN. Exactly so.

Mr. BALL. Yes.

Senator DIRKSEN. I think that you ought to amplify this record and indicate what is ahead of us for the next 10 years I would rather not project it 50 years; that is a long time, and in accelerating it there are always many changes. I doubt whether you can adequately and accurately foresee what is going to happen. But I think for a 10-year period you can make at least a reasonable estimate, and I think you ought to add to this record some memorandums in this whole field of hospital costs because your figures and your plans all go out of the window if your cost estimates are unsound.

Mr. COHEN. Senator, could I just clarify one point?

Senator DIRKSEN. Yes.

Mr. COHEN. There are three factors in hospital costs and we have only been talking really when we speak about it; one, there are the average costs per day; then there are the proportion of people who are admitted to a hospital, that has been going up somewhat, along with the labor rate; and then there is the length of stay in the hospital. Those three factors together——

Senator BENNETT. There is another one, which is the increasing complexity of hospital treatment.

Mr. COHEN. Yes. Well, that really is, that is encompassed in my first one, although you are quite correct, that the reason in part for the average daily rate per se going up is the fact that you have more technological equipment, and that equipment costs, plus the payroll costs which represents about two-thirds of the hospital, they have to pay for more technically competent people, and I would say in connection with Senator Dirksen's question that that is probably going to continue to go up because hospital wages represent, if you compare wages, represent only about 60 percent of industrial wages, and in a competitive society, to keep people in the hospital it is going to go up.

But Senator Douglas made an extremely important point yesterday.

Even though that first factor goes up, the rate of admissions, and the length of stay in hospitals doesn't necessarily have to go up if you have alternative methods in our society for treating people's medical care needs, and if we were to expand the extent of skilled nursing homes, convalescent care, and progressive patient care that would not keep people in the high-cost hospital bed, and provide for the visiting nurse service, then the total economic cost, and this would be true whether it would be Blue Cross or King-Anderson, could be kept in a more reasonable balance and, therefore, I think that although the daily rate per day might continue to go up, the fact of the matter is as you know in many cases, for instance, like in maternity cases the average stay has gone down, so the dollar costs per patient stay doesn't necessarily have to go up.

So, I think you would have to take all—that is the reason why it is rather complicated, and I would say, Mr Myers says it will continue to go up, but I would hope in connection with the Hill-Burton program, the nurse education program that you passed, these other things, that the economic cost to society, whether you pay it out of your private pocket or Blue Cross or a public program would not continue to rise as fast in the future as it has in the past.

Senator DIRKSEN. Well, Dr. Cohen, all I can say is in this whole field of imponderables you just try to get into a hospital today, and they almost have to slide you in with a shoehorn in order to get in.

Mr. COHEN. That is correct,

Senator DIRKSEN. They have that caseload there which shows that people will get hospital treatment.

Mr. COHEN. That is, of course, the reason——

Senator DIRKSEN. And they will stay in hospitals. Sometimes they fairly have to drive them out. Human nature is going to continue in exactly that way in the future, so the only thing you can do is to deal with the hard realities of rising costs, and how you are going to keep your funds actuarially sound.

Mr. COHEN. Of course, Senator, just the other day you passed these very extensive amendments to the Hill-Burton program to build many more hospital beds and nursing home beds, which, as you say, are very importantly needed.

Now, after you build the hospital bed and the nursing home bed, you have to build up now to help train more nurses and then you are faced again with the question Senator Douglas raised yesterday, How are you going to help people to pay for the service when they get into the hospital and use the hospital bed or skilled nursing?

Senator DIRKSEN. Of course, what you are up against is Parkinson's law. You are going to provide these beds and those beds are going to be filled.

Mr. COHEN. What I am really saying, Senator, is the point you make with regard to hospital costs as applicable to King-Anderson is equally applicable to Blue Cross and private insurance in our economy because if you are going to meet these costs, and I presume they have such a high priority in the marketplace, that people are going to pay the costs in the hospital even if we say they were uneconomic.

As you can see Blue Cross plans frequently are changing their rates, commercial plans are changing their rates. The State 65 plans are losing money in many of the plans because they can't adjust their rate structure fast enough.

So, I would say Blue Cross, public hospitals, public insurance, all are faced with this exact same issue.

Senator DIRKSEN. Well, Mr. Myers, can you supply in tabular form that information I requested?

Mr. MYERS. Yes, Senator.

Senator DIRKSEN. And if you would put in a table showing for the last 10 years, the appreciation in hospital costs by years.

Mr. MYERS. Yes, I will do that, Senator Dirksen.

Senator DIRKSEN. Thank you.

Thank you, Carl.

(The information referred to follows:)

AUGUST 7, 1964.

MEMORANDUM

From: Robert J. Myers.
Subject: Actuarial cost analysis of hospitalization benefit proposals—Assumptions and results.

This memorandum will present a discussion of various aspects of the actuarial cost estimates for the hospitalization and related benefits that would be provided under the King-Anderson bill (H.R. 3920 and S. 880).

PAST INCREASES IN HOSPITAL COSTS AND IN EARNINGS

Table 1 presents a summary comparison of the annual increases in hospital costs and the corresponding increases in earnings that have occurred since 1954 and up through 1963.

The annual increases in earnings are based on those in covered employment under the old-age, survivors, and disability insurance system as indicated by first quarter taxable earnings, which by and large are not affected by the maximum taxable earnings base. The data on increases in hospital costs are based on a series of average daily costs (including not only room and board, but also other charges) as prepared by the American Hospital Association.

The annual increases in earnings have fluctuated somewhat over the 10-year period, although there have not been too large deviations from the average annual rate of 4 percent; no upward or downward trend over the period is discernible. The annual increases in hospital costs likewise have fluctuated from year to year around the average annual rate of 6.7 percent; the increases in the last 2 years were relatively low as compared with previous years.

Hospital costs then have been increasing at a faster rate than earnings. The differential between these two rates of increase has fluctuated widely, being as high as somewhat more than 5 percent in some years and as low as a negative differential of about 1 percent in 1956 (with the next lowest differential being a positive one of about 1 percent in 1962). Over the entire 10-year period, the differential between the average annual rate of increase in hospital costs over the average annual rate of increase in earnings was 2.7 percent.

In the future, it is likely that earnings will increase at a rate of about 3 percent per year. It is difficult—and perhaps impossible—to predict what the corresponding increase in hospital costs will be. It would appear that, at the least, hospital costs would, on the average, increase perhaps 2 percent per year more than earnings for a few years and that at the most, hospital costs would increase in the near future at an average annual rate that is 3 percent in excess of that for wages. It is recognized, of course, that these "minimum" and "maximum" assumptions result in a relatively wide spread in the cost estimates for hospital insurance proposals if the estimates are carried out for a number of years into the future.

ASSUMPTIONS UNDERLYING ORIGINAL COST ESTIMATES FOR KING-ANDERSON BILL

The actuarial cost estimates for the King-Anderson bill are presented in detail—as to assumptions, methodology, and results—in Actuarial Study No. 57 of the Social Security Administration.

In considering the hospitalization-benefit costs in conjunction with a level-earnings assumption for the future, it is sufficient for the purposes of long-range cost estimates merely to analyze possible future trends in hospitalization costs relative to covered earnings. Accordingly, any study of past experience of hospitalization costs should be made on this relative basis. The actual experience in recent years has indicated, in general, that hospitalization costs have risen more rapidly than the general earnings level, with the differential being in the neighborhood of 3 percent per year—2.7 percent in the last 10 years.

One of the uncertainties in making cost estimates for hospitalization benefits, then, is how long and to what extent this tendency of hospital costs to rise more rapidly than the general earnings level will continue in the future—and whether or not it may in the long run be counterbalanced by a trend in the opposite direction. Some factors to consider are the relatively low wages of hospital employees (which have been rapidly "catching up" with the general level of wages and obviously may be expected to "catch up" completely at some future date,

rather than to increase indefinitely at a more rapid rate than wages generally) and the development of new medical techniques and procedures, with resultant increased expense. In connection with the latter factor, there are possible counterbalancing factors, in that the higher costs involved for more refined and extensive treatments may be offset by better general health conditions, the development of out-of-hospital facilities, shorter durations of hospitalization, and less expense for subsequent curative treatments as a result of preventive measures. Also, it is possible that at some time in the future, the productivity of hospital personnel will increase significantly as the result of changes in the organization of hospital services or for other reasons, so that, as in other fields of economic activity, their wages might in the long run increase more rapidly than hospitalization prices.

Perhaps the major difficulty in making, and in presenting, these actuarial cost estimates for hospitalization benefits is that—unlike the situation in regard to cost estimates for the OASDI monthly benefits, where the result is the opposite—an unfavorable cost result is shown when total earnings levels rise, unless the provisions of the system are kept up to date (insofar as the maximum taxable earnings base and the dollar amounts of the deductibles are concerned). The reason for this is that there is the fundamental actuarial assumption that the hospitalization costs will rise at the same rate over the long run as the total earnings level, whereas the contribution income would rise less rapidly than the total earnings level unless the earnings base is kept up to date, since contributions depend on the covered earnings level, which is dampened if the earnings base is not raised as earnings go up. Accordingly, it is necessary in the actuarial cost estimates for hospitalization benefits to assume either that earnings levels will be unchanged in the future or that, if wages continue to rise (as they have done in the past), the system will be kept up to date insofar as the earnings base and the deductibles are concerned.

The basic assumption underlying the actuarial cost estimates in actuarial study No. 57 is that the relationship between earnings and hospital costs will, on the average, be the same into the future as in the 1961 experience. Alternatively and equivalently, these assumptions mean that earnings and hospital costs will rise, on the average, at the same rate in the future and that the earnings base will be adjusted proportionately with changes in the earnings level. Under these assumptions, it is estimated that the financing provided in the King-Anderson bill will be adequate to support the cost of the benefits and the administrative expenses. It will be recalled that the cost of the bill, on these assumptions, is estimated at 0.68 percent of taxable payroll, of which 0.5 percent is derived from the increased combined contribution rate on employers and employees, and the remaining 0.18 percent is derived from savings due to raising the earnings base from $4,800 to $5,200. It will also be recalled that the bill provides that the hospital insurance trust fund shall be completely separate from the OASI and disability insurance trust funds, so that the assets of the latter cannot be used to pay hospital benefits.

PROPOSED ALTERNATIVE ASSUMPTIONS FOR HOSPITALIZATION-BENEFITS COST ESTIMATES

One alternative that has been discussed would assume the continuation into the long-range future of recent trends in the relationship between hospitalization costs and the general wage level, while at the same time assuming that on into the long-range future there would be no change in the maximum earnings base under the OASDI system.

In the recent past, the general earnings level has increased at a rate of about 4 percent a year, while hospital costs have risen about 7 percent a year, so that there is a differential of about 3 percent. Assuming the continuation of these trends into the indefinite future and assuming at the same time no change in the maximum earnings base would have the following effects:

(1) Eventually hospitalization costs would exceed 100 percent of the earnings of all workers in the country—let alone, of taxable earnings.

(2) Virtually everyone entitled to cash benefits under the OASDI system would have the maximum benefit prescribed under the law, since they would have their benefits figured on the maximum creditable earnings. The earnings of the lowest paid part-time workers would eventually rise to the present maximum earnings base.

(3) The cash benefits of the OASDI system would be only a very small proportion of a person's previous earnings.

(4) As a percentage of taxable payroll, the cost of the OASDI system would be considerably less than it is presently estimated to be—to the extent of about 1¼ percent of taxable payroll.

Such an assumption was not used in the cost estimates because I consider that it is completely unrealistic—and is even an "impossible" one. It is inconceivable that hospital prices would rise indefinitely at a rate faster than earnings because eventually no one—a currently employed wage earner, let alone an older person—could afford to go to a hospital under such cost circumstances.

As a numerical example, let us consider a full-time male worker now earning the "typical" amount of $20 per day, or $5,200 per year. The average daily cost for hospitalization (including not only room and board, but also other charges) for persons of all ages is about $40 currently, or twice the average daily wage. If wages increase 4 percent per year, and is hospital costs increase 7 percent per year—indefinitely into the future—then the following situation will occur:

Item	At present	In 20 years	In 50 years
Average daily wage	$20	$43.82	$142.13
Average daily hospitalization cost	$40	$154.79	$1,178.28
Ratio of hospitalization cost to wage—percent	200	353	829
Proportion of wage covered by $5,400—do	100	47	15

Consideration of the foregoing figures indicates that whereas the cost of a hospital day now represents, on the average, 2 days' wages, in the future if the assumed trends take place, the cost of a hospital day will in a half century be over 8 days' wages. Quite obviously then, it is an untenable assumption that there can be a sizable differential between the increase in hospitalization costs and the increase in earnings levels that will continue for a long period into the future.

One important reason for the fact that recently hospitalization costs have risen faster than the general earnings level is that the wages of hospital employees have risen at a faster rate than the general earnings level. Personnel costs are about 60 percent of all hospital costs. The fact that the wages of hospital employees have been rising at a faster rate than all earnings reflects a "catching up" from a situation where hospital workers were significantly underpaid in relation to other workers.

It is obvious that such a trend cannot continue and that a point will be reached after which wages paid to hospital workers will rise, on the average, at the same rate as the general earnings level. Nor can other elements in hospitalization costs be presumed to rise indefinitely at a faster rate than the general earnings level.

It is not unlikely that the price of hospital services will for a considerable time rise faster than other prices, but if the price of any product continues to rise faster than earnings, it would eventually be priced out of the market. Actually, over the long run, hospitalization costs to the consumer are likely to show conflicting trends. On the one hand, improved technology is leading to more expensive hospital services and to the need for additional personnel. On the other hand, the duration of hospital stays is declining as a result of the improvement in care.

Another alternative that has been discussed is to assume a continuation of recent trends for a period of time, say 10 years, with hospitalization prices from then on rising at the same rate as earnings, but with no change in the maximum earnings base indefinitely into the future. This assumption has the same basic defects and weaknesses as did the previous assumption of continuously rising earnings and hospitalization costs rising continuously at a more rapid rate, except that the effects are somewhat deferred. The only major difference is that hospitalization costs would not exceed 100 percent of the earnings of all workers in the country, although they would exceed 100 percent of taxable earnings.

Still another alternative that could be considered is to assume a continuation of recent trends for a period of time, say 10 years, with both hospitalization costs and earnings leveling off thereafter, and with no change in the maximum earnings base from the presently proposed $5,400 at any time. This assumption has the following effects:

(1) The estimated cost of the hospital insurance proposal would be somewhat higher than presently estimated. But, on the other hand, the estimated level-

cost of the OASDI cash-benefits program, using the same assumptions, would be lower than now by about 0.6 percent of taxable payroll. This reduction in estimated cost of the OASDI cash-benefits program would be somewhat greater than the increase in the hospitalization cost estimate of about 0.5 percent of taxable payroll that would occur under these assumptions.

(2) The highest earnings subject to contributions would be more than 30 percent below average earnings. As a result, much as under the previous alternative assumptions, a vast majority of those entitled to OASDI benefits would eventually be getting close to the maximum benefits, and these benefits would represent a relatively low proportion of past earnings.

I did not use this assumption in the official cost estimates because I consider it also completely unrealistic. It seems to me that it would be unwise to base the cost estimates on an assumption that, even though earnings may rise substantially in the future, no adjustments would be made in the cash benefits and the maximum earnings base. Such an assumption leads to estimates showing a significant reduction in the level cost of the OASDI system and would indicate the system to be substantially overfinanced. This might then result either in a decision to increase cash benefits now or to reduce the statutory schedule of contribution rates.

Yet, as a matter of fact, as increases in earnings did occur, it would become necessary to increase the benefits under the program if the beneficiaries are not to be forced to live at a level which, with time, would become increasingly below that of other Americans. Thus, since these assumptions result in estimates showing lower costs for the cash benefits than will occur, because they are counting on gains to the program from assumptions that will almost certainly require the program to be liberalized, they are not conservative assumptions. In my opinion, they are dangerously lacking in conservatism.

An alternative assumption that has been proposed and that is reasonable is that we should consider the relationship between hospitalization costs and wages as it can reasonably be anticipated to be in 1965 and that we should assume that hospitalization costs rise more rapidly than wages only for 5 or 6 years (with the aggregate differential after 1965 being 10 percent). From then on, it is assumed that, on the average and over the long run, covered earnings levels and hospitalization prices will rise at the same rate. This assumption has been adopted for my current cost estimates.

In the event that earnings do rise as they have in the past, it is assumed that the maximum earnings base will be increased from time to time. This is a realistic assumption based on past performance. The maximum earnings base has been increased from $3,000 in 1939 in a series of steps until today it is $4,800. If, however, by any chance the earnings base were not increased for a few years in the future, even though earnings rose, then the system as a whole would still be actuarially sound since the savings to the OASDI cash-benefits portion, under any set of reasonable assumptions, would more than offset the "loss" to the hospitalization portion. The hospital-benefits portion taken alone would also be soundly financed if later on the earnings base were raised sufficient to preserve the prior relationship to wages.

COMPARISON OF RESULTS OF COST ESTIMATES FOR KING-ANDERSON BILL

This section will present the cost estimate for the King-Anderson bill that is currently being used and will analyze it in relation to the cost estimate that was made at the beginning of 1963 when the bill was introduced (as contained in Actuarial Study No. 57).

The cost estimate originally made showed a level cost of 0.68 percent of taxable payroll, on a $5,200 earnings base. The underlying cost assumptions were as follows:

(*a*) 1961 earnings levels.

(*b*) Hospital costs would, in the future—on the average and over the long range—rise at the same rate as wages.

(*c*) The earnings base and the dollar amounts of any deductibles would be kept up to date with the changing earnings levels (i.e., so that from time to time in the future, the earnings base would be adjusted so that it would bear the same relationship then as $5,200 would in 1961).

In regard to assumption (*b*), it was recognized that hospitalization costs would undoubtedly increase more rapidly than wages in the near-future years following 1961, but it was assumed that in the long-distant future, hospitalization costs would increase somewhat less rapidly than wages—just as in the past,

and likely in the future, the general level of price rises less rapidly than the general level of earnings. This initial estimate of a level-cost of 0.68 percent of taxable payroll, on a $5,200 earnings base, remains valid under the assumptions made, which seems to me to represent one reasonable set of assumptions.

The estimated level-cost of the hospitalization and related benefits in the King-Anderson bill (when applied to the provisions of the Mills bill as to earnings base and insured-status provisions) is, under current estimates, 0.85 percent of taxable payroll with a $5,400 earnings base and with different underlying cost assumptions, as will be indicated hereafter. The cost assumptions being used in the current estimates are considerably more conservative than those used in Actuarial Study No. 57 and seem to me to represent another reasonable set of assumptions, as follows:

(*a*) 1963 earnings levels.

(*b*) Hospitalization costs will increase more rapidly than wages until 1965 (in accordance with past experience), and thereafter, the differential between the rate of increase of hospitalization costs and the rate of increase of earnings will diminish until after about 5 or 6 years, when the two rates will be the same—on the average and over the long run remaining the same thereafter.

(*c*) The earnings base would be kept up to date with the changing earnings levels in the future so that, on the average, it would bear the same relationship to wages as $5,400 does in 1965.

(*d*) The dollar amounts of any deductibles will be kept up to date with changes in the earnings levels after 1963.

There are several reasons for the current cost estimate of 0.85 percent of taxable payroll, on a $5,400 earnings base, being so much higher than the original estimate of 0.68 percent of taxable payroll, on a $5,200 earnings base, as follows:

(1) The more conservative assumptions as to the interrelationship of hospitalization-cost trends and earnings trends.

(2) The $5,400 earnings base in 1965, under the Mills bill, is less than what would have resulted if the $5,200 proposed in the King-Anderson bill were kept up to date with what the latter amount was in 1961 (in other words, a $5,800 base in 1965 would be needed to be comparable with $5,200 as relative to 1961 earnings levels).

(3) The number of persons eligible for benefits as of 1965 is higher under the Mills bill than under the King-Anderson bill because of the "transitional insured status" provision of the former.

COST ESTIMATES FOR KING-ANDERSON BILL UNDER ALTERNATIVE ASSUMPTIONS

Request has been made for an estimate of what the cost of the King-Anderson bill would be under certain assumptions that I do not believe to be realistic, for the reasons indicated in the previous discussion.

Under one of these assumptions, it would be hypothesized that the 3-percent differential between the rate of increase in hospitalization costs and the rate of increase in earnings that had been experienced in the past decade would continue for the next decade (and that thereafter hospitalization costs and wages would rise at the same rate). At the same time, it would be assumed that the earnings base would be kept up to date with the rising earnings trend—or, in other words, would increase from time to time so that it would bear the same relationship to wages in the future as the $5,400 base will be in relationship with the earnings level in 1965. This means that in 1975 the earnings base would be approximately $7,200 if it were kept up to date with the assumed increase in the earnings level.

Under the rather unlikely assumption of such a "hospitalization cost-wage" assumption, the cost of the benefits under the King-Anderson bill would be 1.04 percent of taxable payroll. The additional cost of 0.19 percent of taxable payroll over the present estimate of 0.85 percent of taxable payroll could be met in several different ways. First, if such an unlikely situation developed, the cost could be financed by a higher contribution rate of 0.1 percent on both employers and employees. Second, the cost could be financed by a higher earnings base than one which kept the relationship of $5,400 to earnings in 1965—namely, one that would keep the relationship of $6,100 to earnings in 1965. Third, if such an unlikely situation developed, the cost could be financed by transferring from the OASDI trust funds to the HI trust fund, a portion of the gains to the former resulting from the rising earnings level and from

increasing the earnings base from time to time to keep it up to date with the earnings level (so that only part of this gain would be used to increase the cash benefits to keep them up to date with the rising earnings level).

Another set of assumptions for which a cost estimate was requested was to hypothesize, as in the previous estimate, that the 3-percent annual differential of the increase in hospitalization costs over the increase in earnings rates would continue for 10 years, and would then disappear, but to assume that the earnings base would not be changed from $5,400. In my opinion, such a set of assumptions is not at all realistic when applied to as long a period as 10 years. The estimated cost of the benefits under the King-Anderson bill for this set of assumptions is 1.35 percent of taxable payroll. This represents an increase of 0.50 percent of taxable payroll over the present cost estimate.

At the same time, however, it is most important to recognize that the estimated level cost of the OASDI cash benefits, using the same assumptions, would be lower than now by about 0.60 percent of taxable payroll. It seems unlikely that over a period as long as a decade, the cash benefits portion of the program would be allowed to deteriorate in this manner by not raising the earnings base, and by not keeping the benefits up to date. In any event, however, it can be seen that the reduction in cost of the cash benefits portion of the program would offset the increased cost of the HI benefits that would result under these assumptions.

Table 2 summarizes the various cost estimates for the benefits that would be provided under the King-Anderson bill, under the different cost assumptions that have been made in this memorandum.

TABLE 1.—*Comparison of annual increases in hospitalization costs and in earnings*

Calendar year	Increase over previous year		Calendar year	Increase over previous year	
	Earnings in covered employment	Hospitalization costs		Earnings in covered employment	Hospitalization costs
	Percent	*Percent*		*Percent*	*Percent*
1955	3.8	7.3	1960	4.3	6.8
1956	5.7	4.5	1961	3.1	8.5
1957	5.5	7.1	1962	4.2	5.3
1958	3.3	8.6	1963	2.4	5.6
1959	3.3	6.8	Average [1]	4.0	6.7

[1] Rate of increase compounded annually that is equivalent to total relative increase from 1954 to 1963.

TABLE 2.—*Summary of cost estimated for King-Anderson bill under various cost assumptions*

Assumptions as to earnings base	Assumptions as to relative trends of hospitalization costs and earnings	Estimated level cost [1]
(1) Keeps up to date with what $5,200 was in 1961.	Over the long range, hospitalization costs and earnings increase at same rate from 1961 on.	0.68 percent (actuarial study No. 57).
(2) Keeps up to date with what $5,400 will be in 1965.	Past experience projected to 1965; in next 5 or 6 years, hospitalization costs rise more rapidly than earnings—by a total differential of 10 percent; thereafter, hospitalization costs and earnings rise at same rate.	0.85 percent (current estimate).
(3) Keeps up to date with what $5,400 will be in 1965.	Past experience projected to 1965; in next 10 years, hospitalization costs rise more rapidly than earnings—by 3 percent per year; thereafter, hospitalization costs and earnings rise at same rate.	1.04 percent (requested estimate 3).
(4) Remains at $5,400	Past experience projected to 1965; in next 10 years, hospitalization costs rise more rapidly than earnings—by 3 percent per year; thereafter, hospitalization costs and earnings rise at same rate.	1.35 percent (estimated estimate [2]).

[1] Expressed in terms of percentage of taxable payroll.
[2] See text for discussion as to why the assumptions for (3) and (4), especially the latter, are unrealistic.

Senator CURTIS. I don't mean to take so long but this is an important program; it will last a long time. I think the proponents will agree with that.

What would the bill, as written now, do in the King-Anderson part of it for the people who are already retired and are paying no social security tax?

Secretary CELEBREZZE. They are covered under King-Anderson.

Senator CURTIS. Have they paid for it?

Secretary CELEBREZZE. You are now referring to the two or two and a half million people who were never covered by social security?

Senator CURTIS. No. How many beneficiaries do you have under social security, Mr. Myers, roughly?

Mr. MYERS. At the——

Senator CURTIS. Receiving benefits.

Mr. MYERS. Receiving benefits?

Senator CURTIS. Receiving old-age benefits, not survivors.

Mr. MYERS. The primary beneficiaries, that is retired workers aged 65 and over, let's see, are approximately 9½ million, and the total beneficiaries aged 65 and over, including wives, widows, and parents, are now 13.4 million.

Senator CURTIS. All right.

Now, Mr. Celebrezze, how many of those 13.4 million, if the bill is passed, the Gore bill, will receive the benefits of King-Anderson?

Secretary CELEBREZZE. All of them, Senator.

Senator CURTIS. All of them? How much have they paid for it?

Secretary CELEBREZZE. About two or two and a half million have never contributed.

Senator CURTIS. No, no. I am talking about how many of them have paid for King-Anderson benefits?

Secretary CELEBREZZE. Well, they wouldn't have paid anything specifically but they are part of the social security system.

Senator CURTIS. Oh, yes, they got in?

Secretary CELEBREZZE. Well, let me develop that point just a little longer. I think I know what you have in mind. [Laughter.]

Senator CURTIS. It is very plain what I have in mind. You are going to give these benefits, which you contend are very fine, helpful and generous, to 13.4 million people who haven't paid a dime.

Secretary CELEBREZZE. I think that the Congress has in the past expressed itself as intending that those who were under the social security program and who have already retired are entitled to increased benefits. You have done that in the past.

Senator CURTIS. Increased retirement benefits.

Secretary CELEBREZZE. Increased retirement, or any other increased benefits.

Senator CURTIS. What other benefit have we given a retired man aside from increased retirement benefits or those related to retirements benefits such as survivor or widow, without payment?

Mr. BALL. Senator, I think perhaps a comparable situation was when the program was extended to the new risk of disability. You will remember that what the Congress did at that time was to allow people to receive disability benefits if they had contributed in the past under the social security program for a given period of time, even though they never, after the passage of the disability provision, made a specific earmarked contribution for disability. For example, the group was picked up who worked, say, between 1937 and 1942 and then became disabled even though the program didn't become law until 1956.

Senator CURTIS. It is partially in point. But retirement comes from two causes or in two ways, one from reaching the retirement

age, and the other from being totally disabled so you have a compulsory retirement. It is still a retirement benefit.

Mr. BALL. My only point was that the Congress did establish something of a precedent, in covering a new risk, by saying that you did not need to make an earmarked contribution under social security for the new risk, but rather said they would use past earnings under social security as a basis.

Senator CURTIS. But it was still a benefit that was based upon wages.

Mr. BALL. That is right.

Senator CURTIS. And that is what the retirement benefit is, isn't it, to offset wage loss?

Mr. BALL. Yes.

Senator CURTIS. If this Gore bill is passed, are you going to give these King-Anderson hospital benefits to all of these 13.4 million people who have not paid for that particular risk, regardless of property ownership or income?

Mr. BALL. Yes, sir, in the same way, really, that was done when disability insurance was passed, and people who had not contributed for it got disability benefits.

Senator CURTIS. Is the disability fund solvent?

Mr. BALL. Under the House bill, there is a reallocation of 0.15 percent of payroll over to the disability fund. At the present time there is a long-range actuarial imbalance of 0.14 percent.

Senator CURTIS. What do you mean by an imbalance? Shortage?

Mr. BALL. It means that it is estimated that over the long run you would need 0.14 percent of payroll more to pay the benefits as they fall due.

Senator CURTIS. Then it isn't paying its way without the House bill change?

Mr. BALL. It needs 0.66 percent instead of the 0.50 percent presently allocated, it is 0.66 under the bill because of the increase in benefits.

Senator CURTIS. Then if you want to classify these together—first, let me ask how many disabled people are there drawing benefits?

Mr. BALL. A little over 900,000 workers and, I would say, around 300,000 dependents of those workers.

Senator CURTIS. Only about a million two hundred thousand.

Mr. BALL. 600,000 dependents—1.5 million altogether. I should correct that.

Senator CURTIS. A million five.

Mr. BALL. All together.

Senator CURTIS. And you had an imbalance of how many percentage points?

Mr. BALL. Fourteen one-hundredths of 1 percent is the estimated amount.

Senator CURTIS. Until you propose to correct it now.

Granted it has some similarity, I don't expect you to agree but I do not think it is comparable, you are taking on a load of 13.4 million.

Mr. BALL. But Senator, the disabled get an average benefit of about $90 a month, and we are talking here of a hospital insurance policy that is worth in the neighborhood of $7.50. The numbers of people aren't the only thing.

Senator BENNETT. Now, wait a minute. You are comparing benefits to costs. Ninety dollars is a benefit, how many dollars would the hospitalized elderly person get? Do you assume that the hospital is going to take care of these people for only $7 a month?

Mr. BALL. $7.50 a month, Senator, is the average for all the people covered, not just for those in the hospital. In other words——

Senator CURTIS. But you have talked about $90 for the people drawing benefits.

Mr. BALL. Of the 13½ million people you spoke of, only a relatively few are in the hospital at any given time. But if you take all the costs of hospitalization and say how much it is worth for the 13½ million, as a matter of protection, then it is $7.50.

Senator BENNETT. How many people are covered against potential total disability, not just 900,000, everybody on social security is covered for potential disability.

Mr. BALL. About 53 million are exposed to the risk and protected.

Senator BENNETT. Sure.

Mr. BALL. But not beneficiaries. The Senator, I believe, was comparing two groups of beneficiaries in terms of costs.

Senator BENNETT. You are getting us lost in technical semantics. And you are trying to say to us that it costs so much more to take care of 900,000 people than it can possibly cost to take care of the potential of 13½ million.

Mr. BALL. Senator Bennett, perhaps this would help. The comparable costs of the two protections, measured as a percent of payroll, are that the King-Anderson benefits are worth 0.85 percent and, as we said, disability benefits are worth 0.64 percent. I am not making the point that it is a big difference. I am saying they are not too far apart. Disability is somewhat less. I thought Senator Curtis was making the point that hospital insurance was much, much more. They are not too far apart.

Senator CURTIS. Out of every thousand workers——

Mr. BALL. I beg your pardon?

Senator CURTIS. Out of every thousand workers how many of them, according to past statistics, are going to become totally and permanently disabled before they reach 65?

Mr. MYERS. Senator Curtis, I would say that about one per thousand eligible workers become disabled in a year.

Now, over the course of a working lifetime, probably, if you took a group starting out at age 20, somewhere between 2 percent and 5 percent might ultimately go onto the disability benefits roll before they are 65.

Senator CURTIS. Two to five percent.

Senator LONG. That is a wide variation, can't you be more precise than that?

Mr. MYERS. Senator, I don't have the figures with me, and I don't recall exactly.

Senator LONG. Can you provide it for the record? I would like for the record to be more precise than that.

Mr. MYERS. I can give you a much more precise figure. I just wanted to give you some idea of the relative magnitude.

(The information referred to follows:)

AUGUST 7, 1964.

MEMORANDUM

From: Robert J. Myers.

Subject: Proportion of persons becoming disabled.

At the hearings of the Senate Committee on Finance today, question was raised as to the proportion of persons who become disabled during the course of their lifetime and meet the definition of disability so as to qualify for disability benefits under the old-age, survivors, and disability insurance system. Such qualification requires, in general, a condition of 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 that has lasted for at least 6 full calendar months, and the possession of the necessary insured-status qualifications.

At the hearings, I gave the rough estimate that for a group of individuals entering the system at the younger ages (say, 20–24), the proportion that would become so disabled would be from 2 to 5 percent. Subsequently, I have made an exact computation of this proportion on the basis of the operating experience of the OASI program and find that an intermediate estimate thereof is 8.4 percent (subject, of course, to some range of variation, depending upon how closely future experience would follow the past experience).

Senator CURTIS. Coming back to these 13.4 million you are going to cover without any contribution, out of every thousand people over 65, how many of them are going to have to have hospitalization?

Mr. BALL. You mean at some time between 65 and death?

Senator CURTIS. Yes; that is what we base the disability on; of somewhere between 2 and 5 percent.

Mr. BALL. Including terminal illnesses, Senator, probably 90 percent would be in the hospital at some time.

Senator CURTIS. So while 2 to 5 percent of our people become totally disabled, 90 percent of the people over 65 are going to have to have some hospitalization?

Mr. BALL. Yes, sir; and when they have it, of course, it will be for an average amount of $400 or $500, while the 2 to 5 percent disabled may come on the rolls at 50 or 55 and get $90 a month for the rest of the time.

Senator CURTIS. Oh, no; they would get it at 65 anyway.

Mr. BALL. Yes, from say 50 or 55 to 65 at $90 a month. I am not arguing with your point, Senator, but merely saying that the comparable costs between disability and hospital insurance are best measured, I believe, by saying the hospital and other benefits of King-Anderson are 0.85 percent of payroll, and the disability cost is 0.64 percent.

That is what it comes out to be when you put all these things together.

Senator CURTIS. Now, this disability group that the House bill corrects—to put it in balance, to take up the shortage—is the percentage of people availing themselves of it and proving that they are totally and permanently disabled, and that is what they have to be now.

Senator CURTIS. It isn't totally and temporarily disabled.

Mr. BALL. Yes, sir.

Mr. BALL. No; that is an approximately of the definition—permanent and total. The law actually has a——

Senator CURTIS. Is the number increasing?

Mr. BALL. Yes, sir.

Senator CURTIS. They are?

Mr. BALL. Yes.

Senator CURTIS. Is that because of failure of medical science that closes the benefit off?

Mr. BALL. No; it is largely the newness of the program.

At first, Senator, the roll builds up because terminations by death or other reasons don't balance the numbers coming on.

Senator CURTIS. I will put my question this way: Is the number of new enrollees in the category of permanently and totally disabled increasing?

Mr. BALL. To an extent that is true, too, because you have a larger group at risk, a larger exposed group. Remember I referred to the fact there are about 53 million who are insured for disability. You have to meet a special test and the number who meet it is growing.

Senator CURTIS. My question was on a percentage basis.

Mr. BALL. As a rate of disability related to the insured population I don't think——

Mr. MYERS. Not significantly, no.

Senator CURTIS. What does the King-Anderson bill, as now written and which you support, do for civil service retirees who, we will assume, do not have social security retirement?

Mr. BALL. They are not covered, Senator, on the assumption that there is a Government-supported voluntary plan available for retired Federal civil servants in the area of health care if they wish to take it.

Senator CURTIS. How about railroad?

Mr. BALL. Railroad employees are included.

Senator CURTIS. How about the individual who had to leave the work force before his category of employment was ever covered by social security, so he has little or no social security record; will he be covered by King-Anderson.

Mr. BALL. He is covered for the benefits of theKing-Anderson bill, Senator, with the costs being paid from general revenues.

Senator CURTIS. But for the other people who contributed nothing to this new insurance program, so-called, general revenues does not pay it.

Mr. BALL. That is correct; for social security beneficiaries it comes out of social security contributions.

Senator CURTIS. So, how many of those people are there who have no social security, little or no social security record of employment?

Mr. BALL. The total number of those who would be brought in by the general revenue provisions of the King-Anderson bill, at the time it would go into effect, is right around 2 million, Senator, perhaps 2.2.

Senator CURTIS. I used an illustration which was said was an extreme case. I cited the lawyer who had millions of dollars and the highest income of his life and not retired but would come in under the benefits of King-Anderson.

We won't make that a situation of someone that high on the ladder, but suppose there is someone well able to pay their own medical bills and hospital bills even though they are not extremely rich and they are part of this 13.4 million. Their benefits will be paid by the workers and the self-employed and the employers who are now working and will be working in the future, will they not?

Mr. BALL. Senator, I think it perhaps depends on how you look at the financing of the social security program. I certainly think the way you say it is one perfectly proper way.

Ordinarily, we have thought that the employer's contribution was the one that was available to the system for the various situations in which individual workers did not fully pay their own way. That that was the source of the——

Senator CURTIS. As a matter of fact, the employers' taxes are never segregated and bookkeepingwise attributed to the individual worker, are they?

Mr. BALL. Right. That is my point, that we tend to think of the employer contribution as being used generally but, of course, the law does not say that.

Senator CURTIS. Now, I was interested in the allusion yesterday in the hearing and today to the contention that many States are unable to have good Kerr-Mills programs because the sources of local and States taxes were dwindling and thus they were unable to fully participate in the matching program of Kerr-Mills.

It has also been indicated that the passage of the King-Anderson bill would free as much as 40 percent of these State funds for other purposes, possibly improvement of Kerr-Mills. Realizing that all taxes come from the people, the worker or producer of income who has to pay it to the local unit, the State government or to the Federal Government and what he is faced with is this total amount of taxes.

So, I have just examined that contention with respect to a State that has a good Kerr-Mills law. I refer to the State of Michigan.

My information indicates that Michigan has a relatively good Kerr-Mills program. I do not have the figures for 1963 but in 1962 they spent over $20 million on that program, which included the Federal contribution which amounted to more than half of that.

Now, I find that if you impose King-Anderson and the nearest most accurate estimate I could find is if the King-Anderson bill were passed this year, that taxpayers of Michigan would be hit for more than $120 million in extra King-Anderson taxes.

In fact, the King-Anderson taxes on the people of Michigan would be more than that since these figures don't take into account the present plans for raising the wage base to $5,400 instead of $5,200 in the original bill.

Nor do they take into account the testimony in the Ways and Means Committee were Chairman Mills asserted that and I think Mr. Myers was there and agreed, that the original estimates of the cost of the King-Anderson program might be 50 to 100 percent higher.

Mr. COHEN. Senator, can I say something on that since I am a resident of Michigan?

First, let me say that I am glad you call it a good law since when I was at Michigan I drafted the Michigan Kerr-Mills law.

Senator CURTIS. Good for you. That is a good law, that takes care of the people very well.

Mr. COHEN. Well, the fact of the matter is that Michigan hasn't a very adequate Kerr-Mills law because the legislature——

Senator CURTIS. You wouldn't have drafted that.

Mr. COHEN. I tried to persuade the legislature to pass a better program but they refused to do so.

Senator CURTIS. You are very persuasive to this committee.

Mr. COHEN. I was not as persuasive as I would like to be with the Michigan Legislature in 1960. The fact of the matter is, Senator, that there are large elements excluded from the Kerr-Mills law in Michigan, and the income and asset provisions and the relatives' responsibility provisions exclude a great many needy people in Michigan, and the legislature itself at the time we discussed it said they didn't want to change those provisions because otherwise the cost would go up so much.

Senator CURTIS. If they had given you what you asked for in Michigan instead of costing $20 million it would cost twice that much.

Mr. COHEN. I think probably in the neighborhood of maybe three times as much.

Senator CURTIS. $60 million. So they pay $60 million for Kerr-Mills and if we pass King-Anderson the people of Michigan are going to pay an extra $120 million that is based on a $5,200 wage basis.

Mr. COHEN. May I follow Senator Bennett's point earlier? I don't think you are comparing two comparable things now. King-Anderson provides hospital coverage for all of the people over 65, and, as you pointed out, without any income or assets or relatives' responsibility provisions so obviously among the group of aged in Michigan who go to the hospital many more will get a payment for hospital care under King-Anderson.

Whereas under——

Senator CURTIS. I will grant that. I am not talking about the benefits. I am talking about the matter of picking the pockets of the taxpayers by the tax collector. You are going to pick the pockets of the people of Michigan for $120 million more at a time when you say that their sources of revenue are dwindling away.

Mr. COHEN. We already have a 4-percent sales tax in Michigan, we have a very difficult financial situation, and I think on the basis of my experience that the State legislature there is not in a position at the present time to really take advantage of all of the provisions in Kerr-Mills.

Senator CURTIS. Those are the same people whose pockets you are going to pick for King-Anderson.

Secretary CELEBREZZE. I would like to put in the record at this time, because I believe it is important to an understanding of the limitations of Kerr-Mills, that 74 percent of all the Federal funds under the Kerr-Mills bill in May 1964 went to five States with only 32 percent of the aged because these States have more liberal programs. Michigan is one of those States.

The five are New York, California, Massachusetts, Pennsylvania, and Michigan. I think that it is significant that 74 percent of the Federal expenditures under the Kerr-Mills Act went to five States representing only 32 percent of the aged population. The effectiveness of a Federal-State program depends on State initiative and what they can afford to do.

Senator LONG. What did you say, 74 percent?

Secretary CELEBREZZE. Seventy-four percent.

Senator LONG. Would you pass me the chart you might have on that to show—I would like to see where the Southern States come in on it. Unless I miss my guess Louisiana is doing pretty well because we had very little program to begin with.

In fact, unless I miss my guess, both Oklahoma and Louisiana did pretty well.

Senator DOUGLAS. They generally do.

Senator LONG. Not everything. They don't make out as well. I am not going to apologize for Louisiana doing well, may I say to my good friends from Illinois. [Laughter.]

Go right ahead and answer his question.

Secretary CELEBREZZE. I just wanted to get that into the record.

(The table referred to by Secretary Celebrezze follows:)

Medical assistance for the aged (MAA): Vendor payments and recipients, May 1964

State	Total payments			Federal share of payments			Recipients		
	Amount	Percent of national total	Average payment per recipient	Matching percent	Amount	Percent of national total	Number	Percent of national total	Number per 1,000 aged population [1]
Total	[2] $35,219,429	10.0	$194.52		$18,105,953	100.0	[3] 181,056	100.0	[4] 14.3
New York	[2] 10,757,600	30.5	317.82	50.00	5,352,024	29.6	33,848	18.7	18.9
California	7,990,328	22.7	287.31	50.00	3,995,164	22.1	27,811	15.4	18.3
Massachusetts	[2] 4,274,823	12.1	160.94	50.00	2,088,785	11.5	26,562	14.7	44.7
Michigan	1,937,462	5.5	351.56	50.00	968,731	5.4	5,511	3.0	8.0
Pennsylvania	1,889,240	5.4	231.33	50.00	944,620	5.2	8,167	4.5	7.0
Washington	1,333,006	3.8	143.49	50.00	666,503	3.7	9,293	5.1	31.9
Connecticut	[2] 1,093,257	3.1	183.68	50.00	546,168	3.0	5,952	3.3	23.0
New Jersey	[2] 1,053,786	3.0	210.63	50.00	522,056	2.9	5,003	2.8	8.2
Oregon	463,413	1.3	135.38	50.00	231,706	1.3	3,423	1.9	17.2
Iowa	379,640	1.1	126.42	57.63	218,787	1.2	3,003	1.7	8.8
Kansas	[2] 332,673	.9	155.09	56.63	182,116	1.0	2,145	1.2	8.5
Maryland [5]	320,910	.9	31.05	50 00	160,455	.9	10,335	5.7	42.2
District of Columbia	302,196	.9	411.15	50.00	151,098	.8	735	.4	10.1
Kentucky [5]	267,232	.8	32.12	75.27	201,146	1.1	8,319	4.6	27.3
North Dakota	[2] 256,404	.7	228.52	73.03	185,590	1.0	[3] 1,122	.6	18.4
Idaho	245,126	.7	127.27	67.43	165,288	.9	1,926	1.1	30.6
Florida [5]	238,298	.7	383.73	60.69	144,623	.8	621	.3	.9
Utah	234,160	.7	110.92	62.28	145,835	.8	2,111	1.2	31.5
Tennessee	218,255	.6	46.45	75.53	164,848	.9	4,699	2.6	14.4
South Carolina	201,468	.6	168.88	80.00	161,174	.9	1,193	.7	7.3
West Virginia	186,719	.5	23.45	71.76	133,990	.7	7,964	4.4	43.8
Oklahoma [5]	179,439	.5	160.50	65.65	117,802	.7	1,118	.6	4.3
Illinois [5]	169,988	.5	309.63	50.00	84,994	.5	549	.3	.5
Hawaii [5]	157,654	.4	311.57	50.00	78,827	.4	506	.3	14.9
Arkansas	137,094	.4	55.87	80.00	109,675	.6	2,454	1.4	11.9
Virginia	120,138	.3	142.51	65.05	78,150	.4	843	.5	2.7
Puerto Rico	102,466	.3	32.71	50.00	51,233	.3	3,133	1.7	23.0
Maine [5]	97,981	.3	241.93	65.65	64,325	.4	405	.2	3.7
Louisiana	94,646	.3	177.24	73.46	69,527	.4	534	.3	2.1
New Hampshire	72,497	.2	61.23	56.38	40,874	.2	1,184	.7	16.4
Alabama	69,324	.2	268.70	89.29	54,274	.3	258	.1	.9
Vermont [5]	30,245	.1	245.89	64.75	19,584	.1	123	.1	2.7
Wyoming	8,291	(6)	(7)	50.00	4,146	(6)	15	(6)	.5
Guam [8]	2,276	(6)	17.51	50.00	1,138	(6)	130	.1	130.0
Virgin Islands	1,394	(6)	21.78	50.00	697	(6)	64	(6)	32.0

[1] Based on preliminary population estimated by Social Security Administration as of Jan. 1, 1964.

[2] Includes money payments to recipients not subject to Federal matching: Connecticut, $920; Kansas, $11,084; Massachusetts, $97,253; New Jersey, $9,674; New York, $53,551; North Dakota, $2,275.

[3] Includes an unknown number of persons who received money payments only, causing average vendor payment to be slightly understated.

[4] Based on States listed in this table. Rate including States not making MAA payments is 10.1 per 1,000 aged persons.

[5] Represents medical assistance for the aged segment of program for aid to the aged, blind, or disabled and medical assistance for the aged.

[6] Less than 0.05 percent.

[7] Average payment not computed on fewer than 50 recipients.

[8] Data for March; April and May data not available.

Source: Department of Health, Education, and Welfare, Welfare Administration, Bureau of Family Services, Division of Program Statistics and Analysis.

Senator CURTIS. Mr. Chairman, may I insert four pages of tables from which I was drawing figures when I was speaking of Michigan?

Senator LONG. I was going to ask I want this chart put in the record.

Senator CURTIS. That is what I want to put in.

Senator LONG. They will be in the record then at this point.

(The tables referred to by Senator Curtis follow:)

Medical assistance for the aged: Payments for vendor medical bills: Total amount and amount in all States reporting for specified type of service by State, fiscal year ended June 30, 1963 [1]

[In thousands]

State	Total	In all States reporting for specified type of service						
		Physicians' services [2]	Other practitioners' services [2]	Inpatient hospital care	Prescribed drugs	Nursing home care	Dental care	Other
Total	[3] $287,375	$6,692	$440	$134,399	$6,498	$136,249	$352	$2,715
Alabama	685	[4] 3	(4)	681				
Arkansas	1,311	72	1	877		272	55	34
California	59,295	767	165	29,967	782	26,256	70	1,289
Connecticut	11,549	175	27	886	345	10,039	5	73
District of Columbia [5]	75			75				
Guam	16	(6)	3	11	1			
Hawaii	1,356	2		141	6	1,201	(6)	5
Idaho	2,342	268		475		1,599		
Illinois	3,536	152		3,385				
Kentucky	901	166		450	241	39	5	
Louisiana	976	105		796	5	70		(6)
Maine	989			988				1
Maryland	2,855	227		2,107	466		7	47
Massachusetts	45,122	921	209	9,739	2,506	31,201	113	434
Michigan	20,379	778		19,010		513		77
New Hampshire	175	30	(6)	137	(6)			8
New York	103,534	1,397	27	46,403	1,143	54,072	83	409
North Dakota	2,233	165	1	550	147	1,330	3	36
Oklahoma	1,587	359		1,079		122		26
Oregon	632	177		455		49		1
Pennsylvania	16,843			10,587		6,117		139
Puerto Rico	698			632				66
South Carolina	1,409			1,331		50		29
Tennessee	782			656	84	41		
Utah	2,131	103		306	69	1,637	9	8
Vermont	198	1		197				
Virgin Islands	[5] 29							
Washington	2,979	157	6	165	40	1,604	1	5
West Virginia	2,708	668	1	1,312	664	34	2	28

[1] For States operating pooled funds or other prepayment plans, data represent payments out of these funds to specified type of vendor. Totals do not agree with those shown in tables 2, 6, and 11 of "Source of Funds Expended for Public Assistance" which represent assistance payments into these funds. Program initiated in October 1960 under the Social Security Amendments of 1960.

[2] Includes drugs dispensed by medical practitioners when these costs are not reported separately.

[3] Amount for the Virgin Islands not reported by type of service.

[4] "Other practitioners' services" included in "Physicians' services."

[5] Vendor medical program in operation less than 1 year.

[6] Less than $500.

Source: U.S. Department of HEW, Welfare Administration, Bureau of Family Services, Division of Program Statistics and Analysis, Nov. 4, 1963.

EXHIBIT 2

Federal medicare taxes by States, 1963-64, bill H.R. 3920

State	1961 taxes (millions)	1965 taxes (millions)	Estimated additional taxes		Contribution to general revenue		Total additional taxes	Persons over 65 (thousands)	Tax per eligible beneficiary
			Percent	Millions	Share	Million			
	(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)	(9)
					Percent				
Alabama	$114.3	$155.4	8.9	$13.8	1.0	$2.6	$16.4	281	$58
Alaska	9.9	13.5	10.3	1.4	.1	.3	1.7	7	243
Arizona	59.0	80.2	9.8	7.9	.6	1.6	9.5	114	83
Arkansas	52.1	70.9	7.5	5.3	.4	1.0	6.3	204	31
California	1,091.3	1,484.2	11.6	172.2	11.4	29.7	201.9	1,554	130
Colorado	99.9	139.9	9.7	13.6	1.0	2.6	16.2	172	94
Connecticut	207.7	282.5	11.7	33.1	2.1	5.5	38.6	269	143
Delaware	59.8	81.3	10.8	8.8	.4	1.0	9.8	38	258
District of Columbia	68.6	93.3	9.5	8.9	.7	1.8	10.7	72	149
Florida	214.1	291.2	8.6	25.0	2.2	5.7	30.7	722	43
Georgia	172.7	234.9	8.5	20.0	1.4	3.6	23.6	313	75
Hawaii	36.9	50.2	10.5	5.3	.4	1.0	6.3	31	203
Idaho	36.3	49.4	9.3	4.9	.3	.8	5.7	63	90
Illinois	899.4	1,223.2	11.7	143.1	7.5	19.5	162.6	1,055	154
Indiana	238.7	324.6	11.3	36.7	2.5	6.5	43.2	471	92
Iowa	138.2	187.9	10.3	19.4	1.3	3.4	22.8	342	67
Kansas	106.3	144.6	9.7	14.0	1.0	2.6	16.6	254	65
Kentucky	99.7	135.6	8.8	11.9	1.0	2.6	14.5	307	47
Louisiana	107.7	146.5	9.2	13.5	1.1	2.9	16.4	266	62
Maine	40.8	55.5	8.6	4.8	.4	1.0	5.8	108	54
Maryland	164.3	223.4	10.2	22.8	2.0	5.2	28.0	251	112
Massachusetts	367.5	499.8	10.9	54.5	3.5	9.1	63.6	602	106
Michigan	672.9	915.1	12.1	110.7	4.8	12.5	123.2	712	173
Minnesota	208.4	283.4	10.6	30.0	1.6	4.2	34.2	387	88
Mississippi	58.2	79.2	7.6	6.0	.4	1.0	7.0	198	35
Missouri	295.6	402.0	10.3	41.4	2.2	5.7	47.1	534	88
Montana	28.9	39.3	9.9	3.9	.3	.8	4.7	70	67
Nebraska	87.5	119.0	9.4	11.2	.7	1.8	13.0	174	75
Nevada	19.4	26.4	9.7	2.6	.2	.5	3.1	20	155
New Hampshire	35.7	48.6	9.7	4.7	.3	.8	5.5	69	80
New Jersey	409.6	557.1	11.6	64.6	4.4	11.5	76.1	629	121
New Mexico	35.2	47.9	8.3	4.0	.4	1.0	5.0	59	85
New York	2,126.9	2,892.6	11.8	341.3	12.8	33.3	374.6	1,848	203
North Carolina	212.9	289.5	8.8	25.5	1.3	3.4	28.9	341	85
North Dakota	26.7	36.3	9.1	3.3	.2	.5	3.8	60	63
Ohio	641.7	872.7	11.7	102.1	6.0	15.6	117.7	958	123
Oklahoma	116.5	158.4	9.3	14.7	.9	2.3	17.0	264	64
Oregon	106.6	145.0	10.8	15.7	1.0	2.6	18 3	201	91
Pennsylvania	871.4	1,185.1	11.4	135.1	6.5	16.9	152.0	1,210	126
Rhode Island	59.8	81.3	10.3	8.4	.5	1.3	9.7	94	103
South Carolina	84.9	115.5	8.5	9.8	.6	1.6	11.4	161	71
South Dakota	26.7	36.3	9.1	3.3	.2	.5	3.8	76	50
Tennessee	146.2	198.8	9.0	17.9	1.2	3.1	21.0	331	63
Texas	445.4	605.7	9.6	58.1	4.3	11.2	69.3	810	83
Utah	42.0	57.1	9.8	5.6	.4	1.0	6.6	67	99
Vermont	21.8	29.6	9.0	2.7	.1	.3	3.0	44	68
Virginia	170.7	232.2	9.0	20.9	1.7	4.4	25.3	311	81
Washington	183.6	250.0	11.1	27.8	1.7	4.4	32.2	301	107
West Virginia	64.9	88.3	10.2	9.0	.7	1.8	10.8	175	62
Wisconsin	250.1	340.1	11.2	38.1	2.1	5.5	43.6	437	100
Wyoming	15.7	21.4	9.3	2.0	.2	.5	2.5	30	83
United States	12,307.1	16,737.7	11.1	1,841.1	100.0	260.0	2,101.1	18,097	116

Sources: Annual statistical supplement of the Social Security Bulletin, 1961, tables 23 and 24. Statistics of income, 1960, individual income tax returns, U.S. Treasury Department, Internal Revenue Service, publication No. 79 (10-62), table 16. Congressional Record, May 17, 1962, p. 1018. Calculations by Economic Research Department, American Medical Association, as explained on attached sheet.

SUMMARY OF OPERATIONS IN CALCULATING FEDERAL MEDICARE TAXES BY STATE

Col. 1—Annual statistical supplement of the Social Security Bulletin, 1961, table 23.

Col. 2—Figures in col. 1 adjusted to reflect rate increases since 1961 and expansion of coverage plus economic growth at the rate of 3 percent per year: 3.625 divided by 3 times 1.03 times 1.03 times 1.03 times 1.03 equals 1.36.

Col. 3—Tax increase for United States estimated at 11.1 percent per calculations on attached sheet. Increases for individual States calculated from average taxable earnings per worker given in annual statistical supplement of the Social Security Bulletin, 1961, table 24, as follows: 11.1 percent times average reported taxable earnings per worker, State, divided by average reported taxable earnings per worker, United States, equals percent tax increase for State.

Col. 4—Col. 2 times col. 3.

Col. 5—Telephone conversation with R. J. Myers, Chief Actuary, Social Security Administration, L. S Drake, Feb. 28, 1963.

Col. 6—U.S. total ($260,000,000) times percentages in col. 5.

Col. 7—Col. 4 plus col. 6.

Col. 8—Congressional Record, May 17, 1962, p. 1018.

Col. 9—Col. 7 divided by col. 8.

Senator CURTIS. This comes back to your statement, Mr. Secretary, I want to hurry on.

In your statement you give an analysis of the problem for many elderly people in buying what you term adequate health insurance protection and you state, and I quote:

> Reasonably adequate health insurance for an aged couple (health insurance covering the cost of, say, one-half of their total medical bills) costs from over $400 to $550 a year when it is available. This represents one-sixth or more of the income of the average older couple and they just cannot afford it.

For these elderly beneficiary couple whose income is below, say, $3,000, and hence the ones you say cannot afford reasonably adequate health insurance, would you be willing to supply them with enough additional income through increasing social security benefits?

Secretary CELEBREZZE. That wouldn't do what we are trying to do, because social security benefits, in my opinion, for low-income people—those without significant other income—are hardly enough to buy the bare necessities of life. If you give people additional money, many are going to spend it for everyday expenses rather than for hospital insurance.

Senator CURTIS. So if people who have an income below $3,000, if we increased their cash social security benefits, to, say, from $400 to $550 it is your feeling that it probably will be used for better food and clothing and housing and that sort of thing?

Mr. BALL. I think, Senator, it would be mixed. That would be true of some people. Some would buy health insurance policies, others would buy more protection than they do now. Some would buy inadequate policies and some would buy good ones.

Senator CURTIS. Well, Mr. Secretary, why, in your first reaction, did you have a feeling that they would spend it for other necessities first?

Mr. BALL. Senator, this is the median we are talking about. Half are below the $2,800 figure. Many have incomes of $1,200, $1,300, $1,500 and so on. At such income levels people might well feel—even with the additional amount you suggest—they might feel they couldn't afford to put all of that into hospital insurance as against other expenses—food, clothing, shelter, and other needs.

Senator CURTIS. Don't you think if we would pay them something more we should put these needs first, clothing and food and shelter?

Secretary CELEBREZZE. Over and above hospital care?

Senator CURTIS. No, instead of.

I think they should come first.

Secretary CELEBREZZE. It is not either, or. Our experience shows that these individuals have high hospital costs after age 65, and we are trying to provide protection for them at that time, because with their low income they can't pay the high premium costs for protection under private insurance.

If you gave them a benefit increase—and, we support the King-Anderson benefits on top of the benefits of the House bill—if you gave them the King-Anderson bill and also an increase——

Senator CURTIS. I mean instead of the King-Anderson bill. Suppose you increased the social security cash benefits to these poor people by $400 or $500.

Mr. BALL. Senator, I think there are several problems, if I get the general direction of your argument. You are suggesting, I believe, that maybe you can increase the cash enough so that people——

Senator CURTIS. I am not suggesting; I am asking you.

Mr. BALL. So that perhaps they would then buy private insurance to cover this?

Senator CURTIS. Yes.

Mr. BALL. There are all these difficulties: One, private insurance giving broad coverage on an economical basis is not available to all of the aged by any means. A large proportion of the aged must seek individually bought policies, which have very high retention ratios. Between 40 and 50 cents on the dollar that the person pays for these individually sold commercial policies goes not for benefits but for administration—selling and other costs. So that on these individually sold policies you get a very small return on the money you put in.

Another difficulty is that there are absolute barriers to getting insurance for some people in terms of preexisting conditions that they have, and their age and so forth.

Senator CURTIS. Well, confining my question, then, to those few or whatever percentage it is, that could get insurance coverage, would you favor giving them the cash instead of the King-Anderson bill?

Secretary CELEBREZZE. Not instead of. We would favor, as a second choice, giving them an option, of taking the King-Anderson benefits or taking a cash increase.

Senator CURTIS. You would?

Secretary CELEBREZZE. Yes. That is, in other words, if the King-Anderson benefits could not be adopted——

Senator CURTIS. How much of an option?

Secretary CELEBREZZE. Well, if the King-Anderson benefits were added, you could say to the individual, "Well, we will give you $5 cash per month, or you can choose the King-Anderson benefits."

Senator BENNETT. Isn't that a horse and rabbit deal?

Secretary CELEBREZZE. What?

Senator BENNETT. Isn't that a horse and rabbit deal?

Secretary CELEBREZZE. No.

Senator CURTIS. What could they buy for $5 a month?

Mr. BALL. The average values of the benefits we were discussing earlier, Senator Bennett, would be, if you took all the people over 65, about $7.50 a month. The $5 figure the Secretary referred to is about the value of King-Anderson protection for people in the younger part of the older group, those who are the better risks—$5 would be about the value of the King-Anderson protection per month for them.

Senator CURTIS. They couldn't buy much for $7.50 per month.

Mr. BALL. No. This is what the actuarial worth of these benefits is. But, as you suggest, in the open marketplace, to get the protection on an individual policy basis is much more expensive, because of what I was saying earlier—the high costs of selling individual policies and the high administrative costs. As against 40 to 50 cents on a dollar retained in individual commercial policies, under social security the estimated administrative costs would be about 3 cents.

Senator CURTIS. It wouldn't be much of a choice.

Mr. COHEN. That would depend. In cases where the man had been connected with a payroll and the employer continued to pay part of his hospital insurance, adding the $5 to, let's say, what the employer paid or will continue to pay might buy him a minimal policy.

Senator CURTIS. And your bill does permit that election?

Secretary CELEBREZZE. No, the King-Anderson bill does not provide it. It is a second choice.

Senator CURTIS. Mr. Secretary, you said before the Ways and Means Committee last November: "My intent is to show that the proposal"; that is, the King-Anderson bill, H.R. 392 or S. 880, "is a logical extension of the present social security program."

Is it a logical extension?

Secretary CELEBREZZE. Very much so, based on the same principle that we adopted in the social security program in 1935.

Senator CURTIS. Well, now, here are some of the principles that I want to ask about.

In the first place, in retirement benefits, there is the work test. Under King-Anderson you would extend medicare protection or hospital care protection to those 65 and over where they are retired and drawing benefits or still working and, hence, not entitled to benefits. I would like to call your attention to what Arthur Altmeyer said before the Ways and Means Committee in the 81st Congress in the act of 1949, pages 12, 13, and 14. He said this:

> I think we have to bear in mind that the purpose of social insurance, whether old-age insurance, social security, or unemployment insurance or any other kind of insurance, is to insure against a portion of the wage loss. Now, if the person has not retired and has not suffered a wage loss, then I do not believe that under social insurance he should receive benefits.

The individual that you propose to g've the benefits to under King-Anderson, who has not retired, hasn't suffered any wage loss.

Mr. COHEN. He suffered a presumptive loss by being hospitalized. That is the logical extension of that principle.

Secretary CELEBREZZE. First of all, I want to get back to the first part of that.

Senator CURTIS. I do not follow that, no, because his mere coverage may relieve him of providing his own hospital insurance, and he hasn't suffered any wage loss.

So the theory that the architects of our original social security program, that they were writing a program to take up for the loss in wages——

Mr. COHEN. But the Secretary says it was a logical extension.

He didn't say it had to be solely related to wage loss. It is an extension of the idea of compensating people for a hazard or a loss, and the loss in this case is suffering a period of hospitalization, which is a presumptive indication of having to meet some kind of a cost, Senator.

Senator CURTIS. Yes. But he may be 65 and be relieved of his necessity of paying for a very good hospitalization program that he will never use for 5 or 6 years.

Mr. COHEN. But, similarly, in the wage——

Senator CURTIS. And he has suffered no loss of wages.

Mr. COHEN. But, similarly, in the wage-loss program, for instance, while the man is retired we don't go and look at his income.

Senator CURTIS. I am talking about the fellow who isn't retired. You are going to give it to people who are not retired.

Mr. COHEN. That is right. But I am saying——

Senator CURTIS. And they haven't suffered any wage loss and if that person who is making quite a little money and is paying $400 or $500 for his private insurance you have relieved him of that and he has suffered no wage loss and that is contrary to one of the basic philosophies or principles of the social security law.

Mr. COHEN. The Secretary didn't say it was idential with the principles of the present social security program. He says it is a logical extension of the principle of dealing with a hazard or a loss, as represented presumptively in the first case by being retired, and in the second place by having a period of lost savings because of hospitalization.

Senator CURTIS. Well, now, the AFL–CIO was quoted in the Congressional Record of March 28, 1960, page 6397, in its opposition to elimination of the retirement provision of social security because it would "go counter to the basic purpose of the system which is to replace part of the earned income lost by retirement."

They have always contended that, haven't they?

Mr. COHEN. Mr. Ball said previously that if you could devise a retirement test for hospital insurance that was effective, we would be for it.

The problem, Senator, is not a conceptual or a philosophical one. The difficulty is that the day the fellow gets sick, if you have a retirement test, apply for retirement to get the hospitalization, and, therefore, I think it is really not a question of philosophy or concept, it is really a practical problem.

You can't devise an effective enough retirement test to distinguish between the man when he is working and nonworking, as to whether he ought to be considered retired or not.

Senator CURTIS. Well, I think that if you relieve a high-income earning individual from age 65, say, to 72, of the necessity of carrying his own hospitalization insurance that you have given him a benefit, and it hasn't been based upon any wage loss, which both Mr. Altmeyer and the AFL–CIO have said is the essence of the social security program.

Mr. COHEN. Of the essence of the system at that time, that is correct. They were talking about a wage loss system. What the Secretary says is a logical extension of a social insurance principle applied to the insurance of hospital costs; of course you have to leave off the wage part of the wage loss because you are not compensating in hospital insurance for a wage loss, you are compensating for a presumptive loss due to the costs of hospitalization, and I think that is a logical extension of that principle.

Senator CURTIS. Well, I will point out where it differs from social security in another aspect.

Social security benefits—did you want to say something, Mr. Secretary?

Secretary CELEBREZZE. I think, Senator, I am being quoted and somebody else is answering, and I think I ought to answer for the record.

In the same statement that you are quoting from, Senator Curtis, on page 5 of my House testimony I gave the reason why it is a logical extension. I said "Protection against the cost of hospital care in old

age is a logical and necessary extension of the retirement protection furnished by the present social security program. Monthly cash benefits can meet the regular recurring expenses of food, clothing, and shelter, but such benefits alone cannot give economic security in old age. It is also necessary that older people have protection against the unpredictable and unbudgetable costs of expensive illness. A person may go on for a long time with little in the way of medical expense and then, in a very short period, have hospital bills running into thousands of dollars. Cash benefits are not a practical way to meet this need. What is needed is a substantial measure of protection against a cost of major illness in addition to cash benefits."

I am sure you will recall that in 1935, when we adopted the social security program, one of the reasons, among other reasons for adopting it, was that we should protect the individual from going onto welfare rolls by letting him protect himself while working by contributing to a program for benefits on retirement. That was one of the reasons we adopted the social security program.

We now protect him against loss of earnings and it is feasible that the same program protect him against the high cost of hospital care, and that is why I say it is a logical extension—what we are proposing now.

Senator CURTIS. Your recent quotation again referred to retirement benefits, but in this King-Anderson proposal you are giving it to people who aren't retiring and so it is a departure.

Mr. COHEN. They are certainly not working when they are in a hospital.

Senator CURTIS. No, no. But you people have said that good hospital insurance would cost from $400 to $550.

Mr. COHEN. Yes.

Senator CURTIS. Here is a fellow at 65 who doesn't retire. He perhaps has very high earnings, the highest earnings of his life. You relieve him of that $400 or up to $550 burden of carrying his own hospitalization, and he has had no wage loss because of retirement.

Mr. COHEN. I agree on the wage loss. But the day he goes into that hospital, may be "the day"; we don't know that he is ever going to come back to work. That may be his cancer, may be his terminal illness, and the point we are trying to make is on the day he goes in and applies for his hospitalization he may then from that point on be a retired person or not. That is the——

Senator CURTIS. That would apply to a fellow only 30 years old.

Mr. COHEN. Oh, no. I am talking about a fellow of 65.

Senator CURTIS. No, what you are talking about would apply equally to a fellow who was 30 or 35 years old.

Senator DOUGLAS. Mr. Chairman——

Senator CURTIS. I want to go to another——

Senator DOUGLAS. I wondered if the chairman would inquire of the Senator from Nebraska how much time he wants to take in questioning the witnesses. He has been questioning the witnesses now for 2 hours and 8 minutes, and has worn out Senator Ribicoff, who was Secretary of Health, Education, and Welfare, and who probably is best prepared of any member. I wondered if the chairman would ask the Senator from Nebraska how much more time he intends to take.

Senator CURTIS. It won't take very much more time, and I here and now authorize the distinguished and learned Senator from Illinois to go over the record and strike out any question I asked that wasn't relevant.

Senator DOUGLAS. Not at all. I merely want to point out that the procedure of the committee under which no limitation is placed upon the time that any Senator can take up, can be abused and the Senator from Connecticut, who is very experienced in this matter, was simply worn out and left about a half an hour ago. In all kindness I want to say that I think all of us on the committee should consider other members.

Senator LONG. I would like to suggest—off the record.

(Discussion off the record.)

Senator DOUGLAS. I think we have to consider there are 17 members of this committee and this morning we had the Senator from Connecticut here——

Senator LONG. You haven't been burdening the Senator from Connecticut for the last half hour because he hasn't been here for the last half hour.

Senator CURTIS. I would have been through except for the interruption.

Senator LONG. I don't criticize the Senator about this matter. I found sometimes as a member of the committee the only way I can get information as a member of a committee is to sit and ask witnesses questions. Sometimes the witness is evasive. The Secretary has not been evasive. And sometimes you have to get at an evasive witness for a while before you can get an answer.

Mr. Secretary, you have been most cooperative and helpful and not evasive.

Let me say to Senator Curtis and Senator Douglas I will suggest if I am occupying the chair in the future when we have a Secretary or Cabinet member we should work out some arrangements to limit ourselves.

But since no limitation was imposed on any other Senator no limitation should be imposed on Senator Curtis.

Senator CURTIS. One more point I want to cover.

The cash benefits are wage-related, aren't they?

Secretary CELEBREZZE. Yes.

Senator CURTIS. The health benefits will not be, will they?

Secretary CELEBREZZE. No.

Senator CURTIS. It might be recalled by some that in the hearings before the Finance Committee on Mr. Cohen's nomination as Assistant Secretary of HEW, this question was asked and Mr. Cohen agreed to it, in effect, that the medicare protection was a flat benefit; and I have this to read from the Ways and Means social security hearings, 85th Congress, 2d session, pages 770 and 771, this quotation is from the AFL–CIO testimony:

Social security was conceived as a wage-related system with benefits related to wages. In this respect, we were meshing it with our whole free enterprise system. So Congress has also meshed our social security system with a concept of a wage-related benefit in contrast to the European systems that have a flat benefit, the same for everyone. We think it is highly important that this wage-related approach be maintained in our whole social security system.

I am not here advocating that if the Congress adopts a medicare program that it be on a wage-related basis. I merely point out that in many, many major characteristics the King-Anderson bill is not an extension of the social security system which applies a work test, which calls for retirement and which is a wage-related benefit.

That is all, Mr. Chairman, unless they have something else.

Mr. COHEN. Could we just ask since the Senator referred to a statement that I made in connection with my nomination as Assistant Secretary, to save time I would like to put a statement in the record as to why I don't agree wtih the Senator that hospital insurance is not consistent with the logical extension of the social security system.

Senator LONG. I will be glad to put it in the record as you suggest.

(The document referred to follows:)

STATEMENT BY WILBUR J. COHEN, ASSISTANT SECRETARY OF HEALTH, EDUCATION, AND WELFARE

Our reaction to other points raised by Senator Curtis concerning the relationship of hospital insurance to some of the principles of the present program are brought out in the questioning. This statement, therefore, is related solely to the question of adding hospital insurance benefits that are not related to past wages to a wage-related program.

Adding the hospital insurance and related benefits of the King-Anderson bill to social security benefits would result in giving the beneficiaries insurance protection worth about $7.50 on the average. In this sense it is similar to adding a flat amount to the present benefit structure.

Although the present cash benefits of social security are wage-related, there is of course a minimum benefit which is guaranteed to all who meet the insured status requirements. The addition of hospital insurance protection for all seems to me similar to an increase in this minimum benefit. After the addition of hospital insurance, everyone who meets the insured status requirements would be entitled at the minimum to a cash benefit and hospital insurance rather than just the cash minimum of $40 as at present. Cash benefits would, of course, continue to vary in relation to wages above the minimum just as now.

There have been many increases in the minimum in the past which have been similar in result to the addition of hospital insurance. It does not seem to me that the addition of a standard hospital benefit policy as part of the minimum guarantee for those who meet the insured status requirements is significantly different in terms of the benefit-wage relationship from a flat increase in the minimum cash benefit.

Senator CURTIS. Thank you.

Senator LONG. I believe Senator Douglas has some questions he wanted to ask.

Senator DOUGLAS. Only if the Senator from Nebraska is finished.

Senator CURTIS. Yes, I am finished.

Senator DOUGLAS. After 2 hours and 13 minutes.

Senator CURTIS. Again, I say if I have asked a frivolous question or one that was not relevant, without even consulting me I will give you total authority to strike it from the record.

Senator DOUGLAS. It is not the point as to whether the questions were frivolous. The point is that the Senator from Nebraska took up an undue amount of time.

Senator LONG. Let's get on with the business.

Senator DOUGLAS. All right.

I will allow the Senator from Louisiana to be the pacifier.

I am very reluctant to ask questions, very frankly, because the witnesses have been on the stand for 2¼ hours and I had hoped the Sena-

tor from Connecticut would ask questions. The questions which I might ask would be much inferior to those which he would ask. Nevertheless, if the witnesses are not too exhausted, I would like to ask a couple of questions, and they are primarily directed to Mr. Myers, whom, I think, is a great public servant. I have worked with Mr. Myers over a quarter of a century. I think he is one of the greatest actuaries of the country, an absolutely truthful and honest man.

I think the country is very fortunate in having him, Mr. Celebrezze, and I hope you will promote him to the top of the civil service grade.

Senator LONG. You had better put something in there for all these men, Mr. Ball.

Mr. COHEN. Mr. Hawkins.

Senator LONG. He is a good man, also; you ought to mention him.

Senator DOUGLAS. We voted for an increase for the Secretary, too.

Senator LONG. At the time I voted for a pay raise I had in mind they were more entitled to it than I was, and I am very happy they are going to get a pay raise.

Senator DOUGLAS. Now, in the discusions of the costs and the shying away from King-Anderson because of the increased cost, no mention has been made of the size of the reserve that will be accumulated under old age insurance. And on page 30 of the report of the House Ways and Means Committee we have statistics which I imagine are based upon the figures which Mr. Myers presented.

This shows that under the present system, plus the increased benefit cost under the House version of H.R. 11865, the reserve amounts to about $18½ billion.

In 1967 it will be approximately the same, $18.9 billion, and 1971, $32.2 billion; in 1990, $90 billion; the year 2000, $121 billion; and 2020, $246 billion. Are those figures approximately accurate, Mr. Myers?

Mr. MYERS. Senator Douglas, these figures for the OASI trust fund in the House report are the ones that I prepared; I hope they are the best possible.

Senator DOUGLAS. Right. They were intermediate costs; and you think they are the best that can be made? Is that true?

Mr. MYERS. That is correct, Senator.

Senator DOUGLAS. These estimates are based on the assumption that earnings will be constant; isn't that true?

Mr. MYERS. Yes; that is true.

Senator DOUGLAS. In the past, earnings have increased. At about what rate did they increase each year?

Mr. MYERS. Between 3 and 4 percent a year, nearer to 3 percent, I would say.

Senator DOUGLAS. And has not the increase in earnings raised the income or contributions to the fund more than the increase in standard benefits? I don't mean the taking on of additional persons, but standard benefits.

Mr. MYERS. That is correct. As we went over this matter before, if wages increase, then the contribution income increases more rapidly than the benefit liability.

Senator DOUGLAS. What would you estimate would have been the net savings?

Mr. MYERS. I would say that each year there is net savings that arises of perhaps 0.07 percent of payroll. These have accumulated in the past and, when Congress has seen the new actuarial cost estimates, these have been taken into account in the liberalizations that have been made in the past years.

Senator DOUGLAS. Is that per year?

Mr. MYERS. Per year.

Senator DOUGLAS. 0.07?

Mr. MYERS. Yes.

Senator DOUGLAS. So that over the course of 15 years, there would be approximately a full 1 percent?

Mr. MYERS. That is correct.

Senator DOUGLAS. Of payroll?

Mr. MYERS. Yes.

Senator DOUGLAS. Of payroll.

Well, now, assuming that these savings continue in the future could we not get sufficient savings to finance King-Anderson by a transfer from OASI to the hospitalization fund?

Mr. MYERS. Yes. This is one offsetting element; namely that if hospital costs keep going up and if wages keep going up, the savings generated in the cash benefits portion of the program could offset any increases in cost on the hospital insurance side of the program.

Senator DOUGLAS. Couldn't it also meet part of the original cost in the hospital savings program?

Mr. MYERS. It could. Of course, in the past, those savings or reductions in cost have been utilized for the various benefit liberalizations and changes which have been made from time to time.

Senator DOUGLAS. Couldn't they be used this time to increase the hospitalization side of the benefits rather than the cash benefits side under "old-age insurance"?

Mr. MYERS. These savings could be utilized in this way, but I wouldn't think it would be wise to take into account the savings that are apt to occur in the future and capitalize them now.

Senator DOUGLAS. I understand.

But there is great exaggeration in the statements about the terrible dangers ahead in the future. Isn't the system overprotected, so to speak, so far as old-age insurance is concerned?

Mr. MYERS. If there are rising wages, as you stated there is a definite safety factor against——

Senator DOUGLAS. Do you think that the country will wish to build up this fund to $246 billion, drawn out of current earnings, and have that left more or less immobilized? Do you think we will want to have a trust fund of $246 billion?

Mr. MYERS. Well, Senator Douglas, this figure has been developed from the contribution rates that the Ways and Means Committee proposed.

Senator DOUGLAS. I understand. You are an actuary. I shouldn't ask you this question. Does anyone here think that the country will build up a reserve of $246 billion?

Senator LONG. That is a good way of retiring the national debt, I will say to the Senator.

Senator DOUGLAS. Pardon?

Senator LONG. It is a good way to retire the national debt, just cover it in the social security fund.

Senator DOUGLAS. Out of the contributions of those in the lower income groups?

Senator LONG. That is one way we retire it. I am not insisting we do it, you understand, but that is what it amounts to.

Senator DOUGLAS. I will ask Mr. Celebrezze, who is a politician, an honorable profession if honorably pursued. You are not inhibited by civil service restraints. Do you think it is possible we will ever build up a reserve of $246 billion?

Secretary CELEBREZZE. Even if it was possible, I wouldn't advise it because it might be taking too much out of the current economy at any given time.

Senator DOUGLAS. That is right.

Secretary CELEBREZZE. On the other hand, we have to take into consideration what the costs are going to be in the long run.

Senator DOUGLAS. We should be concerned for the future, but I have never thought that we could predict very accurately what would happen 60 years from the present.

But I think I can predict that we will never have a reserve of $246 billion.

Secretary CELEBREZZE. No, I think you are accurate on that, because it might well be taking too much out of the economy at one time.

Senator BENNETT. This doesn't come out of the economy. They just put the bonds in the safe and the Federal Government takes the money and puts it in it, spends it to maintain the Government.

Secretary CELEBREZZE. There is a difference. For one thing, you are getting a broader effect of the money when many individuals are spending it, rather than the Government loaning it.

Senator DOUGLAS. To the degree that the reserve is not built up to $246 billion, but contribution rates remain the same, could there not be a transfer of funds from OASI to hospital insurance funds?

Secretary CELEBREZZE. Yes; that is possible. Congress has the authority.

Senator DOUGLAS. This is in addition to the safety factor which would come with an increase in earnings.

Secretary CELEBREZZE. That is right. That is correct, Senator.

Senator DOUGLAS. I think I had better stop there, to indicate that, if you take a long view of this matter, King-Anderson can be put on top of social security. We can affect economices which can be transferred to hospital insurance both through the increase in earnings and through a policy of not building up a reserve to the fantastic extent, not contemplated, but predicted under the present actuarial figures. I will stop at that point.

Senator BENNETT. Mr. Chairman, I won't be long. I will be very short.

I share Senator Douglas' feeling that the fund will never be built up to any such astronomical figure, but I hope he shares my memory of the action of this committee in the past when it looked as though the fund was going to rise, our committee and the House Ways and Means Committee has said, let's increase the benefits without increasing the costs, and so we already have established the pattern that we are going to use any potential surplus and, Mr. Cohen, it is apparently fashionable to quote your own words to you.

Mr. COHEN. It has been done many times to me, Senator.

Senator BENNETT. I am on page 122 of the Senate hearings in 1961, and, interestingly enough, Mr. Curtis was doing the questioning.

[Laughter.]

Senator BENNETT. And Mr. Cohen said, I am not going to read the whole page, but he was talking about his concepts of the future of the system, and he said:

I would think my proposals to increase benefits 50 percent, to raise widows' benefits a hundred percent, child benefits to age 21—

and this is now going into the law, this one particular one—

raise the family maximum benefit to an appropriate amount, and to increase the wage base to $9,000 would probably cost another 1½ percent of payroll in 1970 over the 9 percent contribution rate for that year in our schedule.

In other words, is it fair, Mr. Cohen, to say you envision a future and maybe by 1971 when we would be taking 10½ percent of $9,000 of payroll just to finance the improvements in the basic social security system which you felt should be made?

Mr. COHEN. Yes. The statement that I made was made, I think, about 1957 or 1958, and I was looking about 10 or 15 years ahead.

Senator BENNETT. You actually quoted this in your confirmation hearings in 1961.

Mr. COHEN. That is correct, and it was based——

Senator BENNETT. I didn't go beyond that.

Mr. COHEN. No.

Senator BENNETT. So we are not talking about a situation today in which we are going to freeze the regular benefits of the system at today's level and then have money to spend on hospitalization. We are talking about a continuation of the existing program which is that every time either we see a little surplus in the fund or we see a good election year coming along then Congress decides to increase the standard benefits.

Secretary CELEBREZZE. On the other hand, there has been since the inception of the social security program a diminishing contribution, measured as a percentage of total payroll, on the part of the employer—that is in terms of the expectation when the act was passed. In 1935 when the act was passed, it was contemplated that the employer would pay 3 percent on $3,000 for old-age benefits and also 3 percent of total payroll for unemployment benefits. This meant that the old-age benefit tax represented about 2.8 of total payroll because we covered 92 percent of total payrolls under the $3,000 maximum base.

Since the 3 percent for unemployment was on total payroll, the total ultimate tax which was anticipated by the employers in 1935, under the act, was 5.8 percent of payroll.

Now——

Senator DOUGLAS. Including unemployment?

Secretary CELEBREZZE. Yes.

Mr. BALL. Total.

Secretary CELEBREZZE. Now, if we establish—the reason I want to bring this out, Senator, so much has been said about a 10-percent ceiling and the burden on employers.

Now, if we established a 5-percent ultimate employer rate under old-age survivors and disability insurance, with the $5,400 earnings base, this is actually only 4 percent of total payroll, because only 80 percent of the payroll would be affected.

The employer cost for unemployment insurance today is not 3 percent; it is currently about 1.6 percent of total payroll.

Thus, the total ultimate employer tax as a percentage of total payroll that would be anticipated, if we had an ultimate rate of 5 percent or a $5,400 base is 5.6 or less than what was anticipated in 1935 when it was expected to be 5.8.

Now, you have to take another thing into consideration—the effect of the corporation income tax for those paying at the maximum rate—48 percent now compared to 16 percent in 1935, the net employer tax rate ultimately anticipated for social security purposes would have been 4.9 percent of total payroll under the original act for such an employer as compared to 2.9 percent under even a $6,600 base with a 5-percent rate under present conditions.

So that I think when we are talking about this 10-percent ceiling and the increasing burden on employers, we have to take these facts into account. Under the original act, the ultimate employer tax measured as a percent of total payroll for old-age benefits and unemployment was 5.8 percent, not taking into account the effect of the corporation income tax. All the changes in the program in the past, and including those we are proposing, do not increase that percentage.

Senator BENNETT. Let's talk about the employees tax. What was the original employees tax under the original bill?

Secretary CELEBREZZE. The employees tax was 3 percent.

Senator BENNETT. All right. What is it now?

Secretary CELEBREZZE. The employees tax is 3⅝.

Senator BENNETT. What will it be in 1971?

Secretary CELEBREZZE. 1971?

Mr. BALL. Under present law, Senator, it goes to 4⅝ percent; under the House bill it goes to 4.8 percent.

Senator BENNETT. And if you add the King-Anderson on top it goes to 5.2 with no additional—5.2, with no additional benefits on the retirements side from now on?

Mr. BALL. As was brought out, I think in earlier discussion, Senator, wages would rise in the future and there would develop income——

Senator BENNETT. We have been over that so much.

Mr. BALL. Yes.

Senator BENNETT. But the Secretary started to talk about rates.

Mr. BALL. Yes.

Senator BENNETT. And I wanted to stay with the discussion of the rates.

What is the burden on the self-employed person? You didn't cover him at all to start with.

Secretary CELEBREZZE. The self-employed is always one and a half times whatever the employee rate is.

Senator BENNETT. So, in 1971 the burden of the self-employed will be something about 7½ percent of his first $5,400?

Secretary CELEBREZZE. Yes. Because there he is partly in the position of employer and employee and part of the consideration——

Senator BENNETT. We understand the theory, but actually in dollar output he is going to pay 7½ percent of his first $5,400.

Mr. BALL. Under the House bill it is 7.2 percent.

Senator BENNETT. There are two other questions I would like to get into the record and then I am through.

Yesterday in your prepared statement, Mr. Secretary, I think you used the word "degrading" to describe a means test.

Secretary CELEBREZZE. No, "humiliating."

Senator BENNETT. My memory is fairly clear that the word "degrading" is somewhere in that statement, but I will accept "humiliating" or whatever the word was. It implied that this embarrassed and disturbed, or could disturb, the individual who was subjected to it.

For the record, I would like to offer a list of 10 Federal programs which apply the means test.

Secretary CELEBREZZE. It is on page 10, "Subject, the Aged to the Humiliation of a Test of Need."

Senator BENNETT. All right.

We now apply the means test to old-age assistance, to medical assistance for the aged, to aid for needy family with dependent children, to aid to the blind, aid to permanently and totally disabled, to people who get the benefit of low-rent public housing, low-rent farm housing, total and permanently disabled veterans, and hospital care for all veterans on non-service-connected benefits, and to those who get surplus food. Do you think these humiliate the people who accept these particular benefits?

Secretary CELEBREZZE. To a degree it may be humiliating. I think it is humiliating to an individual who spent a lifetime contributing to the economy of a community. Older people like to be independent. They don't like to depend on their children, to have to go to a welfare office with hat in hand and say, "I am 65 years old and I need medical attention," and fill out a list of assets and have a worker say, "Well, you have an insurance policy worth $2,000 just to bury you, you cash that policy in," and as a result, if he liquidates his insurance and uses up most of his other assets then you can put him on public assistance. I think there is something humiliating about that when you go to assistance or charity. If there can possibly be an adequate plan to protect the individual so that during his working years he can pay and have the protection in old age as a matter of right rather than as a matter of——

Senator BENNETT. Are you going to move to take the means test out of these other systems?

Secretary CELEBREZZE. As a last resort you have to have them, Senator, but in certain areas like hospital care you can remove much of it from the means test and that is why I say that hospital insurance is an ideal addition to the social security program. You can greatly reduce the need for a means test program here.

Senator BENNETT. Now, when you were talking with Senator Curtis, the two of you discussed at some length the fact that there is a wage test in the standard social security system, there is a working test, an earning test, which you ignore when you do what you say is a logical extension of the system, and include hospital care benefits.

Secretary CELEBREZZE. Well, there is no test at all after age 72.

Senator BENNETT. That is right. Between 65 and 72, however, there is a test which because you are dealing with income, wages, is in a sense the equivalent of a means test.

Secretary CELEBREZZE. No.

Mr. BALL. I wouldn't think so, Senator Bennett. I think the purpose there is, as Senator Curtis was bringing out, to measure where there has been a loss of earned income. You need to test whether this

person has stopped working more or less full time. But on the other hand, one of the most important ideas, I think, in the social security——

Senator BENNETT. You not only test whether he has stopped working. If he has not stopped working, you test how much money he is earning.

Mr. BALL. Yes, but it is related to a test of whether he is partially or fully retired, and there is no interest at all in how much he has in the way of private pensions or dividends or savings. It is hoped that he will build on top of social security other income of his own.

So it is a retirement test, not a means test.

Senator BENNETT. But the principle that the Government is interested in the man's financial situation while it is applied in a different way still exists.

Mr. BALL. No; I think——

Senator BENNETT. You do not open the door and say, "When you become 65 you get this service automatically with social security and old-age and survivors benefits, and so on," as you are going to do with this particular proposal.

Mr. BALL. I would say you are interested in only whether there has been a loss of earned income and not in his financial condition. You would pay, as we de every day, people with very large savings and other income. It is just that there is a loss of earned income when he retires and you pay to make up for that. I don't think it is at all like a means test, Senator.

Secretary CELEBREZZE. You can draw $50,000 a year in dividends and still get your benefits under the social security program.

Senator BENNETT. I understand that. But he can't earn more than the maximum of something less than $3,000.

Mr. BALL. About $3,700 in the maximum case for a couple.

Senator BENNETT. Without losing his benefits.

Mr. BALL. Yes.

Senator BENNETT. There is one final question which was left with me, and which I don't completely understand. Senator Dirksen had hoped to discuss the question of actuarial study No. 57, and this is the memo I have. I hope it make sense to you.

Is this the base on which the estimates that you have put into the record in this hearing and the House Ways and Means Committee, is this still the basis of those estimates?

Mr. MYERS. I understand the question.

Senator BENNETT. Yes.

Mr. MYERS. The answer to that question is that the estimates that were initially discussed with the House Ways and Means Committee were entirely on the basis of Actuarial Study No. 57.

In these discussions, some concern was expressed that there should be more of a margin of safety or margin of conservatism in the estimates. In regard to this single factor of rising hospitalization costs and earnings that we have discussed before and that I am also going to discuss in the material I am putting in the record for Senator Dirksen, I can expand on this point. In the original estimates, it was assumed that hospital costs and wages would, on the average, rise at the same rate from 1961 on; if hospital costs rose faster than wages for a few years, then later on the differential would be made up

by wages rising more rapidly than hospital costs, just as in many fields the costs of things that you buy do not rise as rapidly as wages. In other words, the cost of living does not increase as fast as wages.

In the discussions with the Ways and Means Committee it was suggested, and I agreed that this would be desirable, to adopt somewhat more conservative assumptions by assuming that we would consider the actual trend of hospital costs against wages up to 1965, and to start in effect from 1965 on and to assume that from then, in the next 5 or 6 years, hospital costs would increase faster than wages, but only with a margin that would narrow, until after, say, 1971, hospital costs and wages would be assumed to increase at the same rate.

Therefore, the current estimates—or at least the latest estimates that we discussed with the Ways and Means Committee and the estimates which we are quoting here (for example, the 0.85 percent of taxable payroll for the King-Anderson bill)—are based on these revised assumptions, as compared with those in Actuarial Study No. 57.

Senator BENNETT. Has study No. 57 estimated the increase in cost per King-Anderson 0.68 percent of payroll?

Mr. MYERS. It showed a level-cost of 0.68 percent of taxable payroll for the King-Anderson bill, and we are now quoting a figure of 0.85 percent on these more conservative assumptions. Both estimates, I would say, are valid and accurate estimates, but they are based on different underlying cost assumptions.

Senator BENNETT. Has the new study been put in the record?

Mr. MYERS. Well, this new estimate is a modification of the earlier one. The new estimates are based on a modification of Actuarial Study No. 57, and in the memorandum that I am preparing for Senator Dirksen I will indicate——

Senator BENNETT. Those will be indicated so it will be possible to compare study No. 57 with the revised study?

Mr. MYERS. Yes, Senator Bennett.

Senator BENNETT. I assume that discharges my responsibility.

Senator DOUGLAS. Would you like to have it put in the record, Senator Bennett?

Senator BENNETT. I understand Senator Dirksen has asked for it and Mr. Myers is preparing them for the record.

Senator DOUGLAS. Without objection.

(See p. 141.)

Senator BENNETT. I have no further questions.

Senator DOUGLAS. Thank you. I have just one question. I would like to have you explain your study, the estimate 68/100 of 1 percent, the cost.

Mr. MYERS. That was the estimate in actuarial study No. 57 for the King-Anderson bill.

Senator DOUGLAS. Whereas, the added assessments will be .50 percent under King-Anderson?

Mr. MYERS. No; what you might say the current estimate for the King-Anderson bill.

Senator BENNETT. Is 0.85 as compared with 0.68?

Mr. MYERS. In other words, the current estimate has increased the estimate of the cost of the King-Anderson bill.

Senator DOUGLAS. Wait a minute.

Mr. MYERS. Senator Douglas, in the original King-Anderson bill, the contribution rate was half a percent, on employer and employee combined. But the rest of the cost, the difference between that half percent and the 0.68 percent, in other words, a difference of 0.18 percent, was to come from the savings to the system from raising the earnings base from $4,800 to $5,200.

Now, when we are talking about our current estimates, the savings in raising the earnings base to $5,400 in the Mills bill has already been utilized to finance the benefit changes in the Mills bill, so that if the King-Anderson bill were put on top of the Mills bill, it would have to be financed—or at least as per our discussion here—entirely by an increase in the contribution rate, as Senator Gore has done. Of course there would be the alternative, as Commissioner Ball said yesterday, of a higher earnings base.

Senator DOUGLAS. The bill as it now stands before us calls for ultimate contributions of 4.8 percent for each party, a total of 9.6, is that true?

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

Senator DOUGLAS. If the King-Anderson bill is superimposed on top of that, the total itself would be 10.4.

Mr. MYERS. Yes.

Senator DOUGLAS. And this would be met from contributions?

Mr. MYERS. Yes; this would be met entirely by a higher contribution rate under the Gore amendment.

Senator DOUGLAS. What about a higher base?

Mr. MYERS. Well, you wouldn't need a higher base under the Gore amendment, but if you wanted a lower contribution rate than 10.4 percent on employer and employee combined, you could get it by getting part of the necessary financing from a higher earnings base and part from a higher tax base.

Senator DOUGLAS. And this does not take account of the economies which I mentioned, namely, an increase in the earnings or a possible transfer of cash surpluses from OASI trust fund to the hospital fund?

Mr. MYERS. No; this does not take into account the possibility of that in the future.

Senator DOUGLAS. Thank you.

Thank you very much, gentleman, you have been very patient.

I ask unanimous consent to insert in the record a statement by Frederick B. Arner, of the Education and Public Welfare Division, on the "Effect of the Assumption of a Constant Earnings Level on Cost Estimates of the Social Security System's Cash Benefits and Proposed Hospital Insurance for the Aged Programs."

Hearing no objection, it will be inserted in the record at this point.

(The document referred to follows:)

THE EFFECT OF THE ASSUMPTION OF A CONSTANT EARNINGS LEVEL ON COST ESTIMATES OF THE SOCIAL SECURITY SYSTEM'S CASH BENEFITS AND PROPOSED HOSPITAL INSURANCE FOR THE AGED PROGRAMS

(Frederick B. Arner, Education and Public Welfare Division, June 2, 1964, Washington, D.C.)

In a social insurance system here long-term estimates as to its financial soundness must be made well into the 21st century, many assumptions are made as to the future. Population projections are prepared based on different assumptions as to mortality and fertility. Certain assumptions as to employment and

retirement are used, as are assumptions as to disability incidence and termination rates for the disability program. For the proposed hospital insurance program, assumptions are made as to utilization rates and the relationship of hospital care costs to earnings. These assumptions and the methodology used are discussed in detail in the annual reports of the trustees of the social security trust funds and in the actuarial studies prepared by Robert J. Myers, the Chief Actuary of the Social Security Administration. (Annual report of Federal old-age and survivors insurance and disability insurance (OASDI) trust funds, fiscal year 1963, H. Doc. 236, 88th Cong., app. I; actuarial study No. 57, Social Security Administration, July 1963.)

This paper, however, is focused on one assumption that has been used by the actuary over the years which has drawn increased attention because of its effect on the cost estimates and financing of the Administration's hospital insurance for the aged bill (King-Anderson bill, H.R. 3920, S. 880, 88th Cong.).

THE ASSUMPTION

The latest trustees' report in commenting on the acturial condition of the old-age, survivors, and disability insurance system, states that "level average earnings at about the 1963 level were assumed." The official cost estimate on the Administration's hospital insurance bill (actuarial study No. 57) states that "the long-range cost estimates of this study are based on level-earnings assumption, at the 1961 level." In layman's terms this means that it is assumed that the average earnings of workers under the system will not rise but will stay at the level of the year indicated.

IMPLICATIONS OF ASSUMPTION

In brief.—If average earnings do rise, the effect will be markedly different as to the "cash" old-age, survivors, and disability benefits as contrasted to the proposed hospital insurance "service" benefits. As to cash benefits, a rising earnings level generates a "saving" or gain to the OASDI system. However, as to the hospitalization benefits, a rising earnings level generates a deficiency if there is static financing, and some adjustments would then be required to keep the program in actuarial balance. Such financing could come from an increase in the tax rate, in the wage base (the maximum taxable earnings), the deductible features in the hospital benefit, or a combination of these approaches. It also has been suggested, in the alternative, that such a deficit in the hospital benefits program because of increased earnings levels could be met, at least to some extent, by a transfer of the "savings" on the OASDI cash benefit portion of the system. The details are spelled out in the following pages.

Cash benefits.—It has been recognized by the actuary, the trustees, and the congressional committee reports on OASDI legislation that average earnings have risen in the past. The trustees' report states:

"In the past, average earnings have increased greatly, partly because of inflation, partly because of increased productivity, and partly because of the changed occupational composition of the labor force and related factors * * *." (H. Doc. 236, 88th Cong., p. 66.)

When earnings rise, "savings" are generated for the OASDI program. This is because of the "weighted" nature of the benefit formula. The actuary points out:

"* * * the primary benefit for an average monthly wage of $300 is $105 per month (or 35 percent of average wage), while the corresponding benefit for an average monthly wage of $360 is $118 per month (32.8 percent of average wage). Thus, for an average wage that is 20 percent higher, the primary benefit increases only 12.4 percent. The effect on the financing of the program is evident, since contributions increase directly proportionately with increases in covered earnings, whereas benefits rise less than proportionately. In addition, there is the decreasing-cost effect that results from the lag involved when earnings levels rise, since the average wage is, in essence, a lifetime one and thus is affected by the lower earnings levels of the past." (Actuarial study No. 57, p. 12.)

The rationale for an assumption of level earnings has been stated many times. Mr. Myers has written:

"Throughout the entire history of the program, the cost estimates have been based on level economic conditions, except for experimental calculations not used as the basis for legislative consideration. At first glance, this might seem unrealistic—some criticism of this procedure has come from economists—since

earnings levels have increased so significantly during the 25 years of operation of the program (as well as before its inception). It does not seem appropriate to use rising earnings assumptions in the cost estimates, rather than level ones, since the system of benefits and also the earnings base for contributions has been established on the economic foundation of the existing level. If the earnings level changes, the program can be adjusted correspondingly—as it has been in a number of instances * * *." ("OASDI Cost Estimate and Valuations," proceedings, Casualty Actuarial Society, vol. XLVI, 1959, p. 227.)

And the latest trustees' report states: "It is likely, however, that if average earnings increase, the benefit formula and the earnings base used for contribution will be modified" and "if benefit payments are increased in exactly the same ratio as the increase in average earnings, the year-by-year cost estimates of benefit payments expressed as a percentage of payroll would be unchanged" (pp. 66–67).

Mr. Myers indicates in actuarial study No. 57 that such "savings" have actually been used for purposes a little broader than only "benefit formula" modification. He writes:

"In the past, the savings to the OASDI system resulting from the above two factors (rising-earnings levels considered alone, and increases in the maximum earnings base) have been utilized to keep the benefit structure up to date by such changes as increasing the general benefit level, adding new types of benefits, and liberalizing existing benefit provisions" (p. 13).

Moreover, there is some question as to whether these analyses fully acknowledge the "safety factor" aspect of the level-earnings assumption which is mentioned in the latest reports of the Committee on Ways and Means of the House and the Committee on Finance of the Senate on major OASDI legislation (1961):

"It is important to note that the possibility that a rise in earnings levels will produce lower costs of the program in relation to payroll is a very important 'safety factor' in the financial operations of the system. The financing of the system is based essentially on the intermediate-cost estimate, along with the assumption of level earnings; if experience follows the high-cost assumption, additional financing will be necessary. However, if covered earnings increase in the future as in the past, the resulting reduction in the cost of the program (expressed as a percentage of taxable payroll) will more than offset the higher cost arising under experience following the high-cost estimate. If the latter condition prevails, the reduction in the relative cost of the program coming from rising earnings levels can be used to maintain the actuarial soundness of the system, and any remaining savings can be used to adjust benefits upward (to a lesser degree than the increase in the earnings level). The possibility of future increases in earnings levels should be considered only as a safety factor and not as a justification for adjusting benefits upward in anticipation" (H. Rept. 216, 87th Cong., pp. 15, 16).

An example of the "savings" as a safety factor can be shown by the latest change in the earnings level used by the actuary. At the enactment of the 1961 Social Security Amendments, the actuary estimated that there was an actuarial deficiency for the OASDI system of 0.30 percent of taxable payroll on the basis of the 1961 earnings level. The latest trustees' report, based on the 1963 earnings level, shows an actuarial deficiency of 0.24 percent of taxable payroll, an improvement in the condition of the funds of 0.06 percent of taxable payroll. To fill out the picture, however, it should be noted that, in making the new estimates, on the plus side of the ledger were "savings" of about 0.18 percent of taxable payroll from the increased earnings level and 0.15 percent of taxable payroll from the increased interest-rate assumption. On the minus side were some "unfavorable" factors—"somewhat higher retirement rates in the next few years and higher proportion of persons becoming fully insured" and lower termination rates for the disability program which, in all, totaled 0.27 percent of taxable payroll. (Hearings before Committee on Ways and Means, "Medical Care for Aged, 1964," pt. I, p. 367; actuarial note No. 3, July 1963, Social Security Administration.) Thus, all the "savings" from interest plus two-thirds of the "savings" from the increase in earnings level from 1961 to 1963 was needed to balance the "unfavorable" experience.

Although OASDI cost estimates are periodically adjusted to utilize more current earnings data, the trustees' reports transmitted to Congress have not explicitly indicated the "savings" which have resulted from the use of more recent and higher earnings levels. The chairman of the Committee on Ways and Means has requested that in future reports these savings from earnings level increases be spelled out in the trustee's report.

Hospital insurance benefits.—In the actuarial study on the King-Anderson bill, Mr. Myers points out the radically different effect rising earnings have on a hospital "service benefit." He states:

"Perhaps the major difficulty in making, and in presenting, these actuarial cost estimates for hospitalization benefit is that—unlike for the OASDI monthly benefits—an unfavorable cost result is shown when total earnings levels rise unless the provisions of the system are kept up to date (insofar as the maximum taxable earnings base and the dollar amounts of the deductibles are concerned). The reason for this is that there is the fundamental actuarial assumption that the hospitalization costs will rise at the same rate over the long run as total earnings level, whereas the contribution income rises less rapidly than the total earnings level since it depends on the covered earnings level, which is dampened because of the effect of the earnings base. Accordingly, it is necessary in the actuarial cost estimates for hospitalization benefits to assume either that earnings levels will be unchanged in the future or that, if wages continue to rise (as they have done in the past), then from a given point of time, the system will be kept up to date insofar as the earnings base and the deductibles are concerned. In this respect, it may be noted that in H.R. 3920 the '2½ times the average daily hospital cost' deductible associated with the 180-day maximum hospitalization alternative is on a 'dynamic' basis and so is automatically kept up to date, while the deductable of '$10 per day' is not on a 'dynamic' basis." (Actuarial study No. 57, pp. 30–31.)

Chairman Mills in questioning Mr. Myers at the hearings emphasized the "assumption" in the cost estimates that the bill would be actuarially sound only if Congress kept the system "up to date" by increasing the wage base and the deductible proportionately to earnings level increases. He asked Mr. Myers, assuming Congress left the wage base alone, what additional tax rate increase would be required over the bill's 0.25-percent tax increase on both employees and employer if earnings continued to go up 3 percent a year.[1] Mr. Myers answered that by 1975 a 0.35-percent tax increase would be required and 0.50-percent by 1985. Subsequently Mr. Myers was asked that if the wage base and deductible adjustment approach alone was used what increases would be necessary for actuarial soundness. The following wage base figures were given.[2]

Required earnings base for King-Anderson bill assuming wages and hospital costs increase 3 percent a year[1]

1965	$5,800
1970	6,700
1975	7,800
1980	9,000
1985	10,000

[1] Under the provisions of the King-Anderson bill, the wage base is increased from the present $4,800 a year to $5,200 a year.

Mr. Myers in the latest hearings defended the "reasonableness" of his assumption that the system would be kept "up to date." He stated:

"In the event that earnings do rise as they have in the past, it is assumed that the maximum earnings base will be increased from time to time. This is a realistic assumption based on past performance. The maximum earnings base has been increased from $3,000 in a series of steps until today it is $4,800. If, however, by any chance the earnings base were not increased for a few years in the future, even though earnings rose, then the system as a whole would still be actuarially sound since the savings to the OASDI cash-benefits portion, under any set of reasonable assumptions, would more than offset the loss to the hospitalization portion.

[1] Actually in the hearings Mr. Mills asked what would be the additional tax if earnings and hospital prices rise in the same way they have risen in recent years. Another assumption of the actuary for the King-Anderson bill is that after 1961, on the average and over the long run, hospital prices and earnings will rise at the same rate. In recent years hospital costs have been rising much more rapidly than the earnings level, with the differential being in the neighborhood of 3 or 4 percent a year. An examination of this assumption, however, is beyond the scope of this paper, and estimates given here assume hospital prices and earning rise at the same rate.

[2] Memorandum from Robert J. Myers, dated June 1, 1964. Actuarial soundness would also require similarly proportionate increases in the dedcutibles.

"I believe that it can be seen from the previous discussion that this assumption, rather than those mentioned earlier, provides the most realistic basis for financing the program because:

"(1) If increases in earnings are to be anticipated before they occur—as proposed under the alternative assumptions—the cash-benefits portion of the system would appear to be so overfinanced currently that there would be great pressure to increase current benefits on the basis of an ability anticipated under the assumptions to finance them.

"(2) On the contrary, in the assumption that I used, no allowance is made for savings which will occur as earnings rise. It is assumed instead that the OASDI system will be kept reasonably up to date, in that increases in earnings and increases in the maximum earnings base will occur in a parallel manner and will be offset by increases in benefit amounts and that, therefore, the contribution rates scheduled in present law are as necessary in the event of rising earnings as on the assumption of level earnings.

"(3) In the event that hospitalization costs do rise, and if the maximum earnings base and the deductibles are kept up to date, the estimated hospitalization costs would be met fully by the presently proposed financing basis. If, for a time, adjustments in the earnings base fall somewhat behind earnings increases, there will be such savings to the overall program that sufficient funds will be generated to more than support the entire program without increasing the contribution rate, but then funds would have to be reallocated between the cash benefits and the hospitalization portions of the system." (Committee on Ways and Means, hearings on medical care for the aged, pt. I, p. 370.)

Thus, presented with the likelihood of increasing earnings level, at least two important policy decisions are presented to Congress if it is to enact a hospitalization insurance for the aged program under the OASDI system:

(1) Whether a provision providing for the "up dating" of the system should be written into the law, or whether such "up dating" should remain an "assumption" upon whose fulfillment the actuarial soundness of the hospitalization program would rest.

(2) Whether "savings" generated from increased earnings level should be transferred from the cash benefits side to the hospitalization side of the system to make up for any lag in the "up dating" of the wage base and deductibles.

Senator DOUGLAS. We will recess the hearing until Monday morning at 10 o'clock.

(Whereupon, at 1 p.m., the committee recessed, to reconvene at 10 a.m., Monday, August 10, 1964.)

SOCIAL SECURITY; MEDICAL CARE FOR THE AGED AMENDMENTS

MONDAY, AUGUST 10, 1964

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

The committee met, pursuant to recess, at 10 a.m., in room 2221, New Senate Office Building, Senator Herman E. Talmadge presiding.

Present: Senators Talmadge (presiding), Hartke, McCarthy, Ribicoff, Williams, Carlson, and Bennett.

Also present: Elizabeth B. Springer, chief clerk; and Fred Arner and Helen Livingston, of the Education and Public Welfare Division, Legislative Reference Service, Library of Congress.

Senator TALMADGE. The committee will come to order.

The chairman will be a little late so we will proceed with the first witness, Mr. John F. Nagle, National Federation of the Blind.

STATEMENT OF JOHN F. NAGLE, CHIEF OF WASHINGTON OFFICE, NATIONAL FEDERATION OF THE BLIND, WASHINGTON, D.C.

Mr. NAGLE. Mr. Chairman and members of the committee, my name is John F. Nagle. I am chief of the Washington office of the National Federation of the Blind. My address is 1908 Q Street NW., Washington, D.C.

Mr. Chairman, section 5 of H.R. 11865, now pending before this committee for consideration, would make it possible for certain aged persons who have some social security coverage, but not enough to meet the minimum requirements under existing law, to establish eligibility and qualify for limited benefits under title II of the Social Security Act.

This special provision would liberalize the eligibility requirements so that certain elderly people who fail to meet the work requirements in present law could still qualify for benefits on the basis of as few as three quarters of coverage.

We approve section 5 of H.R. 11865 and the enlightened concept which this provision embodies.

We believe that the provisions of the Social Security Act must frequently be reexamined and when special circumstances justify, when legal provision defeats program purpose and benefits are denied to certain persons economically and socially handicapped by age or disability, then the law must be changed.

Section 5 of H.R. 11865 recognizes such special circumstances, and makes such a change—and, because of it, men and women now pre-

cluded from social security benefits will be able to qualify and draw benefits.

We urge this committee to also consider the special circumstances of blind persons now denied disability insurance benefits because they fail to work long enough in covered employment to meet the 20 quarters eligibility requirement.

We ask you to liberalize the disability insurance law for blind persons, by providing that they may establish eligibility for benefit payments when they have worked six quarters in social security covered employment.

For this purpose, we offer as an amendment to H.R. 11865 a bill (S. 1268), introduced by the distinguished senior Senator from Minnesota, Hubert H. Humphrey, and cosponsored by the equally able and distinguished Senators Jacob Javits from New York and Jennings Randolph from West Virginia.

S. 1268 proposes several changes in the disability insurance law with specific reference to blind persons.

First, our amendment would incorporate in the disability insurance cash benefit provision of the Social Security Act the definition of blindness which is generally recognized and used throughout the Nation.

This definition, already included in other Federal laws, would provide an ophthalmological standard for determining blindness: i.e., blindness is central visional acuity of 20/200 or less in the better eye with correcting lenses, or visual acuity greater than 20/20 if accompanied by a limitation in the field of vision such that the widest diameter of the visual field subtends an angle no greater than 20 degrees.

Then, S. 1268 would permit a person whose visual impairment is such as to constitute blindness in accordance with the terms of this definition and has worked in social security covered employment for 6 quarters to qualify for disability insurance cash benefits under the social security program, and to continue eligible for such payments so long as the disability of blindness lasts.

Mr. Chairman, the objective of S. 1268 is to make the disability insurance program a true insurance program for the blind, for those who are now blind, for those who become blind in the future.

S. 1268 would condition the right to receive disability payments, and the right to continue to receive them, upon the existence and the continuing existence of the loss of sight.

Our amending proposal recognizes that the severest of all the consequences resulting from the occurrence of blindness in the life of a working person is not the physical loss, the physical deprivation of sight, but rather the severest loss sustained is the economic disaster which befalls the newly blinded workman, the economic handicaps which are a consequence of blindness.

It is these consequences—the abrupt termination of pay, the diminished earning power, the drastically curtailed employment opportunities open to the recently blinded person, or to the person who has lived a lifetime without sight—these, and not the loss of sight, convert the physical disability of blindness into the economic handicap of blindness.

S. 1268 would provide a partial solution to the financial catastrophe which results from blindness; it would provide a floor of minimum

financial security for those who must learn to live again, to function without sight in a world of sight.

S. 1268 as Federal law would reduce the competitive disadvantages of sightlessness; it would provide a continuing source of funds to meet the extra "equalizing" expenses of functioning, blind, in a sight-structured society.

S. 1268 would be of immeasurable help to the worker suddenly confronted by the devastating effects of blindness—the discouragement of protected unemployment—the despair of a lifetime of unemployment—the shocking loss of independence—the hurts and humiliations of dependency.

S. 1268 would also provide minimum income security to the employed blind person, who has lived for years, or a lifetime, without sight, for such a person must pay an extra price in dollars and cents when he works as a lawyer or teacher, secretary, salesman, or factory assembler.

The usual blind person—with average abilities, with no particular skills or training—such a person works when he can find work, but frequently is the victim of the inexorable law of life for the disabled person—last hired and first fired—gainfully employed, when he is employed at all, on jobs with the poorest pay, the shortest duration.

For this person—the usual blind worker—the 20 quarters eligibility requirement in the disability law makes the protection of disability insurance unavailable to him—and our proposed 6 quarters requirement would be much more reasonable under the circumstances, under the special circumstances which confront such a person.

Mr. Chairman and members of the committee, we of the National Federation of the Blind believe that the social security programs which are intended to diminish the adverse economic and social consequences of advancing years or disabling impairments must never be considered fixed and inflexible in provision, for such rigidity may defeat the purpose to be served by such programs, while flexibility of approach and adjustment of provision to meet special circumstance may assure fulfillment of such purpose—the diminution of the hazards and heartaches of old age, the lessening of the discouragements and disadvantages of disability.

We ask this committee and the Congress, therefore, to liberalize the disability insurance law for blind persons, for the benefit of persons who may become blind.

Under existing law, a person must work in social security covered employment for at least 20 quarters to establish eligibility for disability insurance cash payments.

We ask you to approve S. 1268, to reduce this requirement to six quarters, in order that the benefits under the disability insurance program may be more readily available to more persons when blindness occurs; in order that blind persons, unable to meet the present requirements of employment for 5 years in covered work may be able to qualify for benefits under the disability insurance program.

Under existing law and practice, persons who are disabled and earn anything but the meagerest income are denied disability insurance payments as considered no longer sufficiently disabled and therefore unqualified.

We ask you to change this, to allow persons who are disabled by blindness to qualify for disability benefits and continue to receive

benefits even though they are employed, even though they are earning, in order that disability insurance payments may be available to them to offset the extra "equalizing" expenses incurred in living and competing without sight in an environment geared to sight.

And now, Mr. Chairman, I would like to speak briefly about the bill, S. 880, the Hospital Insurance Act of 1963, introduced by Senator Clinton Anderson from New Mexico in association with so many other Members of the Senate.

We of the National Federation of the Blind support S. 880, and we urge this committee and the Congress to act favorably upon it.

We believe that this proposal as Federal law would serve, in some measure, to mitigate the disastrous economic effect of a sudden accident or a prolonged illness in the lives of elderly men and women retired under social security.

How do the retired elderly meet their health care costs now?

They live on very limited income—income which the House of Representatives considered insufficient for minimum decent living, and so provided for a 5-percent increase in payments in a provision of H.R. 11865.

How do the retired elderly meet the shockingly high costs of hospitalization now?

Some may have savings to draw upon—to pay doctors' and hospital bills, to pay nurses' wages and druggists' charges.

But savings, so long in building , all too soon disappear.

Savings, so slowly accumulated during working years, and so carefully hoarded during retirement and used to supplement inadequate social security payments in retirement, all too soon disappear.

Some of the retired elderly may hold membership in prepaid hospital and medical insurance plans, or they may be covered by regular commercial insurance policies, or special insurance policies designed expressly for the elderly and their health care needs—which, they confidently believe, will fully meet their medical and hospital costs in old age—but all too often they discover, when sickness occurs, when health care bills are presented for payment, that the benefits available under their plan or policy are very limited, or that benefits are not available at all, because of exclusions or restrictions in their plan or policy.

Then, of course, Mr. Chairman, there are family reserves and the earnings of employed children to draw upon—the health care costs of the retired elderly may be imposed upon responsible relatives, and the money saved for the education of the young may be spent to pay the hospital bills of the old.

And finally, the retired elderly, faced with the catastrophe of impaired health or shattered bodies—with meager savings long since used up, without relatives to call upon, or with relatives unable or unwilling to help—for such people there is always charity—for them there is always public welfare or private charity.

We blind people have had much experience with this method of meeting our needs.

We have had centuries in which to become acquainted with the public welfare and the private charity methods of providing subsistence and survival assistance.

Too many of us—unable to obtain employment, although we wanted to work; although we were qualified and able to work, and asked only for the chance to demonstrate our ability to fill a particular job—too many of us have been obliged to apply for public or private help in our desperate need.

Too many of us know of the endless questionings and have experienced the exhaustive inquiries, the suspicious searchings for hidden assets and nonexistent resources when we applied for public or private help in our desperate need.

Too many of us blind people have had our families burdened with the cost of our care which the law imposed upon them—and we know too well of the resentments and antagonisms which are engendered when our needs are a drain upon family resources and earnings, when payment of our bills amounts to the denial of the hopes and plans of others.

We of the National Federation of the Blind endorse the social insurance method, contained in S. 880, for paying the price exacted for restored health and repaired bodies.

We much prefer the "advanced payments with established rights" method, to the public or private charity or responsible relatives method.

We support S. 880, because it would provide benefits specified and described in Federal law and regulation, rather than have such benefits dependent upon a social caseworker's uncertain whim or biased judgment.

We support S. 880, because as Federal law it would provide benefits by right to those who establish eligibility for them, in accordance with standards specified and described in Federal law and regulation, rather than have receipt of such benefits dependent upon a "means" test standard of proven poverty or demonstrated destitution.

But, Mr. Chairman, just as the men and women who are elderly and retired on social security must live and manage on very limited income have a need that their health care costs be met by the social insurance method, so too is it necessary that the health care costs of those who must live and manage on limited income because they are disabled and beneficiaries of the Federal disability insurance program be met by the same concept of social insurance enacted into law.

The limited income problem of the disability of insurance beneficiary is the same as that of the retired elderly person—for the amount of his payment is the same as the amount of the old-age benefit for which he would be eligible if he were to retire.

We would also remind you, gentlemen, that disabled persons must have medically determinable disabling conditions to qualify for disability insurance benefits, and oftentimes these conditions are chronic, requiring constant hospital and medical assistance, while elderly persons, although advanced in years, may still be robust and well during their years of retirement.

We of the National Federation of the Blind are peculiarly aware of the need for including disabled persons within the scope of S. 880.

As a result of the removal of the 50-year age eligibility requirement in the disability insurance program by the 1960 amendments to the Social Security Act, a number of persons whose disability is blindness, and previously recipients of aid to the blind, were able to qualify for disability insurance cash payments.

This change from a relief program to a "rights" program was cause for much satisfaction to these people—but they soon learned that there was no provision for their health care needs under the social security system.

These people soon learned that, if their disability payments exceeded their need, determined by public assistance standards, that they would even lose their entitlement to medical care protection under public welfare, and would gain no comparable protection as disability insurance beneficiaries.

Under such circumstances, the only recourse available to these people when they are ill or injured is general relief or private charity.

So, Mr. Chairman, the disabled person, rescued from the "means" test of public assistance by action of the 86th Congress, at last able to claim benefits rightfully his because he has paid for them during his working years, still must turn to the local welfare doctor when he needs medical help, still must go to the charity ward when he needs hosiptal care.

Gentlemen, the rescue was not a rescue after all.

Therefore, Mr. Chairman, members of the committee, not only do we urge you to approve S. 880 for the benefit and protection of elderly persons retired under social security, but we ask you to expand the scope of S. 880 to include disability insurance beneficiaries within its provisions.

Thank you, Mr. Chairman, for this opportunity to appear.

Senator TALMADGE. Thank you, Mr. Nagle, for a very fine statement.

(The following statement submitted by Mr. George E. Keane in behalf of the Industrial Home for the Blind was inserted in the record by order of the chairman.)

THE INDUSTRIAL HOME FOR THE BLIND.
Brooklyn, N.Y., August 5, 1964.

Hon. HARRY BYRD,
Chairman, Finance Committee, U.S. Senate,
Senate Office Building, Washington, D.C.

DEAR SENATOR BYRD: I know that you will have before you H.R. 11865 for consideration this week, amendment to the Social Security Act. I am taking this opportunity to put into the record of your hearing, if you will permit us to, the point of view of the legislative committee of the American Association of Workers for the Blind. It has been considered with interest and very real satisfaction at the convention of the American Association of Workers for the Blind, held in New York this past week and I have been directed by the convention to urge the Finance Committee to take favorable action on this matter. We think that it does much to improve and increase the benefits of our people throughout the country, but we were disappointed that some proposals which our association made were not considered in the House. However, you have before you a measure by Mr. Humphrey, S. 1268, which we hope your committee may consider in planning amendments to the House bill. Mr. Humphrey's proposals do two or three very important things for those who become eligible under the disability insurance of the act because of loss of sight. First, it reduces the quarter number to six, we think that this is important and in fact from an insurance point of view we have thought many times that there should be no requirements for periods of coverage when blindness occurs after the individual has been employed. It is logical regardless of the number of periods of coverage, that a permanent and total disability might occur anytime and should be insured against from a practical point of view. However, we understand that some period of employment must be indicated, but six quarters or a year and a half seems like quite a long time.

Mr. Humphrey's bill also provides for a change in the definition of blindness as it is now contained in the act so that it would coincide with the definition of blindness for assistance and for special additional exemptions for income tax.

This definition, 20/200, visual acuity in the better eye is one which is used throughout the States and it seems unfortunate to require a narrower definition simply because financial benefits are involved. In any case, may we urge your committee to consider Mr. Humphrey's approval.

GEORGE E. KEANE,
Chairman, Legislative Committee, AAWB.

(The following statement was made a part of the record at the direction of the chairman:)

STATEMENT OF PAUL KIRTON, AMERICAN COUNCIL OF THE BLIND, FAIRFAX, VA.

The American Council of the Blind is a young but rapidly growing organization, composed primarily of blind persons, with membership now numbering several thousand. We are incorporated under the laws of the District of Columbia and have as a primary purpose the improvement of culture, social and economic opportunities for all handicapped persons, the improvement of the public image of blindness, and the education of the blind in their obligations to the public. Our officers and directors serve on a volunteer basis and are elected from the membership as a whole. Most of the members are independent, self-supporting citizens who wish to donate a portion of their time and effort to make it easier for blind and other handicapped persons to achieve this same position of self-support and independence.

My name is Paul Kirton, I am an attorney in the Office of the Solicitor in the Department of the Interior, and a member of the board of directors of the American Council of the Blind. Our organization appreciates the opportunity to appear before you and express its approval of the basic ideas incorporated in the two pieces of legislation which you are now considering: H.R. 11865 and H.R. 9393. We are particularly appreciative of the provisions in H.R. 9393 which will again permit the retroactive determination of disability. We have no criticism of this bill to make at this time.

We also wish to express our support of the general principles incorporated in H.R. 11865. The recipients of social security definitely need an increase in benefits. The 5-percent increase provided in H.R. 11865 seems quite inadequate and it is not even keeping pace with the increased cost of living since the last increase in benefit payments.

The new provisions to permit the continuation of a child's benefits while in school are badly needed. All those persons who are concerned about the welfare of our Nation and the future of our youth are enthusiastically supporting this principle. However, the very piece of legislation which purports to make it easier for these children to go to college also adds the new subsection(s) to section 203 of the Social Security Act. For example the mothers' payment should definitely be continued while the child is in college. The woman who is able to go to work and who can find work will automatically do so because she can obtain a substantially higher standard of living by doing so. However, many women in the age group to have college-age children have neither the experience nor the skills to find work, nor are they in the age group to start a new employment career. By cutting off the payment of mothers' benefits there is a strong economic compulsion on the child to go to work in order to support the mother instead of going to college.

There is far more cause to believe that children 18 to 22 and in college will seriously consider marriage than those children under 18. It may be good public policy to discourage and even penalize marriage prior to the age of 18, but we feel that the policy of discouraging early marriage is less important than the encouragement of education. Therefore, if any change in attitude were to be made it should be in favor of continuing the social security payments regardless of marital status to the child in college.

The other provisions in H.R. 11865 are desirable and needed changes. We solicit your assistance in submitting these proposals to the Senate at an early date. We also wish to express our appreciation for this opportunity to state our views.

Senator TALMADGE. The next witness is Mr. Nelson A. Cruikshank, AFL–CIO, accompanied by Mr. Andrew J. Biemiller.

STATEMENT OF NELSON H. CRUIKSHANK, DIRECTOR, DEPARTMENT OF SOCIAL SECURITY OF AFL-CIO; ACCOMPANIED BY ANDREW J. BIEMILLER, DIRECTOR, AFL-CIO DEPARTMENT OF LEGISLATION; AND LISBETH BAMBERGER, ASSISTANT DIRECTOR OF THE AFL-CIO DEPARTMENT OF SOCIAL SECURITY

Mr. CRUIKSHANK. Thank you, Mr. Chairman.

Senator TALMADGE. We are happy to have you before our committee and you may proceed at will.

Mr. CRUIKSHANK. Thank you, Mr. Chairman.

Mr. Chairman, my name is Nelson H. Cruikshank and I am director of the Department of Social Security of the AFL-CIO, and together with Mr. Andrew J. Biemiller, director of the AFL-CIO Department of Legislation, I am appearing on behalf of the AFL-CIO. With us also is Miss Lisbeth Bamberger, assistant director of the AFL-CIO Department of Social Security.

Let me assure you at the outset that my presentation will be brief—and not only because of the commonsense time limitations established by the committee.

I will be brief because the distinguished members of this committee are informed in the field of social security. Some of you agree with us, and others do not. But there is no question that all of the members of the committee will know what I am talking about. Therefore, I will not waste your time by belaboring the fundamentals.

The position of the AFL-CIO on the legislation before you is simple and clear. Only 5 days ago, the AFL-CIO Executive Council, meeting in Chicago, took up this matter and adopted the following policy resolution:

> The AFL-CIO has supported every increase in social security benefits and coverage since the original enactment of the program nearly 30 years ago. Therefore, we welcome the modest increase in benefits provided in H.R. 11865, the social security amendments passed by the House on July 29. For people depending mainly on social security benefits averaging less than $80 per month, even $3 and $4 monthly increases are important. For those elderly for whom this bill will provide increases of only $2 a month or less, even this small amount will be welcome, although it is obviously not enough.
>
> So we will continue our fight to improve the social security benefit structure. And let the record show that we have likewise supported the increased taxes on wages and other income necessary to keep the system financially sound. This will continue to be our policy.
>
> This year's House-passed bill, however, must be evaluated not only for the needs it meets but for the needs it fails to meet.
>
> The ever-present danger of a hospitalized illness remains the most serious threat to the economic security of the elderly. And the only practical way to provide protection again this threat is by an extension of the social security principle.
>
> The public assistance—or Government relief method—has been tried. After nearly 4 years, the Kerr-Mills Act is meeting but a fraction of the need and it is still not in operation in all States.
>
> Private insurance, as the recent McNamara committee hearings so clearly documented, is providing protection of a minimum adequacy for only about a quarter of the elderly.
>
> Neither the incantations of the AMA nor the inflated statistical claims of the insurance industry have solved the problem of health care for the elderly.
>
> The AFL-CIO will continue its efforts to meet the problem through the social security method. We are in this struggle to win.

That ends the quotation of the executive council's statement.

We are pleased that H.R. 11865 provides for the inclusion of tips as a part of basic wages, for social security purposes.

Of course, all sorts of philosophical arguments can be made about the whole subject of tipping, but there is no indication that the custom is fading away. Therefore, it is essential to deal with the realities.

Tipped workers are obliged to pay income tax on tips. In recent years, especially, the Internal Revenue Service has exerted considerable effort to make sure of it. It is obviously a matter of simple justice that money taxed as income should also be part of a worker's wage base in calculating his benefits under the social security system. Anything less would be—and has been—an unjustifiable double standard.

In essence, then, we endorse the benefit provisions of H.R. 11865.

Now we come to the basic issue that is not encompassed by the bill before you and which we think belongs in the bill. We have no bombshells to explode here. We have been over the ground many times before.

We are here to say to you—as a matter of conscience, as a matter of deep conviction, on behalf of many millions of Americans who cannot come before you—we are here to say that hospital insurance for the aged must be incorporated into the social security system.

We make this plea in the firm belief that no member of this outstanding body has a closed mind and so we reject the cynical suggestion that we can gain nothing by bringing this issue before you. You have given us the opportunity to appear here, and we have no doubt that our case—even though it may be familiar—will be carefully weighed.

Let me start with a brief restatement of our basic position:

We say that many millions of elderly citizens, living on earned retirement, are each year reduced to penury by catastrophic medical costs.

We assert that private insurance programs, even when they have the best of intentions, cannot prevent this disaster.

We insist that charity—public or private—is an unacceptable remedy for independent, self-respecting Americans.

All this would sound hopelessly unrealistic, as it might have sounded 20 years ago, except for the dedicated, hardheaded work of men and women who refused to recognize the impossible.

There is now before you a sound, practical plan for national hospital insurance to protect the aged. The essence of the plan is an extension of the social security system which already provides for old-age benefits, disability benefits, widows' and orphans' payments, and so on.

That system, surely one of the great achievements of American society in this century, can and should—in our view—be extended to cover this great need for hospital insurance to protect the aged.

With respect to the details of this plan, we are flexible; we, too, have open minds. Some of the criticisms that were made of the proposal we first supported had real merit, and we welcomed them.

We are not committed to a formula, but we are deeply committed to a result. And that result, simply stated, is a hospital insurance program for the aged as part of the social security system.

Of course, there should be provision for the small and shrinking number of citizens who are not a part of the social security system.

Of course, there should be more generous programs of public relief for extreme cases. We always said so.

But when you get right down to the heart of the problem, you find that there needs to be a basic underpinning of Federal insurance—a base from which private insurance will grow, as it has grown in the area of pensions; a base from which public and private charity can, in cases of disaster, give meaning to humanitarianism; a base that will give to the aged this needed protection as a matter of right.

Very much to the point in this whole consideration is the report by the Senate Subcommittee on the Health of the Elderly, which was issued only a few weeks ago.

I am sure you are familiar with it, so I will only cite a few highlights.

Only half of the 18 million persons 65 or older had health insurance at the end of 1962. The committee charged that the figure of 10.3 million covered, claimed by Health Insurance Association of America, is "concocted" and "inflated," those are the committee's words.

Moreover, only one in four among the elderly has hospital insurance that meets the minimum standards of the American Hospital Association. More than half the policies pay only $10 a day for hospital accommodations. Even Blue Cross has faltered in the face of the problem, and so have the so-called State 65 plans.

This special report confirms what we in the AFL–CIO have long maintained—that the commercial insurance plans that do offer realistic benefits are simply too expensive—$500 to $600 a year for a couple, too expensive for the aged to afford.

One of the ironies in this whole debate, it seems to me, is that the AFL–CIO has been pitted, unwillingly, against those whose best interests we seek to support.

The private insurance companies—with a few exceptions— thunder that we are trying to rob them of business. We feel, at times, like throwing up our hands in despair. For the effect of our proposal would be to take the private companies out of an area they cannot possibly handle, and open up to them a vast—and vastly profitable—area of supplementary insurance.

We have said this before but I am going to say it again. How many wage earners could sensibly buy retirement policies from insurance companies before the Social Security Act was passed? And what could they get? Today, insurance companies—despite their cries of despair 30 years ago—are better off than ever before—and because the American citizen is today security minded.

We find the same sort of thing from the American Medical Association. Insurance against hospital costs, they keep saying, is "socialized medicine." The truth, of course, is exactly opposite. Cover the hospital bill through a Federal insurance program, and the patient will have the kind of "freedom of choice" he doesn't have now.

Mr. Chairman and gentlemen, I tell you frankly that a reasoned consideration of hospital benefits for the aged through social security has been handicapped by slogans and shibboleths. We in the AFL–CIO—and I take considerable pride in this—have tried to avoid that course.

We have not attacked anyone or any group, though at times the provocation has been great. We have trudged along, pointing to the need, and supporting our case with facts. We have been receptive to new ideas and new approaches, in a completely nonpartisan way.

We trust that logic, reason, and above all, the facts, will prevail in this committee. The need is real; the solution is logical; and these two

That concludes my statement.

should at last be combined in a legislative enactment.

Senator TALMADGE. Thank you for a fine statement, Mr. Cruikshank.

Any questions, Senator McCarthy?

Senator MCCARTHY. Mr. Chairman, I would like to ask Mr. Cruikshank his opinion on this matter. You will recall that when the Social Security Act was passed and one of the continuing arguments against it was that it would be extremely harmful to small businessmen. The fact is that as it has worked out it has been helpful to them in that they were able to retain employees who had the protection and the security of the social security program.

Is it not your opinion that the same would be true with reference to some kind of medical care or hospital insurance in that in most of your large corporations now, you have rather comprehensive programs of medical care for not only employees but also for their families, a basic national program would put the small and independent businessman who participated in it in a better position to attract workers and to keep them than the present practice gives to them?

Mr. CRUIKSHANK. I believe this is exactly true, Senator McCarthy.

It would give the small businessman a better competitive position in terms of labor, particularly skilled labor that is in short supply. He would be in far better position, when because of the very size of his business, and I believe this is in your mind, it is difficult for him to set up the kind of welfare programs that larger enterprises can do.

Senator MCCARTHY. From the point of view of the employee himself, particularly the highly skilled ones, and even professional people, the establishment of a basic national program would give to them a much greater measure of freedom to move than they have under existing practices.

Mr. CRUIKSHANK. That is correct: yes, sir.

Senator MCCARTHY. This could be a device for freeing people at a time when the mobility of industry is really becoming a new phenomenon; could it not, in American business and industry?

Mr. CRUIKSHANK. Yes, sir; and as you are well aware, I am sure, we did not really realize the extent of the mobility until social security pointed it out, the tremendous mobility of American labor which, I am sure you will agree, is part of its dynamic strength.

Senator MCCARTHY. The fact is that today in many industries, industry is more mobile than are employees.

Mr. CRUIKSHANK. Yes.

Senator MCCARTHY. There was a time when you could move the employees and workers more easily than you could move an industry. But in electronics and new light industries, you can move an industry really without regard to employees, you can set it up in the desert and wait for them to come to you.

Mr. CRUIKSHANK. Yes, sir.

Senator McCarthy. We need to recognize this in all of the welfare and supplemental benefit programs in the Nation.

Mr. Cruikshank. Yes, sir.

Senator McCarthy. I am sure you share my opinion.

Mr. Cruikshank. I am sure you are correct, sir.

Senator McCarthy. This would be a step which would, apart from the benefits which would come to the individual persons, be responsive to the changes that have taken place in the American economy and in the American society.

Mr. Cruikshank. We couldn't agree more, Senator. I am sure you are correct in your analysis.

Senator McCarthy. Thank you. That is all I have to ask.

Senator Talmadge. Senator Carlson?

Senator Carlson. I am one member of this committee who appreciates your opinion of this subject and am delighted when you appear.

In this pending bill there is a provision that will change the requirement for coverage from six quarters to three quarters to be qualified for payments.

Has your organization any views on that?

Mr. Cruikshank. We haven't taken a specific action in respect to that proposal, Senator; no. Our general position is that eligibility for benefits should be geared to participation in the system. That is our general position.

We have not taken any specific action with respect to this specific proposal.

Senator Carlson. It is a new policy, however, and that is the reason I was wondering if you had some views on it.

Mr. Cruikshank. Yes, sir; it is something of a departure from past policy. It is kind of a retroactive coverage or it goes in that direction of a retroactive coverage for persons which is a departure from the previously established policies which the Congress has followed and which we have supported.

Senator Carlson. If we follow through on this, as I remember the testimony, it would cover 600,000 additionally, if reduced from 6 quarters to 3 quarters, and then I assume the next step would be to include all who are over an age of 72 regardless of coverage, and I was just wondering what your view was.

Mr. Cruikshank. Well, we are not always too concerned about these arguments of what the next step can be. We think that the Congress has shown over 30 years a consistent record of protecting the system against the harmful effects of proposals that are not consistent with the basic principles of the system. But any step in this direction is a step away from the basic principle.

In effect, what it does in part is to transfer part of the load of that proportion of these people who are in need. Now, of course, they are not all in need, but it transfers the load of that proportion from the public assistance rolls that are supported by general taxation from the Federal Government and by whatever tax structure there is in the State, to the system that is supported by a payroll tax with a very minimum and almost below minimum requirements of participation of past participation in the system.

Senator McCarthy. There can, of course, be justification for it based on the statements just made.

On the other hand, I appreciate its effect upon the funds and the system as a whole.

That is all, Mr. Chairman.

Senator TALMADGE. Senator Hartke, any questions?

Senator HARTKE. Do you have any thoughts concerning the question of blanketing in all people at age 72 without regard to any contributions?

Mr. CRUIKSHANK. Well, we have opposed that consistently, Senator.

Now, we are not against these people getting benefits. Let me make it clear that many of them are in need of social security benefits and if this is the wish of Congress to give them the benefits provided under social security, bring them in for that purpose but reimburse the funds out of the general revenues of Government and not make it as a load on the wage-supported tax system.

Senator HARTKE. You feel that, in other words, the burden, at the present time, as far as these people are concerned is being borne by other tax means, isn't that right, generally speaking?

Mr. CRUIKSHANK. Well, insofar as it is being borne, yes, sir, and if it's desirable, if the Congress feels that the simpler and more justifiable way of meeting the need of all of these people as a group is to give them the benefits set forth in the social security system, then do so, but pay for it out of the general revenues of Government rather than kind of a retroactive drain on the trust fund that has been built up by a wage contribution or a tax based on wage.

Senator HARTKE. What percentage of those not covered under social security who are under 72 in your opinion are presently receiving some type of tax-paid relief?

Mr. CRUIKSHANK. I don't know, sir, the exact percentage of those over age 72 who are on public assistance. We could supply that figure for you.

Senator HARTKE. I think I have it.

What I was really coming back to is this: As far as these individuals are concerned at the present time they do represent a financial load upon some tax budget, isn't that true?

Mr. CRUIKSHANK. Yes, those in need do, yes, sir.

Senator HARTKE. That is right. And to a great extent in the local communities this is being borne by local property tax.

Mr. CRUIKSHANK. All sorts of taxes. In many communities it is a sales tax, and a property tax, and some States have an income tax and all the State taxes—of course, in addition to the Federal grant part that is paid out of general revenue to the Government which is on a progressive tax.

Senator HARTKE. Yes, I understand that. But in most cases these individuals 72 years and older, if the situation had been earlier as it is at the present time, would have been within the coverage of the present social security system, isn't that true?

Mr. CRUIKSHANK. Well, some of them would, but not all of them.

But if you make the provisions of the system retroactive you could assume that the same proportion of them would have been as the present proportion of the total work force is covered.

Senator HARTKE. Yes, that is right.

Which would have left a very few outside the scope of the social security system at the present time.

Mr. CRUIKSHANK. That is correct.

Senator HARTKE. These people do at the same time represent in society a large burden of the medical cost, isn't that true?

Mr. CRUIKSHANK. It is a substantial burden, yes, sir.

Senator HARTKE. So basically, whatever we can do to put these people in a position of at least some support will relieve the local tax situation.

Mr. CRUIKSHANK. Well, but the amount proposed isn't going to meet the total amount, $35 a month, which would be a small part of the need for those who are really in need. We have to remind ourselves, too, of course, Senator, if we are talking about the kind of a retroactive situation, that these same people—suppose the social security law had been written in 1935 as it now exists.

Senator HARTKE. That is what I said before.

Mr. CRUIKSHANK. You are quite right, most of these people, a high proportion of them would have been in it. But they also would have paid contributions during all these years.

Senator HARTKE. Yes, but this is through no fault of their own.

Mr. CRUIKSHANK. No, it is through no fault of their own and that is why we say it is right for them to have benefits if that group represents a real social and economic need. Let them have the benefit but it should not be chargeable to the account which is built up on other people's wages.

Senator HARTKE. What is the theory of that?

Mr. CRUIKSHANK. Well, the theory of that is the basic principle of our whole insurance system, that this is a system where people through contributions paid by themselves and their employers protect themselves against a wage loss. We could put it this way: we can say they didn't protect themselves; more properly as you point out, we can say they were denied the right to protect themselves.

They may well have wanted to be under the system so they were denied the right to have this kind of insurance. But the fact is they didn't have and the premiums were not paid by their employers and not themselves.

This is not their fault and those who are in need we certainly should meet that need and if in the best way the wisdom of Congress is to meet that need is to give them the social security benefit and supplementing as it will need to be in almost all cases of real need by further public assistance payments, but if the social assistance benefit as a flat amount to all of these people help meet the needs of this group, all right, but it should not be charged to the premiums on the wages that have been paid by people who did have the opportunity to participate.

Senator HARTKE. Mr. Cruikshank, do you support the provision of the bill which provides for the lessening of the required number of quarters in which there must be a required participation?

Mr. CRUIKSHANK. As I have stated, we have not, our organization, has not taken a position specifically on that part of the bill, but we feel that it is not consistent with the principles which we have always supported.

Senator HARTKE. I was going to say, there is not much more inconsistency in being in favor of reducing this to an ultimate three quarters than it is in just giving blanket coverage, isn't that true?

Mr. CRUIKSHANK. The line is getting pretty thin. You are quite right.

Senator HARTKE. It is coming down to the place where all you really have done is leave an avenue for a lot of bureaucratic determinations as to how many quarters have been taken into account, isn't that right?

Mr. CRUIKSHANK. No.

I think the number of quarters is pretty automatic. I don't think it would be a matter of bureaucratic determination.

There is also this to point out, however, that while this does reduce the minimum to three quarters it is progressive and gradually building up for this group under the provisions of H.R. 11865, where, after a number of years the requirement is again the same as it is now, one quarter of the time since 1950, or a maximum of 40 quarters.

Senator HARTKE. I understand that.

Mr. CRUIKSHANK. So it is on a short-term proposition.

Senator HARTKE. That goes back to a different problem. It goes back to your still working your way out of this group who were not covered before, isn't that right? By making the progression in coverage, gradually working back up again to the full amount required for an ordinary recipient, all you are saying in substance is that you are giving special treatment, whether you want to call it that or not, to this group who for one reason or another were not covered under social security benefits but who would have been covered if the law in 1935 had been the law in effect today.

Mr. CRUIKSHANK. That is correct, and it is termed in the bill of course, as you remember, the transitional arrangement.

Senator HARTKE. The truth of it is, if you would blanket these people in at this time, you would also have a gradual slackening or decrease in the number of recipients just by the attrition of age.

Mr. CRUIKSHANK. Yes, this is correct.

Senator HARTKE. And by 1980 practically none of these people would be drawing any benefits.

Mr. CRUIKSHANK. That is correct. But we still do not believe that that argues for paying the benefits out of the trust fund. Let's pay them but let's pay them out of general revenues.

Senator HARTKE. I haven't gotten back to how you are going to pay them yet. I am trying to get established first whether we are going to pay them at all.

But I was trying to establish whether you believe they should be paid out of the social security system at all.

Mr. CRUIKSHANK. No. For those outside of the system—you see in one way, Senator, I think in one way not only is this a departure from the social security principle, the social insurance principle, but in another sense it is in a departure from the public assistance principle.

When you get into the public assistance principle you do pay people who are in need, and whose need is demonstrable.

Now, this has always been the second line of defense against insecurity in the country when you mix the two, you take a group that

some are needy and some are not and I suppose most of them are, I mean a very high proportion of them are, but without regard to that need and give them this benefit then you are not either fish nor fowl, you are not either on social insurance or on public assistance.

Senator HARTKE. Let's come on back then to the present bills blanketing provision with the three quarters requirement. It is your position, then, that this is contrary to the overall principle upon which social security is based, is that right?

Mr. CRUIKSHANK. I think it is a departure from the principle. It is not the most serious departure but it is a departure, yes, sir.

Senator HARTKE. And you agree the line is very thin between doing that and complete blanketing in?

Mr. CRUIKSHANK. That is right. It is a thin line.

Senator HARTKE. You say you have not taken any position, but on theory at least you feel that you would be opposed to this type of approach?

Mr. CRUIKSHANK. Yes, sir, that is correct.

Senator HARTKE. Are there any provisions of the bill that you are opposed to either in principle or directly?

Mr. CRUIKSHANK. No, sir.

Senator HARTKE. Do you feel that the 5-percent increase is justified?

Mr. CRUIKSHANK. I think the 5-percent increase is needed, yes, sir, but it is inadequate, and it does not meet the major need.

You see, a 5-percent increase won't meet anything like, won't give anything like the additional security to an elderly individual or a couple that the protection against hospital insurance would provide.

Senator HARTKE. I quite agree with that. But you do feel that the 5-percent increase is needed?

Mr. CRUIKSHANK. Oh, yes, sir, every bit of an increase that is possible, that is within reasonable limits, every increase is needed by these people who are on social security.

Senator HARTKE. Is it your opinion that this 5-percent increase in social security will prejudice the ultimate end of obtaining some type of hospitalization program?

Mr. CRUIKSHANK. I think any increase in any of the areas in social security that adds to the cost makes it more difficult because you are adding a burden to the system but I don't think it would make it absolutely impossible. I think it would mean that the Congress would have to very soon face up to what limit on the wage base and what limit there is on the tax rate.

But I don't think that it would just close the door finally and forever. But I do think that all of these benefit improvements are in competition with each other in a sense for the social security tax dollar, and I don't think we can escape that.

Senator HARTKE. Do you feel that the 10-percent arbitrary limitation which has been placed by some people upon the fund is in fact a realistic one?

Mr. CRUIKSHANK. I don't think it will be particularly as time goes on, Senator. I think that the part of the wage dollar that people are willing to allocate to their economic security will expand. Many others, who are Government workers, including the elected officers, give a higher percentage for security than the 5-percent ceiling that

is provided in the 10-percent overall cost, and the railroad retirement people, the railroad system now is above that, and that is a public system.

So, our other two major public systems are already above the 5 percent.

Senator HARTKE. Then that brings us to this question: Do you feel that the provisions in this bill, for the 5-percent increase, which is the biggest item, from a long-range legislative viewpoint should preferably be denied to these individuals in the hope that it would bring forth ultimate hospital coverage at a faster rate?

Mr. CRUIKSHANK. Well, I don't, Senator, I don't think that choice is really before us, is it? I hope that it never is.

As we expand the concepts of social insurance I don't think we will have to say either/or on these things. There is this great problem of the insecurity of people, the big threat of this hospitalized illness hangs over them like a Damocles sword all the time, and no matter what we do with other benefits, improved benefits for widows, which we are pressing for, and improved benefits for disability which we are pressing for, and relaxation of the tightness of the definition of disability, no matter what we do, that threat is going to remain the most serious threat to the security of the elderly person in the United States today, and whatever other arrangements we make we are going to have that. We are going to have that, and Congress is going to face up to it sooner or later, I am confident that they are, and so I just can't conceive of a situation where it is one or the other because we are not going to say we are going to take care of their dollar income and disregard this other threat.

I just don't believe that the Congress of the United States is going to say that to the elderly of America.

Senator HARTKE. Let me make the observation that this is an either/or proposition in this Congress at least.

Mr. CRUIKSHANK. I don't quite agree with that, Senator. I think there are a number of arguments that can be made, some of them have been suggested and talked about, and even within the 5-percent limitation you could have a hospital insurance provision and have a choice between one or the other and then people could decide what they need to meet their greatest needs.

Senator HARTKE. Let me say to you, I will permit you to indulge in your own beliefs, but I feel very firmly, from talking with the Ways and Means Committee members, that there is in this, a threat of using this hope for a hospitalization plan as a means of denying to these people what I think are some legitimate benefits.

Mr. CRUIKSHANK. Well, Senator, I suggest that as your committee thinks of this further and as you analyze it further, as you hear further witnesses and you get into executive sessions, I believe that it is thoroughly within the competence of this committee to devise a combination that would be workable.

Senator HARTKE. Do you subscribe to the so-called Ribicoff approach of a choice of benefits?

Mr. CRUIKSHANK. Well, I haven't seen——

Senator HARTKE. I haven't, either.

Mr. CRUIKSHANK. I know what has been talked about in a general way. I think that the idea of an option of this kind, if it is properly

protected, and I believe Senator Ribicoff in his past experience as Secretary of Health, Education, and Welfare and all, would want to protect it, I think if it is properly safeguarded as a thoroughly workable thing that it would be an acceptable middle-of-the-ground approach; yes, sir. I believe this committee can work out that kind of an approach.

Senator HARTKE. Let me say to you, and I would beg of you to consider this before you make this decision in your own mind, isn't this really a form of voluntary hospitalization, making the social security system in effect voluntary? In all reality and practicality, if you put this choice to most people they are going to take the gamble that when the time comes I won't be sick. Social security was made mandatory because otherwise a man will take the gamble that he won't be needing it, that he will be all right and be able to take care of himself in his old age.

Mr. CRUIKSHANK. No, sir; I don't believe that people having the choice of protection against the great risk of high-cost hospital illness—having a chance to have that protection would forgo that great amount of protection for a small amount of cash increase. I think that the vast majority of them would take the hospital protection because, Senator, they are aware all the time of the great threat that this is to them, and they don't want—this might just be a difference of opinion about how, about the way people react.

Senator HARTKE. I have never seen anybody yet who anticipates he is going to be sick.

Yes, there are going to be 55 sick people out of 56, but there is always the one who thinks he is going to be the man who is in perfectly good health.

Mr. CRUIKSHANK. You have 120 million people in the United States who have decided they want to protect themselves against this. This kind of insurance is the most popular insurance there is in America today, and if people want to take that risk, then why Blue Cross, why all of these private insurance plans that have been so popular, and would be popular among the aged if we could set them at rates that they can buy?

No, sir. It think people have proven that they are ready to forgo the cost of this. They are even buying the very poor kind of insurance that is available to them because it is the best they can get.

Senator HARTKE. Let me say to you, I am not interested in taking any road toward any voluntary social security or voluntary hospital insurance plans.

I think they are fraught with danger of the highest order and I would hope we might come up with something satisfactory that is a little bit more of a realistic approach to meeting this very serious economic problem.

Mr. CRUIKSHANK. Well, sir, I wouldn't want to judge it without seeing it in detail. It would be an easy mistake to make to draft something that did have the dangers of voluntary selection in it but I also think that with careful planning and devising that the committee would work out a program that would give an option which would avoid those dangers and when you have done that, I am only saying that the principle we think is acceptable, we would like to see

something worked out but it would have to have those safeguards to avoid the very dangers which you pointed out.

Senator HARTKE. Let me say to you, sir, I think the organization which you represent has done yeoman service in this field of hospital care, and I would really sincerely request of you, because of the influence that you would have in this field, that you give serious consideration before you take a definite step of approving such a voluntary program. At this moment I feel frankly, that it is fraught, as I said, with the highest danger. I think it would lead to disillusionment for many of our older people, and I would sincerely request of you that before you approve any voluntary hospitalization plan, voluntary choices, that you give this matter serious consideration, sir.

Mr. CRUIKSHANK. We assure you we will, sir. We will want to see it and we will want to look at it very carefully and we will keep in mind the caveats that you point out.

Senator TALMADGE. Senator Ribicoff?

Senator RIBICOFF. Mr. Cruikshank, Senator Hartke raised a point that hospital care for the aging would jeopardize the so-called cash benefits of H.R. 11865.

As a matter of fact, isn't the opposite the case, that H.R. 11865 is a method of assuring a long delay in the adoption of health care for the aged under social security?

Mr. CRUIKSHANK. Well, I think that some of the—I am not quite sure I understood your question, Senator.

Senator RIBICOFF. Let's start leading up to it.

At the present time the tax rate without the so-called Mills bill eventually takes the overall tax up to 9.25; is that correct?

Mr. CRUIKSHANK. Yes, sir.

Senator RIBICOFF. And isn't it generally recognized that once we get up into this range of taxation for social security, we are reaching a most difficult area to try to get additional benefits because of the size of the tax?

Mr. CRUIKSHANK. Yes, sir.

As I said, every kind of benefit is in competition with every other kind.

Senator RIBICOFF. With every other kind of benefit. So we are really dealing with a precious one-tenth of 1 percent to try to determine what shall we get for the people of America that would be the greatest benefit with what remains in this precious one-tenth of 1 percent?

Mr. CRUIKSHANK. Well, sir, only in part—you add all of the provision of the Anderson-King bill onto H.R. 11865 if you raise the wage base to $6,600.

Senator RIBICOFF. That is correct.

Mr. CRUIKSHANK. And the wage base of $6,600 barely keeps pace with the wage base established in 1958.

Senator RIBICOFF. Do you think it is practical at this time to raise the wage base from $4,800 to $6,600?

Mr. CRUIKSHANK. Economically, I think it is practical. Legislatively, in this particular moment of time it would be extremely difficult.

Senator RIBICOFF. Extremely difficult.

I think the whole field is difficult, it is difficult enough to try to get a program raising it to $5,400, but to try to raise it to $6,600 at the

present time, may I respectfully suggest, would be practically impossible.

Mr. CRUIKSHANK. In a short time, yes, sir.

Senator RIBICOFF. At this time.

Mr. CRUIKSHANK. I think so.

Senator RIBICOFF. All right.

Now, what do you think of the benefits under H.R. 11865? I mean how good are they?

Mr. CRUIKSHANK. Well, as the executive council statement said, any benefit is good in that these people are already on very low incomes, but as the statement also said, it is not good enough. It does not keep pace even with the rise in the cost of living since the last benefit increase went through. It falls even far shorter of the increase in the standard of living that has gone through since 1958, and for those in the lower brackets of benefits, that is, there are about 1,700,000 who would get $200 a month and less.

Senator RIBICOFF. These are pretty small. There are some that would get between $5 and $6, which would be more meaningful.

Well, the $2, let's assume we have a man and a wife who got $40 a month, his wife would get $20 and let's say he would retire at 62 so his benefits are cut 20 percent for the lower retirement option, so the wife then would receive 5 percent on $18, she would receive something like 80 cents, it would be rounded, she would get 80 cents a month, that is correct. In the present cost of keeping body and soul together how good is 80 cents a month?

Mr. CRUIKSHANK. Your question answers itself, Senator, and you have to also remember that of this number in the bottom scale here there would be, we calculate, about 600,000 of them that would have this small increase wiped out because it would be taken off the public assistance.

That is there are a lot of these people down at the bottom of the benefit scale in social security that are also getting public assistance so that in the case which I am sure you recognize is an extreme case that you cited, the 80-cent-a-month person, or even those up to $2, many of them, remember, have that amount taken off their check in the public assistance.

Senator RIBICOFF. All right.

Let's go on the highest.

Mr. CRUIKSHANK. So there wouldn't be anything. There would be no net advance. This is not a great amount, let me—I don't want to overstate this. This would be less than a million probably all told out of 19 million beneficiaries, but it is important certainly for that number of people and they are the people at the bottom of the scale.

Senator RIBICOFF. Now, let's go to the upper limits of the Mills scale.

The upper limits of the Mills scale would be $6.40.

Mr. CRUIKSHANK. Six dollars and forty cents.

Senator RIBICOFF. Six dollars and forty cents, so we are dealing with a range of eighty cents to six dollars and forty cents.

Mr. CRUIKSHANK. Yes, sir.

Senator RIBICOFF. Now, how long have you been working with people who work for a living: how many years?

Mr. CRUIKSHANK. About 40. I have been working with people working for a living.

Senator RIBICOFF. You must have a pretty good idea of their thinking and their philosophy and their needs.

Mr. CRUIKSHANK. I think I have. We have tried to keep in touch with it, Senator, we have tried to be realistic.

We certainly believe that our organization reflects the needs of the working people of America.

Senator RIBICOFF. Now, as you look at the people with whom you deal, the aged people who work for a living, you get to the question of relative needs.

Let's take the range of cash of 80 cents to a high of $6.40 that they would have for themselves.

Now, as against this, the problem of what happens to Mary or John Jones at 65 when illness strikes. What is their greatest need, the 80 cents to $6.40 or to take care of the basic health costs when illness strikes Mary or John Jones?

Mr. CRUIKSHANK. Very much the question of the illness is certainly the greatest need, and this is why both our conventions last November and reiterated by our recent meeting of the executive council pointed out that this, the threat to the economic security of elderly people in America is this threat, that is put, if I may paraphrase your question, please, for a moment, when if a person has the matter of $6.40 even added to his income it doesn't add anything like the amount to his security as it would if you relieved him of the threat of a thousand or $1,500 hospital bill.

That is when he is budgeting his income against his needs, the protection against this possible high cost is much more meaningful than this, even the $6.40.

Senator RIBICOFF. Let's look at the aged people in America, let's look at what our society is based on.

In the group with basic problems and needs on the lower end of the economic scale, you have individuals who are on public assistance of one type or another; isn't that correct?

Mr. CRUIKSHANK. Yes, sir.

Senator RIBICOFF. So basically their needs are taken care of, they are either taken care of by Government or by private charity or subsidization of those who can afford to pay higher rates in the hospital to give them the free care they can get, or by Kerr-Mills; is that correct?

Mr. CRUIKSHANK. Well, they are taken care of.

You are not suggesting adequately, I am sure.

Senator RIBICOFF. No; I mean but basically they are provided for.

Mr. CRUIKSHANK. Yes.

Senator RIBICOFF. No; you have got those in the upper income group who are taken care of by themselves but not quite because when you are over 65 you are able to deduct from your tax bill the total cost of medical expenses; is that correct?

Mr. CRUIKSHANK. That is right; yes, sir.

Senator RIBICOFF. So if a wealthy person had a thousand dollar doctor or hospital bill and he put it down in his income tax he would get a deduction of $1,000 and that bill would only cost him $200.

Mr. CRUIKSHANK. That is correct.

Senator RIBICOFF. So basically the total society, our Uncle Sam, really pays the hospital or medical bills of those who can afford to pay hospital bills in the final analysis over 65.

Mr. CRUIKSHANK. Yes, sir, it pays a large portion, depending upon what tax bracket they are in; that is correct.

Senator RIBICOFF. So when people talk about people subsidizing the rich, society is already subsidizing them by giving them preferences in these tax laws.

Mr. CRUIKSHANK. That is correct.

Senator RIBICOFF. I would like to give you some examples, in your experience, let us say you have got the same John Jones who has worked all his life for the Ford Motor Co., General Motors, Du Pont, Royal Typewriter, United Aircraft, any of the big companies of America, and he retires with his wife at the age of 65. Now, generally from your experience with these people, an aged person, a person 65, and a wife who may be 63, 64, and 65, what generally is their economic condition from your personal experience with them?

Mr. CRUIKSHANK. Well, the group that you describe, their economic condition has a fair degree of security. Many of them own their homes, most of those working for the kind of industry that you used to illustrate would have a private pension plan.

They would be at the top of the roll in the social security payments, retiring now such a couple would have a primary benefit of $124; if the wife were 65, she would get $62 in addition; $186 social security for the couple, and the typical couple would have some savings, some life insurance, and they would be able to live in decency, and dignity, and self-respect, and a fair degree of security until a serious illness hit them, and then all their planning would be knocked into a cocked hat.

Senator RIBICOFF. From your experience with Kerr-Mills—now this group of people we are talking about represent the bulk of the aged people of America.

Mr. CRUIKSHANK. Well, they are typical. I don't think they are the bulk in numbers, Senator, but they are typical of the more fortunate and of the high wage earner; they are typical of the worker working under a collective bargaining agreement in this country, generally speaking.

Senator RIBICOFF. From your experience with these people, do these people want to go to charity for help?

Mr. CRUIKSHANK. No, sir; that is exactly what they want to avoid. and that is why they are so strong in support of a proposal of the kind in the King-Anderson bill, because they look upon this as preventive; they do not want to be forced on relief. They do not want to have to go to their children for help. They want to have something that will underwrite this security which they have earned by their individual action, their work, their dedication, their skill, their training, their years of work, and their contribution to the social security system.

Senator RIBICOFF. Let's take this couple that you are talking about; they have got $186 total at the top, they have got their own home.

At 65 the chances are the mortgage has been fairly well paid off, and then John Jones goes to the hospital for 30 days.

What would you estimate the total amount of his hospital bill would be?

Mr. CRUIKSHANK. Hospitalized illness for 30 days would run close to $1,000 in most cases.

Senator RIBICOFF. The average in this country today is probably over $40 so it would be about $1,200 for 30 days.

Mr. CRUIKSHANK. Yes.

Senator RIBICOFF. For 60 days it would be $2,400, is that correct?

Mr. CRUIKSHANK. Not necessarily double because some of the high-cost days are always the first days in the hospital. It wouldn't be far from double, you are right. It would be close to that.

Senator RIBICOFF. To this person you are talking about, what would a $2,000 hospital bill do to his financial condition?

Mr. CRUIKSHANK. It would probably force him to take a mortgage on the home or to forfeit some of his life insurance or undermine his security which would be, he would have to go into his capital assets, which would then increase his insecurity for years to come, and one of the big problems, and you may be leading up to this because you, too, have had experience in working with people in your public life, is what happens when that second illness hits.

Senator RIBICOFF. Let's get to the mortgage.

Can a person at 65 who isn't working get a mortgage?

Mr. CRUIKSHANK. Well, you can sometimes, and sometimes he can't. He would eventually have to make an application for public charity or relief of some kind after he had exhausted his assets.

Senator RIBICOFF. Well, from my experience banks really don't give mortgages to try to foreclose. They do not want to foreclose. They hope to pay off. I don't know a bank that will give a mortgage for a person who doesn't have earnings to pay off a mortgage.

Mr. CRUIKSHANK. That is right.

Senator RIBICOFF. So the chance of a person 65 getting a mortgage is pretty slim.

Mr. CRUIKSHANK. That is right.

Senator RIBICOFF. Is pretty slim really when you start to think of it. So the chances are he would have to liquidate his home to take care of the illness of himself and his wife at the same time or a second illness.

Mr. CRUIKSHANK. If they have life insurance that is often the most readily obtainable money.

Senator RIBICOFF. Let's get down——

Mr. CRUIKSHANK. But that undercuts his future security.

Senator RIBICOFF. From your experience, when John and Mary Jones are 65, what sort of family structure would they usually have?

Mr. CRUIKSHANK. Well, the chronology of the normal family, the usual family, is that these high costs come to the elderly couple just about the same time the costs of education come to the children of their children, and when they have to, as many times they are forced to do by an illness, turn to their own children, then that middle-generation group has forced on them the hard choice as to whether they are going to give young John and young Mary a better chance than they had or take care of mother and father.

This is a cruel choice.

Senator RIBICOFF. From your experience, an illness that falls upon an aged couple really affects more than an aged couple but affects three generations.

Mr. CRUIKSHANK. It certainly does.

Senator RIBICOFF. Grandmother and grandfather, the children, and the grandchildren—so, therefore, the impact of a serious illness falls on all three alike.

Mr. CRUIKSHANK. That is very true; yes, sir.

Senator RIBICOFF. From your experience, what weakness do you see in Kerr-Mills as it affects this group of people in our society?

Mr. CRUIKSHANK. Well, the basic weakness of Kerr-Mills, of course, is that it does nothing to prevent the situations which you are describing. It forces people to exhaust all of these other resources before they are eligible for Kerr-Mills.

And instead of being a backstop when other things have failed, it really forces people into these other arrangements which are so catastrophic to the family structure and security and peace of mind.

Senator RIBICOFF. So, then, if you were looking at the problems of the elderly in America, you would agree with Secretary Celebrezze, would you, that the No. 1 problem and the No. 1 objective to try to solve, is the problem of illness and hospitalization of our elderly people?

Mr. CRUIKSHANK. Yes, sir; this is our position exactly; yes, sir.

Senator RIBICOFF. Do you see under the present bill we have before us anything in this bill as presently constituted that solves the problem of our aged population to take care of their health needs?

Mr. CRUIKSHANK. No, sir; it leaves that biggest of all problems untouched and unresolved.

Senator RIBICOFF. This is what we are faced with 2 weeks, less than 2 weeks before Congress adjourns.

Mr. CRUIKSHANK. Unfortunately; yes, sir.

Senator RIBICOFF. How long have people been fighting for health care for the aged now in America?

Mr. CRUIKSHANK. Well, at least 14 years now.

The first specific proposal of this kind, I believe, came in about 1950 or 1951. The first bill that was introduced in the Ways and Means Committee was 7 years ago this month by Congressman Forand, and we have gone through various hearings. There was a White House conference on the subject which incidentally supported this approach. There have been all kinds of efforts made to find some other substitute and none of the substitutes has worked.

The need grows and the logic becomes more impressive as the only way to meet this project.

Senator RIBICOFF. How long has it been since you have been on the Hill representing the AFL-CIO?

Mr. CRUIKSHANK. I have been representing the AFL-CIO in this area since 1944 with one 2-year leave of absence when I was in the Foreign Service—2 years.

Senator RIBICOFF. So basically you have a pretty good feel of the realm of the probable and the realm of the possible.

Mr. CRUIKSHANK. Well, my primary work isn't in the legislative field. I work in the field of legislative proposals, but I rely on my friend, Mr. Biemiller, to sense the feeling of the Congress.

Senator RIBICOFF. Let me ask this question of Mr. Biemiller, with whom I have served in the House of Representatives and who is a knowledgeable man in this field. In an exchange between Secretary Celebrezze and myself, we came, both of us, came to a general conclusion that the passage of this Mills bill as we now have it before us could well mean the putting off of an effective health care for the aged under social security for a decade or about 10 years.

Do you foresee such a danger if this bill goes through as it stands now?

Mr. BIEMILLER. I wouldn't make the statement quite as flatly as you and Secretary Celebrezze seemed to have agreed. I certainly agree it would endanger very seriously the move for a far-reaching program of hospital insurance for the aged.

I think it would certainly complicate the problem endlessly, and your period of a decade may be as good as anybody's, because I am sure you would be the first to acknowledge when you get into this area of trying to predict the date of the enactment you can get yourself shot down.

Senator HARTKE. Will you yield?

Senator RIBICOFF. Of course, the Senator from Indiana and I thoroughly disagree on this proposal and we will have to fight it on the floor.

Senator HARTKE. I want to get a clarification here.

Is it your opinion, or the opinion of the AFL-CIO, that it would be better to lay aside this 5-percent increase in the provisions of this bill from the House?

Mr. BIEMILLER. What we said it would be much better to do would be to find a way of taking the bill that came from the House and adding to it an intelligent program of hospital insurance.

Senator HARTKE. All right.

I think where the Senator from Connecticut and I can agree is that the chances of adding the King-Anderson provisions to this bill for all practical legislative purposes are not only in serious doubt but very near an impossibility. Therefore, I think it is important that we at least have an expression to some extent as to whether or not you approve this bill, whether you endorse the benefits of its provisions, or whether you would prefer that we lay this bill aside.

Mr. BIEMILLER. I don't think that is the only alternative you have in front of you.

Senator HARTKE. It is the only alternative I have in front of me at the moment.

Mr. BIEMILLER. I think there are other aspects of the legislative situation that might result in producing a bill that would not necessarily be King-Anderson but which would produce, as you yourself indicated a good option plan, and I don't think that that should be overlooked as a possibility.

The Senate has already once voted.

Senator HARTKE. Let me ask you this then.

Has the AFL-CIO taken a position endorsing this so-called option plan which I understand Senator Ribicoff intends to propose possibly at a later date?

Mr. BIEMILLER. We have said in our statement that we are flexible and are willing to look into this matter very carefully and if there is the only—if this is the only way you can get hospital insurance we would certainly go along with it because we still maintain that hospital insurance is the No. 1 need of the elderly of this country.

Senator HARTKE. I understand that.

Do you feel this matter should be passed upon without hearings and that we should proceed in spite of all the difficulties we are having on the medical evidence here? Here we are trying to consider a social

security bill and we are taking up a provision which is not in the bill, and we are having a group of witnesses here who are scheduled now through Friday, at least, of this week, with a proposal to attempt the adjournment by August 22.

Do you really honestly and conscientiously feel that this bill can be passed with any kind of proposal of that sort before that time?

Mr. BIEMILLER. I have seen the Senate of the United States move with the most amazing speed in the world on some very difficult problems, and I am convinced that there is a majority in the House of Representatives who are in favor of hospital insurance for the aged.

Mr. CRUIKSHANK. It wouldn't be unusual, of course, for some kind of middle ground or some other proposal to come out as a result of your deliberations.

The Kerr-Mills bill itself was born exactly that way; there were no hearings on Kerr-Mills.

Senator RIBICOFF. In other words, let me put it this way, what position would you like to see taken in the U.S. Senate?

Would you like to see the U.S. Senate take the position of accepting the Mills bill or would you like to see the U.S. Senate make a fight to try to get not only this but to try to get medical care for the aging under social security?

What would you hope to see in the U.S. Senate?

Mr. CRUIKSHANK. We would like to see the Senate face up to the basic issue and the most difficult problem and the No. 1 threat to the security of the American people.

If you are pressed for time that isn't your fault, that isn't the Senate's fault, it isn't this committee's fault.

I personally don't like to see the Senate of the United States put in a position where just on the argument of time they are shut off from considering and meeting the major No. 1 problem.

That isn't your fault. It isn't any member of this committee's fault that you only have 2 weeks. But as my friend Andy says, the Senate can move with great speed, and it can move, and the deliberations can be serious and meaningful, and you can grapple and come to grips with the problem, and this is a problem of the elderly people of America and we certainly hope there is no intention of ducking that problem.

I believe you can and will face up to it.

Senator RIBICOFF. Now, a lot has been talked about an option.

Suppose there was an optional program which did a lot better than the Mills bill in cash and it gave an option to everyone at 65 to take the cash or to take part cash and substantial health care for the aging under social security, all financed with a top limit of 10 percent, 5 and 5, would such a program meet with your approval?

Mr. CRUIKSHANK. Well, Senator, I think there ought to be some safeguards to that. I think that for one it ought to be an opting-out program that the individual should have to make his choice to opt out of the system.

Then I think there should be safeguards so that you don't get all the bad risks, the people who are just about to be ill or the people who are already ill but I think those things can be worked out.

Senator RIBICOFF. This is very simple.

Mr. CRUIKSHANK. This can be worked out.

Senator RIBICOFF. This is very simple. I am talking about the general program.

Mr. CRUIKSHANK. The general program would be acceptable, yes, sir.

Senator RIBICOFF. That would be acceptable.

Senator HARTKE. The 10-percent limitation would be acceptable.

Mr. CRUIKSHANK. I say this, you could work out an acceptable program within the 10-percent limitation.

Senator HARTKE. But as I understand Senator Ribicoff's proposal was that this would be a 10-percent limitation.

Senator RIBICOFF. The program I have would be done within the 10-percent limitation.

Mr. CRUIKSHANK. Yes, sir, and within the $5,400 wage base.

Senator HARTKE. Which would set into the social security system for all time in the future, a 10-percent limitation in theory.

Mr. CRUIKSHANK. Not necessarily.

Senator RIBICOFF. No, just as the bill we are passing on now sets no limit for the future.

Senator HARTKE. For all practical purposes it would.

Senator RIBICOFF. What does the Senator want, health care for the aging or not?

Senator HARTKE. I want something, a real plan not an illusion.

Senator RIBICOFF. The Senator from Indiana is talking about illusions. He is willing to accept a provision out of the House that forecloses medical care.

I am unwilling to do that.

Senator HARTKE. This is the point I have never gotten clear from Mr. Cruikshank yet. I think you asked him this question, and we still haven't come to an answer. He feels there isn't any choice, but if there is a choice of this 5-percent basis and this House bill, or nothing, do you feel it is preferable for us to vote nothing?

Mr. CRUIKSHANK. I would say if it was that choice, if it came down to that choice, which I don't believe it has come, I don't think that is the alternative. You may feel it is, Senator, but I think there are other Senators who don't feel that way and I think that there are a lot of us who are not Senators who feel that way, that that choice doesn't have to be made.

But if that hypothetical situation should arise, if we come alone with just a $1 benefit or 50 cents, I don't think we would say no, but that isn't the choice that is before us, I respectfully submit.

Senator HARTKE. I think as a practical matter you have to face up to this: Assuming you can pass some type of bill, and assuming the King-Anderson bill or the Ribicoff bill in the Senate, wouldn't the conferees in the Senate be reluctant to withdraw their position from that bill, and as a practical matter, wouldn't you hit a conference committee on the other side which would not accept it?

The net result to older Americans, about 18 million social security beneficiaries, is that you might have a wonderful campaign issue for some people to go back home on. They could say, "I voted for social security and the hospital plan under social security, but the House of Representatives conference committee wouldn't agree to it." But the net result is you cut about 18 million people out of benefits, and this is what I am very, very fearful of. To me this is a striking definite

probability, not just a possibility. I ask Mr. Biemiller, and I address this to you, is that not a position which you can foresee would be the likely result?

Mr. BIEMILLER. It is a possible situation that could develop, and under such circumstances as Mr. Cruikshank inferred, there is always a possibility of one House or the other receding from its position.

I have seen that happen many times, also.

Senator RIBICOFF. I have no further questions.

Senator HARTKE. Senator Bennett?

Senator BENNETT. Mr. Chairman, I would like to take the witness back to another item on which he testified outside of this highly controversial field.

We Republicans have been interested sitting here today silent while our Democratic colleagues are fighting over the dilemma in which their party finds itself.

But I would like to talk to you a minute or two about the tipping provision in the bill.

Senator HARTKE. Would my distinguished friend yield at that point?

I would like to see my dear friends from the opposite side, if they have any suggestions as to working out this dilemma, which is a problem not of the party but of the people, come forward with a proposal to meet this serious problem.

Senator BENNETT. Well, of course, the Democrats always want the Republicans to pull their chestnuts out of the fire.

Senator HARTKE. Let me point out to my distinguished friend that if this is a problem of the Democrats only, then we would have to write a new provision in the social security law saying these benefits would go only to Democrats.

I thought this benefit was going to all the people, and that some people who are drawing social security still believe in the principles, whatever there are of principles, of the Republican Party.

Senator BENNETT. Well, the chairman, the acting chairman, has made it clear that he fears the stubbornness of the Democratic chairman of the House committee, and while we Republicans have places on these committees, you outnumber us 2 to 1, and the point I was making is that so far today this discussion has represented an argument between two members of your party.

Senator RIBICOFF. Will the senior Senator yield for a second?

Senator BENNETT. Yes.

Senator RIBICOFF. I think we can all take notice of the fact that while it is supposed to be a problem of the Democratic Party in the House Ways and Means Committee not one of the Republican members of that committee voted for health care for the aged under social security and quite a few Democrats did.

Of course, I don't know what the average would be on the Senate side, how many Republicans would vote for it, but I have a hunch that the average would be the same as in the House.

Senator BENNETT. It has been interesting to me over the last 2 or 3 years to notice that whenever a program of the administration fails it is always the Republicans who killed it, even though the administration has a 2-to-1 majority in our House, and a 3-to-2 majority in the other House.

Those of your party who oppose it are forgotten, those of our party who oppose it are always the villains.

We are always the ones who kill it.

Let's talk about tipping. You have testified that you believed that income received in the form of tips should be used in calculating the base.

Mr. CRUIKSHANK. Yes, sir.

Senator BENNETT. I think there is a great logic behind that argument. But I think the problem we face in this committee is slightly different.

The employer has nothing to do with that income. He doesn't set it, he doesn't handle the money, and yet the proposal would make him pay a tax out of the income he receives otherwise for his share of the income which the employee receives, and so I lead up to my basic question.

Is it logical to assume that tip income is self-employment income?

Mr. CRUIKSHANK. No, sir; I don't think it is. The income that a person receives in tipping is at the establishment of the employer, using all the employer's facilities. All the other relationships between employer and employee are the same for a tipped employee as for one who receives it in a direct wage.

I think, sir, it is really more logical to think of this as a wage in lieu of another wage, and we know that in the practical circumstances of the industries where tipping is a prevalent practice, that wage scales are either formally or informally based on the expectation of tips.

So, let's suppose that here is an employee who is considered by the employer as worth in the wage market about $75 a week, let's say. But he only pays him $50. Why? Because he says, "You will make $25 in tips."

Now, the employer is saved not only that $25 in wage, but he is saved the social security tax on that wage, for the differential.

So that wages are set and maybe I share your view, and maybe I don't, I wish we could get rid of the whole system of tipping but it is here and it is recognized.

It is embedded in our wage structure. Wages in industries where tipping is prevalent reflect that. Of course, if they didn't there would be differences in costs and the whole structure would be different, but this system is embedded and the employer is saved paying the tax on that portion of the wage, and all we are proposing to do is that he pay that share upon the tip.

Senator BENNETT. Yet the employer would be called upon to make a statement to the Government regarding an amount for which he is going to pay a tax over which he not only has no control but with respect to which he has no knowledge.

Mr. CRUIKSHANK. Well, he only has to certify that the statement that the employee gives him is correct for these purposes. He takes the employee's statement of the amount of tips under the bill. He doesn't have to say that he knows as of a certainty that these amounts were received. He only accepts that the employee gave him and the employee must file in writing with him the statement of the tips, and then only if they are in substantial amounts.

You understand, if they are less than $20 the whole thing is off.

Senator BENNETT. It seems to me that since the difference in the scale or the amount of tips will vary from employee to employee, presumably on the basis of the type of service the employee renders, that this is self-employment income. This part of his income is a part which the employee controls. Therefore, probably a more satisfactory solution would be to consider it self-employment income and let the employee pay the social security tax on that portion of his income and on that basis and leave the employer out of it because he is left out.

Mr. CRUIKSHANK. The rationale for the one and a half times the tax for self-employment was—is a difficult one really to establish anyway. It was a rough ready hewn justice which was developed, as you will recall by the Advisory Council of 1948–49, and it resulted in the amendments of 1950, the Social Security Amendments of 1950.

But the rationale that was given by this Council, which had many of the experts in social security in the country on it, was that a person, the self-employed, was serving in the double capacity of employee and manager and entrepreneur, and that part of his income resulted from this.

I don't believe that can be applied to the tipped employee because he has all the employee-employer relationships. He is subject to discharge. He is subject to disciplines. He is subject to time schedules. He is subject to controls. A waiter, for example, is given by the headwaiter certain tables he has to take, some of them sometimes yield good tips and others don't yield as good tips as other stations on the restaurant floor and none of these entrepreneurial or managerial decisions are his, and I think therefore on the basis of the rationale that was recommended to this very committee—incidentally, the Advisory Council of 1948 and 1949 was advisory to the Senate Finance Committee, as you will recall—I don't think any of that rationale applies to those tipped employees.

Senator BENNETT. We can disagree on this, but it seems to me the self-employed rationale more nearly applies because the employer who has, as I say, no control over nor any knowledge as to the amount of the tip, suddenly becomes responsible for paying half of the social security costs for that amount.

Mr. CRUIKSHANK. I think generally now he has knowledge of it. Actually, Senator, you might be interested to know that the employees in the tip industries in the early days of social security did not want to pay this, and they have themselves changed their position, and that change in position arises largely from the fact that it is now generally known by employer and employee what tips are and it is recognized as in lieu of wages, that is, it is just another way of paying the wage.

Now, presumably you could do, as you do, in some areas now, under the present law, you can add an amount to the bill and pay it to the employer and then the employer adds an amount for tips and on this kind of tips social security wages are already paid, as you know.

Senator BENNETT. Yes. This is the European pattern.

Mr. CRUIKSHANK. That is right.

This is the European pattern and it is applied to the banquet sections of our hotels and restaurants now. But I am sure this committee and the Congress wouldn't want to be changing the whole structure of the hotel and restaurant industry, which you would have to do if you made all forms of payment of wages of that kind, like it is in

the banquet department now, and so what they are doing is, what we are asking that they do, is simply recognize the realities of this wage structure, and the employer, because of the tipping system is relieved of a part of the direct payment of wages.

Now, he may make that up in difference in costs, the costs that he has, he may be able to put the price on the bill of fare at a little lower rate than he would if he had to pay this whole thing.

But because it is in lieu of that other wage, he escapes paying the social security tax on that wage, and we think that is the realistic analysis of the economics and the structure of the industry.

Senator BENNETT. I am glad to get this in the record. I think since you testified in a one- or two-line statement that it became important that this particular side of the question be developed.

That is all, Mr. Chairman.

Senator HARTKE. The Senator from Delaware, Mr. Williams?

Senator WILLIAMS. Mr. Cruikshank, in connection with this same question Senator Bennett raised, I can see a reasonable argument as to why these employees would want to include their tips and I have no objection to it if it can be worked out but what bothers me is the mechanics of how we are going to collect the tax.

Suppose an employee just doesn't report to the employer the amount of his tips, as you say the employer is not responsible, but at a later date, maybe next year, the Federal Government finds that these tips do amount to a substantial amount and they come back and reassess both the employer and the employee for income tax and social security taxes. You would make the employer, through no fault of his own, delinquent in his portion of the taxes, wouldn't you?

Mr. CRUIKSHANK. No, sir; not under the provisions of this bill as I understand it.

I do not believe this is a correct statement, Senator. The fact that he would—could be reassessed on a more, if an employee had not reported his full tips and it were established by the Internal Revenue Service that he had received more in tips than he reported either for social security or for income tax purposes he would have to pay the back income tax, that is right. In fact, in such case the employee is required to pay both the employee and employer tax.

But the employer would have two protections. One is that he is not liable under the terms of this bill for any tips that are recorded later than 10 days after the close of the payroll period.

Secondly, he is not liable for any amounts for which he does not have money on hand to pay. That is backwages or something, you see, so he is automatically relieved of that liability, and thirdly, of course, he is relieved of any liability if the tip claimed is less than $20.

Senator WILLIAMS. How would the Government assess the employee in a case such as that?

Mr. CRUIKSHANK. Well, I would say just as they do now.

Senator WILLIAMS. How?

Mr. CRUIKSHANK. That is, they assess him now for his back income tax payments.

Senator WILLIAMS. The employee would be subject to social security taxes of approximately 4 percent and the employer 4 percent under this bill.

Mr. CRUIKSHANK. Yes, sir.

Senator WILLIAMS. 4.6 at the maximum.

Mr. CRUIKSHANK. 4.8 eventually down to 1970.

Senator WILLIAMS. When the Government reassesses this employee, they would be assessing the 4 percent along with the penalties but where would the other 4 come from?

Mr. CRUIKSHANK. No, sir.

Senator WILLIAMS. Would they be assessing him the 8?

Mr. CRUIKSHANK. Yes, sir. For the social security purposes.

Once he makes his declaration and the employer pays the tax on it that is the end of that.

Senator WILLIAMS. No, but I am assuming in the case where that is not reported to the employer and no tax paid thereon.

Mr. CRUIKSHANK. Well, if once he fails to report it and later it is discovered he under reported, he has to pay both his social security tax and the employer's tax.

Senator WILLIAMS. Even though the Government discovers at a later date that the employee had not reported the correct amount to his employer, then he would not be covered and not be subject to the social security tax retroactively?

Mr. CRUIKSHANK. Yes, sir. In fact he becomes subject to a double tax liability.

Senator WILLIAMS. There is a voluntary system then on employee tips?

Mr. CRUIKSHANK. Well, no.

Senator WILLIAMS. Where he could——

Mr. CRUIKSHANK. He has to make a direct declaration of, it is an honest reporting on, tips and of course it is completely covered.

Senator WILLIAMS. I was really trying to clear this up. I am advised by the staff expert he feels the employee would have to pay the tax along with the penalty under the bill when it was discovered.

Mr. CRUIKSHANK. The employee?

Senator WILLIAMS. Yes.

Mr. CRUIKSHANK. The employee might have to pay. But your question as I understood it was the employer.

Senator WILLIAMS. I am advised that the employee would pay both the employee's and the employer's, which would be the full 8 percent.

Mr. CRUIKSHANK. Yes, sir. I recollect now that is the case.

Senator WILLIAMS. Well now, that gets back to the point that it would be similar to a self-employment tax then.

Mr. CRUIKSHANK. It would be worse.

Senator BENNETT. It is a third higher.

Senator WILLIAMS. It is a third higher but it is on the same principle, that he pays the penalty.

Mr. CRUIKSHANK. This is one of the incentives to keep him from doing that.

Senator WILLIAMS. I am just wondering if we wouldn't achieve the same objective if we made it self-employment. I have no objections in covering him as a self employed individual on a mandatory basis.

Mr. CRUIKSHANK. Except, sir, you would be asking the worker to pay a higher rate on his income than any other worker. But employees, as Senator McCarthy pointed out in the earlier questioning, I don't recall whether you were here at that particular moment, employers, particularly many small employers, get a lot of benefit out

of the Social Security Act in the fact that his people have this security and these benefits.

Under the suggestion that you have offered the employer would have all the advantages that accrue the employer from this without paying any tax on that portion of the wage.

Senator WILLIAMS. Well, that is true unless it was taken into consideration with the overall wage scale.

Mr. CRUIKSHANK. It has not been an easy problem, I grant you. The administration and others have wrestled with this problem and it seems to me, and I am sure that it is true with those of our employees who are engaged in these industries who have so long been denied the real protection of social security that this is the most practical and workable solution.

To all intents and purposes, incidentally with an agreement with the New York employers that has been been worked out and they are operating under an agreement now that covers them and it is practically the same system, and it is working.

And also it has worked for several years in several States in the field of unemployment compensation, so we have had some experience there with a very similar system, and it is working.

Senator WILLIAMS. I appreciate your answers. As you say, this is a complicated field we are moving in, and on which we don't exactly know the answer, or how to approach it either.

One other question. There are, I understand, approximately 70 million workers covered by social security.

Mr. CRUIKSHANK. That is those that are currently in the work force, I think that is right; yes, sir.

Senator WILLIAMS. Do you have a figure giving an estimate of the number of retirees who are drawing social security?

Mr. CRUIKSHANK. The number of retirees who are drawing social security.

The aged people I think at the present time run a little over 10 million, that is those getting old-age retirement benefits.

Senator WILLIAMS. There are quite a number of retirees who would not get any benefits under this bill, who are semicovered by social security, such as railroad retirement workers and others, where the social security is meshed in as a part of their company pension plans?

Mr. CRUIKSHANK. You are talking about the provisions of H.R. 11865 now.

Senator WILLIAMS. Yes.

Mr. CRUIKSHANK. Yes, sir; that is correct.

Senator WILLIAMS. That would be true with a lot of private company pension plans, which pay the difference between *a* amount and the social security benefit, are there not?

Mr. CRUIKSHANK. Yes, sir. Those are getting fewer in number all the time, but where there are some still in existence, where there is an offset of social security, that is correct.

Senator WILLIAMS. Do you happen to have an estimate as to the number of retirees who would be covered in that category?

Mr. CRUIKSHANK. No, sir; I don't have it available right now, Senator.

Senator HARTKE. Mr. Chuikshank, at the sake of being repetitious, I would just like to ask you again to give serious consideration to this

question of hospital care, because I am very fearful that we are being led into a well-laid trap which will deny benefits to about 18 million social security beneficiaries, which at least have been offered to them under this plan.

I personally as a sponsor and author of the King-Anderson bill. I voted for it in the committee, and I voted for it on the floor, and I would be willing to vote for it again.

I have no hesitancy upon that, but I think that this legislative matter presents itself to us, and I address this just for your consideration. Assuming that you passed the King-Anderson bill in the Senate, I say to you in all good conscience that the conferees of the Senate, in my opinion, would never be willing to take the responsibility of ever doing anything except sticking right straight to that proposal, and they would be met head on by conferees from the House who would not accept it. The net result would be a stalemate.

Let's assume another proposition, that you come head on into some sort of scheme with a voluntary option, which I feel is delusionary and illusionary. I think the net result is the same in the conference. You would come through with the Senate conferees bound and determined to hold their position, and the House conferees bound and determined to hold theirs, and with time pressing us in this year the net result would be no social security benefits for 18 million people.

So, let me say to you that I think you have five propositions here which I am unwilling to accept, which seem to me to be the basis of the so-called voluntary option plan.

I think, first, that it does assume—an . I think you do not assume this, but this approach does—that there is going to be an arbitrary 10-percent limit set. I think you will be boxed in by that from here on in to Kingdom Come, because every statement that is made about the so-called voluntary options assumes this 10-percent limitation, which was created here, I think, about 2 years ago in an exchange between the chairman and the then Secretary of Health, Education, and Welfare, now the Senator from Connecticut.

I think the second thing that it assumes is the article——

Mr. CRUIKSHANK. Do you mind if I just make a comment at this point? I don't want to interrupt you.

Senator HARTKE. All right, sir.

Mr. CRUINSHANK. But when—I was here when the Secretary, then Secretary Ribicoff made that statement.

Senator HARTKE. That is when it first hit the——

Mr. CRUIKSHANK. That is right.

We all noted very carefully that he did not say at that time 10-percent of what? So that it left open the whole matter of the wages, so I just don't agree there is an arbitrary ceiling.

Senator HARTKE. I understand. This voluntary scheme also, this voluntary option scheme, assumes as was indicated quite clearly this morning, the 10-percent limitation.

The second point I want to make is that here is assumed an arbitrary $4,800 base. Maybe that is not what you said a moment ago, I have forgotten the terms you used; I think you said that legislatively it would be difficult but that economically it was right to make a change in that figure.

But I assume, and I think I have the right to assume, that this so-called voluntary scheme is based upon a proposition that there will not be an increase in the $4,800 base.

Mr. CRUIKSHANK. $5,400.

Senator HARTKE. I am sorry, the $5,400 base.

Mr. CRUIKSHANK. No; it just seems that it just shows how you can do it within that framework, if that is one of the givens of this particular situation, but it certainly does not write it in that it shall never be changed or even contemplated.

Senator HARTKE. I know it doesn't write it in, but in my opinion it surely leaves the inference it is going to be boxed in.

Let me just say this to you. I am not asking you to accept any of my thoughts about this, but I just want to leave these with you.

Mr. CRUIKSHANK. I appreciate that Senator.

Senator HARTKE. Third, I think it states very definitely it sets up what we could call a decade of delay.

If you passed this bill you would have a decade of delay, waving a red flag to scare us to death. I refuse to accept this as necessary.

I think that this approach assumes, although I do not think you do, that it would be preferable to have this bill defeated in its present form without modification if it does not include some type of a hospital plan, even without regard to the ultimate end result as to whether it is going to be a real beneficial plan or whether it is some salve or balm for a real social need.

I think the fifth thing is that this approach assumes that a voluntary system can really be made to work. But I feel that all those who have had anything to do with the social security approach will tell you that when you go into a voluntary system of options, basically on a wide scale, that in and of themselves their ultimate end is defeat.

The thing that has made social security work has been the fact that it has been mandatory in its application and not voluntary.

So, I want you to know that I, too, am receptive to new ideas and new approaches as are indicated in your statement. But I certainly don't want to have a salve or a balm, here in the last 2 weeks of a legislative session, thrown in my face and then go out and have to try to defend this to the American people when I know good and well they are not going to get the benefits they want.

I think you and I can agree that the benefits are in the King-Anderson bill and we certainly don't need to take those down and destroy them any further.

Mr. CRUIKSHANK. Well, sir, may I just make a very brief comment. We do appreciate the fact you have supported these proposals in the past, and we appreciate your point of view and purpose and I would just as you pleaded with me to look at these things very carefully and I promise to do so and believe me we will. I would just plead that we don't toss in the towel just at this stage.

I would plead we give these various proposals when they get before us concretely very careful and serious examination and I would plead with you also that you work with your colleagues on the committee to try to work out a reasonable approach on this.

Now, I believe you will want to do that.

Senator HARTKE. I would do that, but let me point out to you that the very hearings we are having here right at this moment are of such

a nature that they practically put that August 22 deadline beyond all possibility, if you are going to consider this bill, and if you are going to hear these witnesses who have asked to be heard.

And I say this just as a matter of sheer physical time. There is no question about that. I don't want to hold that time limit up so I will withhold any further statement.

Any further questions?

I want to thank you, Mr. Cruikshank. I think all of us agree you are one of the most outstanding individuals in this field and I respect your opinions very highly.

Mr. CRUIKSHANK. Thank you. It is always a privilege and a pleasure to appear before your committee, sir.

Senator HARTKE. Thank you.

The next witness will be Mr. John S. Mears, of the American Legion.

I would hope that we can hear all the remaining witnesses on the schedule.

STATEMENT OF JOHN S. MEARS, ASSISTANT DIRECTOR, NATIONAL LEGISLATIVE COMMISSION, THE AMERICAN LEGION

Mr. MEARS. Mr. Chairman, the statement I have to make will probably take 3 minutes.

Senator HARTKE. I think all of these witnesses will not take over 5 minutes unless you have some questions.

Senator BENNETT. Of course, the chairman is in position to proceed.

Senator HARTKE. Let us proceed and see how we can do, Mr. Mears.

Mr. MEARS. Mr. Chairman and members of the committee, I appreciate very much this opportunity to appear here this morning to present the views of the American Legion in connection with certain facets of this legislation in which we are interested. I know your schedule is heavy and I shall be quite brief.

First, I should like to submit for the record a statement of Mr. Edward J. Weiland, assistant director of our National Americanism Commission, in support of those provisions of H.R. 11865 which will amend title II of the Social Security Act to authorize the continuance of payments to students after they reach age 18, but not beyond age 21, so long as they are enrolled in an approved school and remain unmarried.

In his statement Mr. Wieland points out that as of December 31, 1963, there were approximately 2½ million children under the age of 18 receiving social security benefits. He discusses the serious problem of school dropouts and its adverse results within this group, particularly in the form of high incidence of unemployment and juvenile delinquency.

He urges favorable action on this proposal because the extension of these benefits will be a great step forward in stemming the tide of school dropouts. He also points out the economic soundness of this proposal as well as the resulting human and social values which cannot be measured in dollars and cents.

Mr. Chairman, if the statement could be included in the record at this point.

Senator HARTKE. Yes, without objection it will be included in the record.

(The statement of Mr. Weiland referred to follows:)

STATEMENT OF EDWARD J. WIELAND, ASSISTANT DIRECTOR, NATIONAL AMERICANISM COMMISSION, THE AMERICAN LEGION, ON H.R. 11865

Mr. Chairman and members of the committee, at the 1962 National Convention of the American Legion, resolution No. 544 (copy attached) was adopted urging Congress to amend title II of the Social Security Act to authorize the continuance of payments to students after they reach age 18, but not beyond age, 21, so long as they are enrolled in an approved school and remain unmarried. In fact, the American Legion initiated and supported such legislation as early as its 1959 national convention.

The American Legion has a long sustained interest in providing opportunities for the youth of our Nation, including those opportunities obtained through education. The American Legion's participation and interest in the passage of the GI bill of rights for veterans of World War II and Korea is well known. The support of legisaltion by the American Legion which resulted in the enactment of the War Orphans Educational Assistance Act, popularly referred to as the "junior GI bill," is also a matter of record. Many well-known programs of the American Legion, designed to further the education and training of our youth, are further evidence of the Legion's deep concern for the future welfare of our young citizens. In recent years our compilation of career and scholarship opportunities bearing the title "Need a Lift?" has been furnished to nearly 1 million recipients. Hence, the American Legion's support of this amendment to title II of the Social Security Act is consistent with our long established position.

Studies reveal that, as of December 31, 1963, there were 2,521,000 children under the age of 18 receiving social security benefits because their wage earner parent was either decreased (1,730,000), totally and permanently disabled (451,000), or over 62 years of age and no longer employed (340,000).

Under the present social security law, payments to children terminate in the month the beneficiary reaches 18 years of age. Undoubtedly, in too many cases, this termination of financial assistance either eliminates the possibility of any education beyond high school level or is the cause of dropping out of school before graduation from high school. In fact, studies indicate that financial need in the home is the major cause of approximately 40 percent of all school dropouts. School dropouts is a matter of increasing concern. Advances in technology daily lessen the job opportunities for the unskilled members of our labor force. This is borne out by statistics which show that our highest unemployment ratio exists in the group composed of school dropouts of recent years. This problem is aggravated by the fact that the incidence of juvenile delinquency in this group is 10 times higher than among youths who have completed high school. This latter fact does not mean, of course, that high school education is a satisfactory level of attainment, because young people today need every opportunity to obtain higher education if they are going to compete successfully in the labor market. Our inquiry reveals there are over 600,000 students presently attending high school who are over 18 years of age. This is due mostly to illness and local school regulations, which do not permit children to start school early enough to complete their high school education prior to age 18.

The present termination of benefits at age 18, therefore, affects many children still in high school. And in addition, it eliminates the opportunity of a great many more to obtain sorely needed higher education or technical training. The proposed amendment to title II would be a great step forward toward correcting a bad situation. Insofar as it is directed toward those children who have lost the financial support of their wage earning parent, it will benefit a most deserving segment of our youth.

Providing opportunities for the better education of our youth will ultimately result in an upgrading of our economy and eventually will repay its cost. This fact is borne out from our experience with the GI bill of rights after World War II. It is estimated by the Veterans' Administration that this legislation cost the American taxpayers approximately $15 billion. It is believed that in less than 6 years from now—by 1970—the almost ten and a half million veterans who received their education and training by virtue of its provisions will have returned to the country the full cost of the program. These same veterans are paying over an extra billion dollars a year in Federal income taxes, because of higher incomes directly attributable to their additional education. This

estimate is based upon recent studies available from the U.S. Bureau of the Census and the U.S. Office of Education. These studies indicate, for example, that the 1958 college graduate will earn on the average during his lifetime $177,000 more than a high school graduate. It the foregoing statistics are reasonably accurate, we believe it is safe to say the proposed amendment to title II of the current social security law, over and above its humanitarian justification, is desirable when viewed only in the cold light of dollars and cents.

To further support our position, we invite your attention to estimates made by the Bureau of Old Age and Survivors Insurance, Division of Program Analysis, Actuarial Branch, dated February 13, 1964. They estimate 240,000 children would benefit from the amendment during the month of September 1964. The additional cost per child for the 3-year extension would be approximately $2,000. We believe it is reasonable to state that the increased income potential from the additional 3 years of education and training would result in the return to the taxpayers of this country a sum equal to about six times the $2,000 investment.

These harsh estimates dealing only with the economics of the proposal do not take into account, of course, the incalculable human and social values, hard to measure in dollars and cents, which will accrue to both the individual and to society.

Finally, we do not believe that this proposal will meet with any objections of those who believe that Federal aid to education will have a tendency to place the Federal Government in position to influence our local educational systems because the assistance given is directed to the individual who has the sole choice of selecting his school and course of education.

That concludes my testimony, Mr. Chairman. I want to thank you and the members of this committee for your courtesy in affording me this opportunity to present the views of the American Legion in connection with this portion of the legislation under consideration.

Mr. MEARS. I would now like to address myself to another aspect of the bill in which the American Legion is deeply concerned. The increases in social security benefits proposed by this legislation will have an adverse effect upon a great number of needy war veterans, their widows, and orphans who are in receipt of non-service-connected pension from the Veterans' Administration.

This is due to the fact that the eligibility for such pension and the amount which is paid is determined by the total annual income of these pensioners from all sources.

Social security benefits are counted in determining annual income.

In a great many cases social security benefits are the only other source of income. As was the case when social security benefits were last increased, many pensioners will lose all or a substantial part of their pension because of the relatively small increases in social security payments resulting from the enactment of this legislation.

The House Committee on Veterans' Affairs last week reported a bill, H.R. 1927, which will make some modest improvements in the current pension law.

One of its features is to permit veterans, widows, and orphans in receipt of pension to exclude 10 percent of the amount received from social security (and other public and private annuities) from the computation of their annual income.

I mention this legislation to you because it was scheduled for consideration by the other body today.

Because of the untimely death of Congressman John B. Bennett, of Michigan, we understand no business will be conducted in the House today. However, indications are that it will be acted upon favorably very soon and of course it will then be referred to this committee.

In that event, we urge you to give this measure favorable consideration so that these many needy war veterans, their widows, and orphans will not lose substantial portions of their incomes as a result of the enactment of H.R. 11865.

That is the point I wished to make.

Senator HARTKE. Any questions?

No questions.

Senator WILLIAMS. That does not mean we will not note your presence.

Senator HARTKE. Very, very fine statement, sir.

(The following letter by Senator Frank E. Moss, U.S. Senator from Utah, was inserted in the record at the request of the chairman:)

U.S. SENATE,
COMMITTEE ON INTERIOR AND INSULAR AFFAIRS,
August 7, 1964.

HON. HARRY FLOOD BYRD,
Chairman, Finance Committee,
U.S. Senate, Washington, D.C.

DEAR SENATOR BYRD: As you know, under the Social Security Act, an adopted child is entitled to benefits if the child is adopted by the wage earner, while alive, or has been adopted by the surviving widow within 2 years of her husband's death provided the child was living with the worker at the time of his death.

However, in many such adoption cases, adoption processes are often delayed and drawn out, particularly when a husband has died and the surviving widow must convince appropriate authorities that she is in a position to care for the child even without the help of the deceased husband. I am basing this on an actual case that has come to my attention wherein a husband and wife had custody of a child, not their own, for 7 years prior to the death of the husband, but adoption was not successfully completed until almost 3 years after the husband's death.

May I therefore respectfully request the careful consideration of your committee for an amendment to the Social Security Act extending from 2 to 3 years the length of the time during which a child may be adopted and receive social security benefits under the deceased worker's entitlement.

Sincerely,

FRANK E. MOSS, *U.S. Senator.*

Senator HARTKE. Mr. John C. Kabachus, International Association of Fire Fighters is our next witness.

STATEMENT OF JOHN C. KABACHUS, SECRETARY-TREASURER, INTERNATIONAL ASSOCIATION OF FIRE FIGHTERS

Mr. KABACHUS. I am John C. Kabachus. I am secretary of the International Association of Fire Fighters and may I, for the record, announce we have a delegation from the Minnesota Fire Fighters.

Our Chicago organization is present here, and their president, John Lynch; and West Virginia Fire Fighters, have taken time out to attend this hearing.

Senator HARTKE. We will note their presence, and we are glad to have them here participating in this hearing.

Mr. KABACHUS. The International Association of Fire Fighters desires to take this opportunity to reaffirm its traditional opposition to the inclusion of members of the fire service under the terms of the Social Security Act.

This has been our stand since the legislation was first enacted; the various amendments to the system and the obvious improvements that

have been made to the program have never altered our position that the best interests of our 100,000 members in the 50 States would be best served by their exclusion from the provisions of the act.

We respectfully urge that section 11 of the proposed legislation be stricken in the cause of preventing irreparable injury to the very people whom you believe ourselves to be helping.

Our association finds small comfort in section 11's opportunity for municipalities to conduct referendums to determine whether firefighters wish to be included under social security or not.

We find disquieting and alarming the language of the Ways and Means Committee report which seeks "to facilitate the extension of social security coverage to State and local government retirement systems." This language may be found in a discussion of the proposed section 12 that would permit the addition of Alaska and Kentucky to the roster of 17 States that are already allowed to further fractionate their local retirement systems.

There are virtually no groups in our profession that are actively seeking inclusion under social security and at every biennial convention of our association the vote against broadening social security to include firefighters is always unanimous.

I will concede that our position is unusual in the trade movement. Most unions believe in extending coverage to groups presently excluded. But our stand was not taken capriciously and without study. Our opposition is based on the knowledge that our present retirement systems, many of them excellent and well established, would inevitably be menaced if firefighters were to be included under the umbrella of social security.

In those areas where no effective retirement plan for firefighters exists, the States and the communities already have the right to include their fire service personnel under social security. Thus, the proposed section 11 would not help this group in the future.

The special and hazardous nature of the firefighting profession was recognized by States and municipalities many years ago and they wisely and justly established special retirement systems for the fire service. They frequently permit retirement at age 50 or 55 after a specified number of years of service. Our retiement systems are, on the whole, vastly better than anything now contemplated by the Social Security Act or likely to be realized for many years to come.

Understandably, we do not desire to see these systems diminished. Nor do we think this is the intent of the Congress. But they will be diminished, inevitably, if communities are permitted to substitute social security for present plans.

The Federal Social Security Act is primarily and basically designed as a social measure. Old-age, survivors and disability insurance is not intended to serve as a retirement plan but rather to meet the basic needs of the entire working population. Although the original rates of contribution were relatively small over the years, today we note the new schedule is at a point where it equals or is near to the rate of contributions being paid by public employees to their local retirement plan.

Now in contrast, State and local government retirement plans are designed to meet the needs of superannuated employees. Benefits are based upon contributions, and are therefor geared to amount of salary

and length of service. A retirement plan may be viewed as an arrangment between one employer and his employees.

There is little individual equity in social security. The contributions are not earmarked to buy protection for the specific employee on whose wages they are based. The principle of a retirement plan is exactly the contrary. In general, OASDI supplies a broad subsistence level. The individual who desires more than mere subsistence is expected to build upon this foundation by means of savings, thrift, and additional retirement allowances.

The communities faced with extending social security coverage have a number of methods to consider—supplemental, additive, coordinated, full offset, semiadditive, integrated, semioffset, and many more. All of these methods can be considered under three means of OASDI extension; namely, (1) supplemental; (2) integrated; and (3) coordinated.

Despite the policy statement of the Congress, it must be pointed out that the community has a perfect legal right to abandon its existing retirement plan.

1. Supplementation: Under this first method, OASDI and the present retirement system would be in full effect. Under the provisions of the pending legislation, each employee would continue to pay his usual contribution into the retirement plan and in addition, 3.8 percent of that part of his salary up to $5,400 for social security after December 31, 1964. The municipality would also contribute 3.8 percent for social security on each employee's salary up to $5,400 annually.

Most authorities agree that supplementation is the simplest method of extending social security to public employees. No changes would be required in the present retirement system. Both systems would be completely independent of each other. Supplementation would give the employee the highest retirement benefits possible under any type of extension of OASDI and, at the same time, enable him to profit from any future increases in OASDI benefits.

The obvious objection to supplementation is the cost to both the employee and employer. Employees would begin by paying a greater percentage of their salaries to the two systems (the percent of his usual contribution to the retirement system plus 3.8 percent to OASDI). For some this would constitute hardship.

2. Integration (full offset): Assuming an employee makes a 5-percent contribution into his retirement plan, then in this type of extension of social security, the employees would continue to pay only the 5 percent of his salary which he pays today under the existing retirement system. However, his payments in theory would be divided into two parts: (1) 3.8 percent for OASDI, and (2) 1.2 percent contributions to his retirement plan. In 1971, 4.8 percent for OASDI and 0.2 percent to his retirement plan.

For purposes of this plan, we can assume in theory that there would be no change in the contribution of the employee to the retirement fund and that for the increases in the social security, taxes would be evenly divided between the municipality and its employees.

In benefits, if the employee retired prior to age 65 had received whatever he is entitled to receive at present, this amount would continue unchanged throughout his life. When he attains age 65 and his OASDI benefits begin, then the municipal share of contribution is

reduced by the amount of social security benefits. From the standpoint of the municipality this plan calls for a careful examination of the cost over the years of its application.

One of the serious objections to the full offset integration plan is in the fact that the retirement system would immediately lose most of its strength and independence. As changes are made in social security, benefits, or contributions, these would necessarily be reflected by similar changes in the retirement plan. In time, the whole status of the retirement plan could become very unclear or uncertain.

3. Integration (semioffset): The semioffset plan is the same as the full offset plan with one very important exception. Where the employee pays one-half the cost of his social security, it is generally argued that he is entitled to one-half of his OASDI benefits in addition to his normal retirement benefit. This type of integration would probably require no higher payments by the employee than are now being made.

Again assuming that an employee makes a 5-percent contribution, this would be divided in exactly the same manner as under the full offset plan: 1.2 percent for retirement system; 3.8 percent for social security, and, in 1971, 0.2 percent for the retirement system; 4.8 percent for social security. The semioffset plan would cost the municipality substantially more than would the full offset plan.

4. Coordination: Under both previous plans for "integrating" OASDI payments with local retirement benefits, the OASDI benefits bring about a reduction in the amount of pension paid from the local retirement system. The coordination plan of extending social security is a similar process except that the municipality computes its system in advance, both as to contributions and benefits, so as to adjust for the effects of OASDI benefits. Therefore, the municipality would determine the exact amount of total benefits which its employees were to receive under the present retirement system at age 65, subtract the amounts to be received from OASDI, and recompute the necessary receipts and payments to provide the difference.

It must be understood that OASDI is an insurance program. A man may pay fire insurance premiums for 50 years and never have a fire. His premium payments are used to pay for the losses of others, so the benefits of OASDI are quite uneven as between given individuals. One employee may contribute for 25 years and obtain no greater benefits than another who contributes for only 10 years. Contributions cannot be refunded because it is an insurance program, not a retirement program.

The attitude of some people is that dual coverage seems to involve the hazards of attempting to ride two horses at the same time. We, as firefighters, know that in difficult times the taxpayer may question the necessity of dual coverage at his expense. Private industry does not have this problem since its payments are usually tax deductible.

No Member of Congress can guarantee that harm will not befall our existing retirement system of the present exclusion for the fire service is removed. The Congress does not have the power to legislate for the States and cities and this is where we would be injured if this Congress opens the door to trouble by dropping our present exclusion.

Meanwhile, we find in section 218(d)(6)(C) of the social security law any retirement system established by States of—

Connecticut	Wisconsin	New York
Massachusetts	Nevada	North Dakota
Minnesota	Alaska	Texas
New Mexico	Kentucky	Vermont
Pennsylvania	California	Washington
Rhode Island	Florida	Hawaii
Tennessee	Georgia	

or any political subdivision of any such State which on, before, or after enactment of this subparagraph is divided into two divisions or parts;

1. One of which is composed of positions of members of such system who desire coverage under an agreement under this section, and
2. The other which is composed of positions of members of such system who do not desire such coverage—

Shall, if the State so desires and if it is provided that there shall be included in such division or part composed of members desiring coverage, the positions of individuals who become members of such system after such coverage is extended—be deemed to be a separate retirement system.

Every Congress considering modifications of the Social Security Act since 1950 has recognized that the fire service was a special case and acted accordingly. We ask that there be no division of the fire service into the haves and the have-nots under social security. We ask only that section 11 be dropped from consideration and that a clear and unmistakable exclusion of the fire service from the provisions of the Social Security Act be made a part of any new legislation. The adoption of Senate amendment 1174 will accomplish our objective.

Senator HARTKE. Thank you, Mr. Kabachus.

Senator Williams? Senator Bennett?

Senator BENNETT. I think you have made your position abundantly clear.

Mr. KABACHUS. I hope so.

Senator HARTKE. Thank you, sir, for your testimony.

I understand the chairman has received numerous substantiating statements from firefighter organizations and unions, which he will place in the record following your testimony.

(The statements referred to above follow:)

STATEMENT OF JOHN J. LYNCH, PRESIDENT, CHICAGO FIRE FIGHTERS UNION, LOCAL NO. 2, IAFF, AFL-CIO, IN OPPOSITION TO SECTION 11 OF H.R. 11865 AND SUBSTITUTE IN LIEU THEREOF, SENATE AMENDMENT 1174

Chicago Fire Fighters Union, Local No. 2, International Association of Fire Fighters, wishes to record, by this statement, its vigorous and unalterable opposition to the provisions of section 11 of H.R. 11865 (Social Security Amendments of 1964).

In speaking for more than 95 percent of Chicago firemen, we are thus reaffirming the position consistently held by our organization since 1935 when social security came into being. At that time, Chicago firemen were opposed to inclusion under the Social Security Act and the wisdom of that position is eminently clear today.

The removal of the exclusion of firefighters from social security, as provided in section 11 must, inevitably, signal the beginning of the end of our local

retirement systems provided by State law. We realize that this is a strong statement and wish to assure the members of the Senate Finance Committee that we offer opposition to section 11 only after sober study and careful analysis of the effects of social security on our firefighters.

We wish to point out to the Senators that our Chicago firemen have labored for more than 50 years in developing a pension and retirement system which has been tailored to our needs, our ability to pay for it and also commensurate with the means of our community. The fact that we are engaged in a profession that is hazardous has long been recognized and many special provisions have been developed in our system as a direct result of that recognition. For example, a Chicago firefighter who has 23 years of service can retire at an averaged half-pay pension (5 highest years of salary of last 10 years of service). If he continues working to age 63 (compulsory retirement), his pension increases 2 percent per year or 70 percent of salary at age 63. In addition, after retirement, an escalator clause increases his pension by one-half percent per year beginning at age 64 to cover cost-of-living increases. Unfortunately, Congress is in no position to guarantee continuation of such provisions once social security takes over. Certainly, it is unrealistic to expect that the Social Security Act, which has been designed to cover many millions of persons, can concern itself with our particular and unusual area of need.

It is also a fact that the basic concept of our retirement system is totally different from the purpose of the Social Security Act. Each member of our system pays into an individual account of his own to which the city adds its contributions. In contrast, the contributor under social security has no individual equity, no individual account, but is rather engaged in buying a kind of insurance designed to secure him against basic minimal needs.

What we stated up to this point does not yet answer the question most often asked of us: Why are you so concerned with a provision which only makes social security available to you, but in no way requires you to accept it? Our answer can be stated as follows:

1. When we are required to make ourselves available for coverage under the provisions of the act against our own better judgment, we must assume that this is the first step toward compulsory inclusion. If it were not, then section 11 has no meaning.

2. Once the exclusion feature is removed, we become subject to having our State included under the so-called further division provisions of section 218 **(d)(6)(c) of the Social Security Act.** This provision divides members of a retirement system into two groups: Those who desire coverage under the act and those who do not, but also adds that all employees entering service after the division takes place *have no choice* but *must be* covered by social security. When this occurs, no new members enter the retirement system and it must eventually die.

3. That the removal of the exclusion is the first step toward inclusion seems to be supported by such language in the report of the House Committee on Ways and Means, page 13, paragraph (b): "Under a provision of the Social Security Act *which is designed to facilitate the extension of social security coverage to members of State and local government retirement systems* * * *"; and again on page 10, section E, 1. referring to doctors: "Your committtee knows of no valid reason why this single professional group should continue to be excluded. *It runs counter to the general view that coverage should be as universal as possible.*" [Emphasis supplied.]

In considering what would happen if Chicago firemen become subject to the Social Security Act, several facts are clear. First, the Illinois Public Employees Pension Laws Commission, a permanent commission created by the General Assembly of Illinois has taken the position that when the Social Security Act becomes operative as to a group of public employees, it will be coordinated or combined with the retirement system. This means, with relation to Chicago firemen, that in arriving at the pension to be paid out, part of it will be paid from social security and the other part from retirement system funds. Experience in other jurisdictions has shown that the contributions of the employer municipality to social security climb steadily with a matching decrease in its contributions to the retirement system. The result is a constant weakening of the retirement system which eventually leads to its complete disappearance. Second, if a municipality is confronted with financial problems and cannot meet all of its commitments, it is clear that social security payments must be met, even at the expense of the retirement system. This is completely undesirable because it is the retirement system which has been carefully constructed solely

for the use and benefit of our Chicago firemen. Third, it is a fact that the cost of social security to the employers and employees has risen sharply during the past 10 years and will continue to increase. Should we be subject to the law, we will no longer be permitted to increase our payments in the areas we believe are important and will have no control whatsoever as to the application of increased contributions to a particular, needed benefit. This we can do, presently, and we wish to retain this privilege.

In conclusion, we would ask the committee to note that each Congress which has considered this problem since the act became effective, has found sufficient reason in our arguments to retain the exclusion feature. There is not, in our opinion, any new or added factor which would justify removal of the exclusion at this time. We request, therefore, that section 11 of H.R. 11865 be stricken in its entirety. In making our statement, we adopt, in its entirety, the presentation made by the International Association of Fire Fighters.

PHILADELPHIA, PA., *August 7, 1964.*

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

The firefighters of Philadelphia Local 22 IAFF AFL–CIO seek your support in Senator Ribicoff's amendment to bill S. 1174 which is the firefighters position on the Social Security legislation which is now pending before this session of the Senate. Our membership solicits your support and the committee's on this matter.

RAYMOND M. HEMMER,
President, Local 22 City Firefighters IAFF AFL–CIO.

INTERNATIONAL ASSOCIATION OF FIRE FIGHTERS, LOCAL 91
Parkersburg, W. Va., August 3, 1964.

Senator HARRY BYRD,
Senate Office Building,
Washington, D.C.

SIR: I have been informed that the Senate Finance Committee is now considered bill H.R. 11865. We are most concerned about a provision of that bill which will remove the blanket exclusion of firefighters from the Social Security Act.

The Firefighters Local No. 91 have voted unanimously to let you know that we do not feel our best interests are being served by being included in this or any other attempt to extend us coverage under social security.

Firemen certainly do not object to higher benefits for any worker covered by social security, we merely wish to point out that firefighters do not wish to be covered. The only fault we find with H.R. 11865 is the section which seeks to remove the exclusion of firefighters from social security.

The firefighters exclusion clause has been part of section 218 of the Social Security Act since it was enacted. We feel this is more beneficial to us as a group for two main reasons.

(1) The great majority of the existing pension laws and plans for firefighters, because of the hazardous nature of their duties, allows retirement at an earlier age and with more adequate pension than is obtainable under social security.

(2) The average firefighters retirement system provides a disability pension for a firefighter at any age if he is disabled in the line of duty to such a degree that he can no longer perform his duties in the department. This is not so under social security. In order to be eligible for disability benefits under social security a worker must (*a*) have earned the required number of quarters, and (*b*) it must be "determined medically that is is so disabled he cannot perform any type of gainful employment and there is little hope of recovery from the disability," in the words of a spokesman for the Social Security Administration in Washington.

State and local authorities have long recognized the need for a separate retirement plan for firefighters because of the hazardous nature of their work.

After weighing all the facts, we cannot help but feel that you will find our position well founded and that we can rely on you to do all in your power to have that portion of bill H.R. 11865, which deals with the blanket removal of firefighters from the Social Security Act, either excluded or amended before this bill is made law.

Very truly yours,

A. T. SMITH,
President, Local No. 91.

STATEMENT OF THOMAS L. DALE, JR., EXECUTIVE SECRETARY-TREASURER, ASSOCIATED PROFESSIONAL FIRE FIGHTERS OF KENTUCKY, IN BEHALF OF H.R. 1165

The Associated Professional Fire Fighters of Kentucky desires to use this means to speak for the adoption of S. 1174; i.e., H.R. 11865.

Speaking for the members of 10 city fire departments, consisting of over 1,200 members—Ashland, Bowling Green, Covington, Henderson, Hopkinsville, Lexington, Louisville, Newport, Owensboro, and Paducah, not to discount our members' families in the other city fire departments of Kentucky, who have no spokesman.

We ask that S. 1174 be adopted which would prohibit the damage and uncorrectible injury to the pension system; i.e., Kentucky firefighters.

We find nothing in section 11, H.R. 11865 which would benefit the firefighters now or in the future.

We feel the language, i.e., House Ways and Means Committee report H.R. 11865 to facilitate the extension of social security coverage to State and local government retirement system will not help the firefighter but will only tend to weaken and in the end destroy present pension systems.

You will find no group or groups of firefighters which would avail themselves should section 11 pass and should the Kentucky State Legislature, by statute, allow referendum by groups to purchase Federal social security, realizing of course, that the Kentucky State Legislature could take an affirmative action, whereas group or groups of firefighters would not have the right to referendum.

The Kentucky firefighter, depending on his area or locale, have in operation pension systems far superior to that of anything the Federal social security can offer. We are sure you will agree that Congress cannot guarantee that pension systems on a State or local level cannot and will not be abandoned. There may be a time when social security will be a national thing, i.e., a method whereas all workers can retire upon reaching a fixed age after meeting requirements of said system, but it is our judgment this is many years in the future.

In the areas where firefighters have no retirement plans, these States and communities have the right to include their fire department personnel under social security now as it is written. We are sure you will agree section 11, H.R. 11865 will not help these groups now or in the future.

The very nature of the firefighting profession is recognized as hazardous, with many being injured in the line of duty and are forced to retire while others pay the supreme price by losing their lives. The local government recognizes this and provides retirement at the early age of 51 and 20 years' service, both being equal, upon request by said firefighter, with a retirement of 50 percent of base pay, with the widow receiving the same amount. Coverage from the date of employment for on-duty injuries and full 24-hour coverage when the member reaches 5 to 10 years' service, depending upon his own individual system, with the firefighter paying from 4 to 6 percent with mandatory retirement 55 to 62 years of age, and again depending upon his own system.

Recognizing that the Federal social security system is designed to cover the Nation as a whole as a survivorship insurance plan and not to be misconstrued as a retirement system but must be supplemented by other income upon retirement, while our pension systems are designed for the full retirement of our members upon the attainment of a fixed age, plus protection for said firefighters' families.

Coverage of employees of State and local governments is by means of a voluntary agreement entered into by a State with the Secretary of Health, Education, and Welfare. The State has the responsibility for initiating such an agreement and for determining within the framework of Federal and State law what groups of employees will be brought under the agreement and when such coverage shall be effective.

The 1954 amendments to the Social Security Act provided the basis for covering under such an agreement employees who are in positions under a retirement system providing a majority of the eligible members of the system vote in favor

of coverage. However, such coverage was qualified by section 218(d)(5)(A) of the Social Security Act, which specifically prevents the extension of coverage of policemen and firemen in positions covered by a retirement system.

This exclusion of policemen and firemen in positions under a retirement system from coverage under the old age survivors' and disability insurance program was as a result of requests made by our international organization along with members of the police departments. The history of our opposition as recorded in the various congressional sessions indicates that, because of the hazardous nature of our work, firefighters as well as policemen usually have special provisions in their retirement systems which provide for retirement after 20 years of service or retirement at the age 50 or 55. Because of these factors our organization felt it would be unwise to coordinate the retirement systems of the firefighters with the old-age survivors' and disability insurance program.

As the result of the 1956, 1957, and 1959 amendments to the Social Security Act (under the guise of senatorial courtesy), the prohibition in the Federal law with respect to the firefighters and policemen in positions under a retirement system was lifted with respect to the States of Alabama, California, Florida, Georgia, Hawaii, Kansas, Maryland, New York, North Carolina, North Dakota, Oregon, South Carolina, South Dakota, Tennessee, Virginia, Vermont, Maine, and Washington. Under section 218(p) of the Social Security Act, these States may, if they wish, extend coverage to their firefighters and police who are in positions under a retirement system, providing the referendum requirements of the Social Security Act section 218(d)(3), where applicable, section 218(d)(7) are complied with.

The Federal law section 218(d)(6) gives these States in certain cases the option of dividing a single retirement system into smaller units. Each unit is deemed to be a retirement system. A separate referendum is held with respect to each unit or each "deemed retirement system."

If a retirement system covers employees of the State and employees of one or more political subdivisions of the State, the State is given the following choice (subject, of course, to the limitation of State law) with respect to what shall be "deemed retirement system" for the purpose of a referendum.

(1) It may hold a referendum for the entire system.

(2) It may hold a referendum for State employees and separate referenda for each political subdivision.

(3) It may hold one referendum for State employees and employees of any one or more political subdivisions.

(4) It may hold a referendum for any single political subdivision or combination of political subdivisions.

If a retirement system covers firefighter positions only or policemen's positions only, the above represents the only options available to the States as to what shall constitute a retirement system for referendum purposes. However, if a retirement system covers firemen's positions and policemen's positions or firemen's positions, policemen's positions and other positions, the State, after it has exercised one of the four options noted above, has the additional option of holding a referendum for only those employees under the "deemed retirement system" who are in firemen's positions, or holding a referendum for only those employees under the "deemed retirement system" who are in policemen's positions, or of holding a referendum for employees under the "deemed retirement system" who are in firemen's and policemen's positions.

* * * under Federal law further divide a "deemed retirement system" if they wish on the basis of the desires of the members and included under the State agreement only those members of the retirement system desiring old-age survivors and disability insurance coverage. It should be noted, however, that the division and subsequent coverage of members of a retirement system in this manner shall result in the compulsory coverage of all new members of the system.

The above represents what the Federal law provides with respect to the coverage of firefighters and/or policemen who are in positions under a retirement system. However, such coverage is also subject to State law and the provisions of the State's old-age survivor's and disability insurance coverage agreement. While State law may not, of course, be broader than the Federal law with respect to the coverage of employees of State and local government under the old-age survivor's and disability insurance program, it may be more restrictive. For example, the laws of some States do not permit a retirement system to be divided for referendum and coverage purposes on the same basis and to the same extent as the Federal law does. While the Federal law states certain requirement with respect to a referendum, such matters as what form the ballot shall take, the length of voting periods, or where the balloting should take place; vote by mail, proxies,

etc., are matters left to the discretion of the State. The State also has the responsibility for determining what constitutes a firefighter position.

The extension of social security is thus dependent upon action both by the U.S. Congress and by the respective State legislators.

SOCIAL SECURITY

History

In 1950 social security was extended to public employees not covered by a State or local retirement system. A number of States dissolved existing local retirement plans.

In 1954 those cities and States under local retirement system could come into social security provided:

1. State enact enabling legislation.
2. Conduction of a referenda to determine desire of those in retirement system.

But there was exclusion of police and firemen in Section 218, d-5 because Social Security was not suited to the special nature of their occupation.

Basic questions to be asked about Social Security coverage are:

1. Initiation of referendums.
2. Options available for conduction referendums.
3. Group included in referendums.
4. Effective data of coverage.
5. Combination of social security with existing retirement system.
   (*a*) Integration
   (*b*) Supplementation
   (*c*) Offset
6. Safeguards of own pension system.

Since 1954 the exclusion of police and firefighters has been removed in 16 States during the different years of legislative action. These states and years are:

1956: Florida, North Carolina, Oregon, South Carolina, South Dakota.
1957: Alabama, Georgia, Maryland, New York, Tennessee, Hawaii.
1958: Washington.
1959: California, Kansas, North Dakota, Vermont.
1960: Virginia.
1962: Maine.

We ask that S. 1174 be adopted, whereas, leaving the firefighter the right to provide for his own needs through his own efforts and his own local government.

STATEMENT OF THE FIREMEN'S ANNUITY AND BENEFIT FUND OF CHICAGO RELATING TO SECTION 11 OF H.R. 11865

The Firemen's Annuity and Benefit Fund of Chicago appreciates this opportunity to file its opposition to the proposed amendment modifying section 11, so as to permit the inclusion of firemen within the coverage of social security. Since the first presentation of the Wagner bill in the Congress of the United States, this organization has been opposed to the inclusion, within the coverage of social security, of firemen. Various amendments that have been made in the system, and the various improvements made in the program, have never changed the feeling of this organization that the best interests of firemen would be served by their exclusion from coverage of social security. Irreparable damage would be done, not only to the retirement system of which firemen presently are members, but to the firemen themselves, by reason of the changes which would be required to be made in the system in the event social security coverage was extended to firemen. For these reasons we respectfully urge that section 11 of H.R. 11865 be removed and nullified, in order that the aforementioned damage will not be done to members of our organization. Removal of the exemption of firemen from coverage by social security would be the first step in doing away with the retirement system of these employees.

The annuity and benefit fund is a creation of the Legislature of the State of Illinois and has for its purpose taking care of aged and disabled firemen, their widows, and children. The retirement benefits have been built up, through the years, by members of the retirement system, and not only provide for a mere subsistence, but permit their beneficiaries to live in a respectable fashion.

While it is apparent from the records of the committee that they believe that there are sufficient safeguards at the State level to protect any firemen who does not wish to participate in social security, in the State of Illinois such safeguards do not exist, per se, even though at the present time the social security enabling legislation which has been adopted by the State of Illinois requires a vote of two-thirds of a retirement system for its members to be included under social security. It still means that if the full one-third membership were opposed to social security, they would be forced to participate by reason of the wishes of the other two-thirds. This enabling act now in existence in the State of Illinois could be modified at any session of the legislature to require a bare majority, or to set up a divisional method, which then would require all new members coming into the fire department to be covered by social security without giving them a choice in the matter. The great danger existing in the removing of the exemption of possible coverage of social security to firemen is the cost that would be involved, which would be required to be borne by the employer, who actually is the taxpayer. The employer, at the present time, contributes to the support of the retirement system for the benefit of its employees. If the employer were called upon to make additional contributions by reason of coverage for these employees by the Social Security Act, it would not be long before the employer would find it necessary to reduce his contribution to the retirement system, and thus the benefits that have been built up over the course of years by the firemen of the city of Chicago would be dangerously reduced.

The occupation of firemen is an extremely hazardous one; they are exposed to all kinds of inclement weather, heat, cold, noxious fumes, danger of falling walls, and collapsing buildings. Because of the very nature of their occupation, firemen are not able to stay on the job and perform these hazardous services, until they reach the age which would be required by social security to secure benefits. Because of the strenuous nature of their duties, and the wear and tear upon their physical conditions, the retirement system which the firemen themselves have helped to create and build up through means of their own contributions, has provided for earlier retirement, by a number of years, than that age which is provided for retirement under the Social Security Act. This retirement system is tailored to meet the needs and requirements of firemen and the duties which they perform. It is not a blanket coverage for all municipal employees, regardless of the job, or nature of the work they do. The Federal social security system has as its basis the basic needs of the working population, generally, of the United States. Originally the contributions were small, but over the years it has begun to approach the rate of contribution made by members of retirement systems. Benefits, however, are merely based for a subsistence level for those who participate in it. Benefits are not specifically designed to meet the needs of employees in hazardous occupations.

What would disable a fireman from performance of duty in the fire department need not necessarily qualify him for disability payments under the Social Security Act. A plan which is designed to meet the needs of the fireman, based on his salary and his years of service is an arrangement between the employer and the employee. In social security there exists no individual equity as far as the employee is concerned. Contributions are not earmarked to provide protection for a specific employee or his widow, as is done in this retirement system. It must be remembered that a municipality, or the State in which the municipality is located, has the right to terminate this retirement system at any time, and if an additional burden, taxwise, were to be placed on the municipality by reason of the inclusion of firemen within the coverage of social security, the temptation to change or terminate the retirement system would be greatly increased.

We realize that a great many people feel that there is no real danger to the retirement systems which now exist by removing this exemption, because of so-called safeguards which have been set up by the States. The safeguards existing in the State's social security enabling act may be changed at any time by the legislature, and what actually appears to be a safeguard may be only a paper wall.

The declaration contained in the existing law, that it is the policy of Congress that the protection afforded members of the State or local government retirement systems should not be impaired by the result of the extension of social security coverage to members of the retirement system, are fine-sounding words and an excellent thought, but doesn't necessarily have any effect upon the members of the legislature who would control future coverage of social security on the firemen in the event the exemption were removed.

We respectfully request that section 11 of H.R. 11865 which would remove the exemption from inclusion in social security of firemen and policemen which is now provided in section 218(d), be canceled and nullified.

Respectfully submitted.

NICHOLAS ZELESKO,
Secretary.
PETER F. CITERA,
President.

Senator HARTKE. Carl C. Bare, National Fraternal Order of Police.

STATEMENT OF CARL C. BARE, LEGISLATIVE CHAIRMAN OF THE NATIONAL FRATERNAL ORDER OF POLICE

Mr. BARE. Mr. Chairman and members of the committee, I am deputy inspector of police in Cleveland, Ohio, and legislative chairman for the National Fraternal Order of Police, an organization representing policemen from departments of all sizes over the entire United States.

I speak also for over 2 million other public employees who are members of the National Conference on Public Employee Retirement Systems. A large proportion of the conference membership is composed of police and fire groups. The conference reaffirmed its opposition to the general inclusion of policemen and firemen under social security at its last annual meeting, on March 15, 1964.

The work of both firemen and policemen is hazardous. Mr. Kabachus has spoken eloquently on behalf of the firefighters, and we concur with his statements as they apply to policemen.

A policeman's job is to protect society and society's property; to apprehend those who would harm society or injure its property. To do this job well under present-day conditions, policemen must be physically alert. Policing is a young man's occupation. A police administrator would not send a 60-year-old man to grapple with a young hoodlum. If he did, the taxpayers would raise a loud cry of inefficiency.

So, what happens when a policeman reaches an age when he can no longer do effective police work? A few are given desk jobs; but, there are not enough desk jobs to take care of all. We must be able to retire these men shortly after they reach age 50 in order to maintain the efficiency of our departments.

During their working careers policemen contribute to their retirement systems and the public pays its share of the cost of pensioning older policemen because the taxpayers feel it is less expensive to support an adequate retirement system than to support a decrepit police force.

We feel very sincerely that if policemen were covered by social security the inducement to remain on the until they qualify for benefits would be great. The earliest they could retire would be 62 and then at reduced benefits. This is not for the general welfare.

Furthermore, we feel certain that the taxpayers cannot afford to support both a retirement system which meets the needs of the police department and social security coverage. Hence, if policemen were covered by social security many municipalities would alter the retirement benefits.

One of the biggest difficulties of police departments today is the recruitment of qualified men at the salaries the municipalities can afford to pay. An important inducement is a sound retirement pro-

gram. If there is danger of this program being weakened this attraction will be lost and consequently the difficulty of recruiting satisfactory personnel will be greatly increased.

What would be the result at time of retirement if the police retirement benefit is reduced to accommodate social security coverage? A policeman would retire in his 50's, receiving a lesser retirement benefit than he can now look forward to, and when he reaches age 62 or 65, his social security benefit would be reduced because his average monthly wage would include maybe as much as 10 years of noncoverage after retirement. He would be compelled to seek other employment and there are few other types of work for which policemen are qualified.

We object particularly to the application of the divisional procedure for coverage of policemen. Especially in small communities where the police force is not large, pressure brought on one or two men might influence them to vote for coverage and all newly employed policemen are then automatically covered.

We have suggested legislation to correct this deficiency in this particular section but we are not pushing for action on it here.

When social security coverage was first made available to public employees in 1950, those who were members of a State or local retirement system were excluded. When the 1954 amendments permitted coverage of members of State and local retirement systems after a referendum, policemen were excluded from those provisions.

Thereafter, in certain States it was felt that social security coverage could be used to the advantage of policemen and special legislation was enacted permitting their inclusion in named States where it was requested. This has worked satisfactorily.

In most States it is still felt that social security coverage would not be beneficial to policemen and, in general, policemen remain excluded. We believe this exclusion should be retained.

Even though elimination of the exclusion would provide under the referendum provisions an opportunity for the policemen to vote for or against coverage, local pressures could be applied inducing them to vote for what their better judgment deems unwise.

I call your attention to the riots in New York City, Jersey City, Rochester, St. Augustine, and other cities. This is no time to create a feeling of insecurity among police and if section 11 of H.R. 11865 is retained, such insecurity will be created.

With us today is Richard Lis, the national trustee from Illinois, and Joseph LeFevaur, president of the Chicago Lodge. The Fraternal Order of Police have asked me to especially call your attention to the unrest in Chicago and other police departments in Illinois as the result of passage of this section.

This also applies to many other police representatives who are present in the room.

Thirteen of the 17 members of this committee represent States where policemen are presently excluded. These policemen do not desire coverage. We strongly urge each of these 13 Senators to support the position of the policemen in his own State.

We also earnestly request that the committee members where police may be covered recognize that their own policemen would not be affected by retention of the exclusion and that the entire committee support amendment No. 1174, by Senator Ribicoff, which would delete section 11 of H.R. 11865.

Thank you, gentlemen.

Senator HARTKE. Thank you. I am advised that the chairman has received a number of statements from police organizations and unions also. These statements will be placed in the record following the testimony of the next witness who represents the National Conference of Police Associations.

Senator HARTKE. Senator Williams?

Senator WILLIAMS. No questions.

Senator HARTKE. Senator Bennett?

Senator BENNETT. No questions.

Senator HARTKE. Thank you, sir, I appreciate your testimony.

(At the request of the chairman, the following telegram of Hon. J. D. McCarty, Speaker of the House of Representatives of the State of Oklahoma, is made a part of the record:)

OKLAHOMA CITY, OKLA., *August 10, 1964.*

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

Vital to exclude Oklahoma from H.R. 11865, an amendment to Social Security Act of 1964. Police officers have unanimously voted to request Oklahoma be excluded from said resolution. As member of House of Representatives I have authored practically every police pension bill for 24 years. We have a fine system and will continue to strengthen it. Our State statutes allow policemen to retire after 20 years. The proposed legislation would definitely impair the recruitment program for young officers entering police profession. Better working conditions to attract the highest caliber of men, plus a good pension plan is essential. Don't let Oklahoma down. At least amend bill giving those cities and towns an option. Respectfully requested.

J. D. MCCARTY,
Speaker, House of Representatives, State of Oklahoma.

Senator HARTKE. The next witness will be Mr. John Cassese, National Conference of Police Associations who is accompanied by Mr. Royce Givens.

STATEMENT OF JOHN J. CASSESE, PRESIDENT, NATIONAL CONFERENCE OF POLICE ASSOCIATIONS, ACCOMPANIED BY ROYCE GIVENS, EXECUTIVE SECRETARY

Mr. CASSESE. My name is John J. Cassese. I am president of the National Conference of Police Associations, and with me is Mr. Royce Givens, executive secretary of the National Conference of Police Associations.

In the room are many police representatives of many States.

Senator HARTKE. We will be glad to recognize them and we are delighted that they are here.

Mr. CASSESE. Thank you.

My presentation is brief, concise and to the point, and because of that, I think if you have any questions that you would like to ask later, I will be glad to answer them as best I can.

My name is John J. Cassese; I am president of the National Conference of Police Associations, which represents about 250,000 police officers throughout the United States and Canada.

The National Conference of Police Associations wholeheartedly endorses the amendment to H.R. 11865 introduced by Senator Ribicoff; this amendment would allow police officers and firemen, covered by State and local retirement systems, to continue their total exclusion from social security coverage.

Our members face unusual hazards in performance of their duties,

because of the nature of their employment, and are forced in many cases to retire at an earlier age than other local, State, and Federal Government employees. Therefore, our retirement systems, which have been developed for over the past hundred years, have been with regard to our special needs, particularly, the likelihood of early retirement.

Mr. Chairman and members of your committee, at our 12th annual conference in Los Angeles, Calif., during the month of July of this year, we sent a telegram to this committee opposing section 11 of H.R. 11865 which I would at this time like to read into the record of this hearing.

The National Conference of Police Associations, representing 250,000 policemen, is strongly opposed to that section of the proposed Social Security Amendments of 1964 which would remove the general exclusion of police officers from social security coverage. Police representatives from throughout the United States now assembled in Los Angeles are unanimous in their opinion that the contemplated amendment poses a serious threat to existing retirement systems by opening the door to local legislation that could impair hard-won retirement benefits.

Accordingly, we respectfully ask that you exert every effort to retain section 218D of the current law and delete those portions of the new bill designed to liberalize police participation under the Social Security Act, but which would, in fact, be contrary to the best interests of all law enforcement officers.

Mr. Chairman and members of this committee, we of the National Conference of Police Associations greatly appreciate the time afforded us and the courtesy extended by this committee in permitting us to voice our views and feelings in connection with section 11 of H.R. 11865. Thank you, sir.

Senator HARTKE. Senator Bennett?

Senator BENNETT. No questions.

Senator HARTKE. Senator Williams?

Senator WILLIAMS. No questions.

Mr. CASSESE. Thank you.

(The following statements received from police organizations and unions were inserted in the record by order of the chairman.)

STATEMENT OF SGT. ALBERT A. APA, REPRESENTING THE COMBINED POLICE ORGANIZATIONS OF CHICAGO, IN OPPOSITION TO SECTION 11 OF H.R. 11865 AND SUBCOMMITTEE IN LIFE THEREOF, SENATE AMENDMENT 1174

The combined Chicago police organizations, representing patrolmen, sergeants, lieutenants, and captains in the Chicago Police Department, desire to place on record their strong, unequivocal opposition to the provisions of section 11 of H.R. 11865 (Social Security Amendments of 1964).

This provision of section 11, if enacted, opens the door to inclusion of police under the provisions of social security, and such action will, inevitably, set the machinery in motion to end our local retirement system, as we know it.

The men of the Chicago Police Department have been covered by their own local retirement system under State law since the turn of the century. They have worked long and hard to develop a sound, responsible fund based on payments which the police officer could afford and which would be within the financial means of the community he serves. The comprehensive system of benefits which has evolved over many years is designed solely and exclusively for men who belong to a semimilitary organization; who are subject to severe physical demands; and who pursue a dangerous occupation. Certainly, it will be many years in the future, if ever, before social security can offer benefits comparable to those we already have.

We wish to emphasize that we are not opposed to change or progress and that our opposition to section 11 was crystallized only after careful consideration of its possible effects and consultation with police officers from other States and municipalities. It seems clear that once the exclusion provision has been removed, the next logical step will be to have movement initiated to begin social security coverage. If that were not true, there would be no real reason for removing the exclusion section, as any State which so desired could request removal of the exclusion on an individual basis. When the protection w now

enjoy has been taken away, the participants in the fund may find themselves subject to the "further division" provisions of the Social Security Act. At this point, it is, of course, true that those who wish can reject social security. But it is also true that from that time forward, each person joining the Chicago Police Department will have no choice and must become a part of the social security system and will have no opportunity to participate in the retirement system. This will result in a closed or static fund, which will eventually require large sums of money from the municipality in order to pay out, in full, the benefits granted to the participants who have elected to remain under the retirement system.

It is important, we think, to point out that Illinois, speaking through the Illinois Public Employees Pension Laws Commission, a commission established by the general assembly, has taken the position that when the Social Security Act becomes applicable to any group of public employees, it will be on a combined or cooperative basis. Thus, with regard to Chicago police officers, in arriving at a total pension to be paid, one portion would be paid from the retirement system and another portion would be paid from social security funds. It is a fact that in recent years the employer and employee contributions to social security have been rising rapidly. With constantly mounting taxes in this area, there is no question in our minds that there will be less money available for our own pension fund and again, the inevitable conclusion, that it finally dies out completely or becomes insolvent.

Lest it be thought that our fears are not grounded in reality, we refer the attention of the members of the Finance Committee to the report of the House Committee on Ways and Means on H.R. 11865 to statements such as: "Your Committee knows of no valid reason why this single professional group should continue to be excluded. It runs counter to the general view that coverage should be as universal as possible," (referring to doctors, on p. 10, sec. E. 1.); and "Under a provision of the Social Security Act which is designed to facilitate the extension of social security coverage to members of State and local government retirement systems * * *."

We submit to the committee that it has never been the intention of Congress to impose social security provisions on those persons who were already adequately provided for with regard to retirement, disability, or widow's or children's support. We believe that it was rather the intention to provide basic minimal benefits for persons who might not otherwise acquire them. With this idea we have no quarrel. We believe our reasoning is supported by the fact that from the inception of the act, each Congress has seen fit to authorize our exclusion. This action was wisely taken and we know of no reason why it should not be continued.

In conclusion, we request that section 11 of H.R. 11865 be stricken and we adopt, in its entirety, the statement made to the committee by the national representative speaking for police officers throughout the country.

HOUSTON POLICE OFFICERS ASSOCIATION,
Houson Tex., August 1, 1964.

HON. HARRY F. BYRD,
U.S. Senate,
Washington, D.C.

DEAR SIR: We have just learned that the Congress is presently contemplating amendments to the Social Security Act which would include all policemen and firemen. The House of Representatives has already passed H.R. 11865 in this respect. We have also learned that this bill has now been referred to the Committee of Finance in the Senate, of which committee you are the chairman.

Speaking for the police officers in the largest city in the State of Texas we urge that the Social Security Act remain as it presently exists. Presently police and firemen are allowed exclusion upon making a request to the Congress and their respective State legislatures. This has proven to be very satisfactory in the past and certainly should not cause any difficulty in the future.

We must say that we are certainly opposed to section 11 on page 38 of H.R. 11865 that repeals the total exclusion of police and firemen from the Social Security Act. We are certainly of the opinion that such action on the part of Congress would certainly be detrimental to police and firemen whose retirement programs are presently in existence.

Therefore, we strongly urge that the U.S. Senate delete from the bill the repeal of total exclusion of police and firemen from the Social Security Act.

Respectfully,

J. A. KNIGGE, *Secretary-Treasurer.*

HAAS MEMORIAL LODGE NO. 7,
FRATERNAL ORDER OF POLICE,
Erie, Pa., August 6, 1964.

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

DEAR SENATOR: The 250 members of Haas Memorial Lodge are vitally concerned about H.R. 11865, specifically section 11. We strongly urge you and ask your support to amend this act and leave the exclusion provision in the social security law as it now stands.

We stand to gain nothing from section 11 of H.R. 11865. We have had a retirement system in effect in the city of Erie, Pa., for police officers since 1915.

Frankly, Senator, with the rate of pay given to policeman, along with their present deductions; pension, insurance, hospitalization, etc., we just cannot afford social security.

Our retirement program calls for protection to the member and his widow and children. Social security will do nothing for our members except give them less take-home pay.

Police work is a young man's work. The possibilities of section 11 of H.R. 11865, would give all the police departments in the State of Pennsylvania, a majority of "old" men to combat the crime of the young. In these trying days for policemen, when force has to be met with force, a 50- or 60-year-old policeman is not match for a 20-year-old punk.

Most of the retirement systems in our State call for 50 or 55 as the retirement age, this proposed section 11 of H.R. 11865 would only extend this age 7 to 12 years at the minimum. Most of our meager paychecks cannot stand an additional 3½-percent bite.

I strongly urge you to amend H.R. 11865 by deleting section 11.

Thank you for your consideration in this vital matter.

Fraternally yours,

FRANCIS J. PILEWSKI, *Secretary.*

ILLINOIS POLICE ASSOCIATION, INC.,
August 5, 1964.

Hon. HARRY F. BYRD,
U.S. Senate,
Washington, D.C.

DEAR SENATOR BYRD: The Illinois Police Association, representing over 16,000 Illinois law-enforcement officers, is strongly opposed to section 11, page 38, of the proposed social security laws of 1964, which repeals the total exclusion of police officers and firemen from social security.

We believe that the proposed amendment is a serious threat to existing pension systems in that it would encourage local legislation detrimental to hard-won pension benefits.

You are respectfully urged to insist upon the retention of section 218(b) of the current law and delete any part of H.R. 11865 which would liberalize police participation under the Social Security Act, contrary to the best interest of law enforcement.

Most gratefully yours,

LAWRENCE B. HOFFMAN,
Secretary-Treasurer.

PARKERSBURG, W. VA., *August 3, 1964.*

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

The police officers of the city of Parkersburg, W. Va., wish to seek your aid and help in the Senate by asking that section 11, H.R. 11865 (social security) be amended to exclude police officers of West Virginia from this act.

The police officers of West Virginia are fortunate to have a good retirement law (retirement at age 50 with 20 years' service at 50 percent of salary) and we

feel that the inclusion under social security would jeopardize our pension law and in the future be detrimental in recruiting police officers.

Please give this matter your every consideration.

Lt. GAIL SMITH,
Secretary, Parkersburg Policemen's Pension and Relief Fund.

CHICAGO, ILL., *August 5, 1964.*

Hon. HARRY F. BYRD,
Senate Office Building,
Washington D.C.:

As representatives of the undersigned Chicago police associations we wish to express to you our disapproval of section 11 in H.R. 11865 and solicit your support in opposing this section in Finance Committee hearing. We feel strongly that the present exclusion of an Illinois policeman from social security coverage should be retained.

Capt. Henry Ediger, Chicago Police Captains Association; Lt. James A. O'Neil, Chicago Police Lieutenants Association; Sgt. Richard Barrett, Chicago Police Sergeants Association; Joseph Le Fevour, Fraternal Order of Police, Lodge 7; Maurice Higgins and John Higgins, Trustees, Chicago Police Pension Fund; Ronald Sieczkowski, Polish American Police Association; Stanley Sarbanek, Police Benevolent Association; Walter Rubyor, Chicago Policemen Annuity & Benefit Fund Protective Association.

DETROIT, MICH., *August 1, 1964.*

Senator HARRY BYRD,
Chairman, Senate Finance Committee,
Senate Building, Washington, D.C.:

The Michigan Conference of Police Associations, representing over 7,000 police officers in the State of Michigan, request that H.R. 11865 not receive favorable consideration in your committee.

The majority of police officers in the State of Michigan wish to remain on the exclusion list of the social security act.

ROBERT SHEEDY,
President, Michigan Conference of Police Associations.

LOUISVILLE, KY., *August 2, 1964.*

Senator HARRY BYRD,
Chairman of Senate Finance Committee,
Senate Office Building, Washington, D.C.:

The 521 police officers of Louisville Lodge No. 6, Fraternal Order of Police, join with all lodges and the national lodge in bitter protest of H.R. 11865. Especially are we opposed to that part giving authority to include police officers in the social security system. We most urgently ask you to do all within your power to exclude police officers from such harmful legislation.

JAMES W. BIBB,
President, Louisville Lodge No. 6, Fraternal Order of Police.

DETROIT POLICE LIEUTENANTS' & SERGEANTS' ASSOCIATION,
August 4, 1964.

Senator HARRY F. BYRD,
Chairman of Senate Finance Committee,
U.S. Senate, Capitol Building, Washington, D.C.

DEAR SENATOR: On behalf of our Lieutenants' & Sergeants' Association, we want to be put on record that we favor the continuation of police officers in the State of Michigan be on the exclusion list for social security. (Bill H.R. 11865, sec. 11, p. 38.)

Our membership is requesting your support in this matter.

Sincerely,

FRANCIS MCGEE, *President.*

FRATERNAL ORDER OF POLICE,
WABASH LODGE 83,
Wabash, Ind., August 3, 1964.

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

SENATOR BYRD: The members of the Wabash Lodge No. 83 of the Fraternal Order of Police of Indiana hereby go on record as opposing H.R. 11865. We are not opposed to social security for those police officers who are not presently covered by some other system of retirement.

The members of this lodge will appreciate your consideration on this bill.

Sincerely yours,

B. R. HETTMANSPERGER, *Secretary.*

WEIRTON LODGE NO. 84,
FRATERNAL ORDER OF POLICE,
Weirton, W. Va., August 4, 1964.

Hon. HARRY F. BYRD,
Chairman, Senate Finance Committee,
Capitol Building, Washington, D.C.

DEAR SIR: The members of the Weirton Lodge No. 84, Fraternal Order of Police, strongly object to being placed under the provisions of the Federal Social Security Act. The 1964 Amendments to the Social Security Act as contained in H.R. 11865, as introduced on July 1, 1964, and passed by the House of Representatives on July 29, 1964, would be detrimental to the police departments throughout the State of West Virginia, which are now under police pension retirement plan.

Therefore, we urge you not to endorse H.R. 11865, amendments to the Social Security Act, unless social security benefits would be in addition to the present police pension retirement plan.

Respectfully yours,

PAUL W. PAGUR, *Secretary.*

CAPITOL CITY LODGE NO. 74,
FRATERNAL ORDER OF POLICE,
Charleston, W. Va., August 3, 1964.

Hon. HARRY F. BYRD,
U.S. Senate,
Washington, D.C.

SIR: H.R. 11865 was introduced on July 1, 1964, and passed by the U.S. House of Representatives on July 29, 1964. Section 11 of that bill removes the provisions which presently excluded from social security coverage those policemen who are members of a retirement system.

The policemen in West Virginia are covered by the policemen's pension or relief fund, which is set up and spelled out in an uncomplicated form in the Code of the State of West Virginia. We have, for a great number of years, worked diligently to preserve and better this law for the betterment of our families. We have nothing to gain; but, to the contrary, a lot to lose if we should be put under the coverage of social security.

We implore you to do everything within your power to kill this bill.

Very truly yours,

G. C. WISEMAN, *Secretary.*

FOREST ROSE LODGE NO. 50,
FRATERNAL ORDER OF POLICE,
Lancaster, Ohio, August 3, 1964.

Senator HARRY F. BYRD,
Chairman, Senate Finance Committee,
U.S. Senate, Washington, D.C.

DEAR SENATOR: The 1964 Amendments to the Social Security Act, contained in H.R. 11865, section 11, of this bill removes the provision which presently excludes from social security coverage those policemen who are members of a retirement system.

The original position of the Fraternal Order of Police was that all policemen under retirement system should be excluded from social security. That position was provided for in the social security laws at the request of the Fraternal Order of Police and it was carried out in this manner for a number of years.

The entire membership of this lodge is opposed to this bill, and to the social security coverage of policemen.

Sincerely yours,

T. R. SHAEFFER, *Secretary.*

POLICE CONFERENCE OF NEW YORK, INC.,
Albany, N.Y., August 4, 1964.

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

DEAR SENATOR BYRD: This letter is in opposition to section 11, page 38, of H.R. 11865—the section that repeals the total exclusion clause of policemen and firemen from social security.

For many years, policemen and firemen in various sections of the United States have opposed inclusion in social security for fear it would affect their local retirement benefits. Until such time as they have legal assurances from their local retirement system that social security would not diminish or impair their present benefits, we feel they should continue to be excluded from social security.

For the aforementioned reason, the members of this association are urging you and the members of the Senate Finance Committee to oppose the repeal of the total exclusion clause pertaining to policemen and firemen.

Yours truly,

AL SGAGLIONE, *President.*

Senator HARTKE. The next and final witness we have this morning is Mrs. Elizabeth Wickenden, National Social Welfare Assembly.

STATEMENT OF MRS. ELIZABETH WICKENDEN, TECHNICAL CONSULTANT TO THE NATIONAL SOCIAL WELFARE ASSEMBLY, INC.

Mrs. WICKENDEN. My name is Elizabeth Wickenden and I am here as technical consultant to the National Social Welfare Assembly in this field, but I am actually testifying for 17 national organizations in the social welfare and religious field and my purpose here is to plead in their behalf with this committee to add hospital-related health benefits to the aged to the House-passed bill.

These organizations—I am going to read you the names in a moment—are very diverse in their character, and in their experience, and their points of view, but this one aspect of the social security program is of such compelling interest that this is the only proposal pending before you or proposed for your consideration on which they have taken a position and they have agreed on the need for hospital and other related benefits for the aged as an imperative lack in the present program.

I would like to read the names of the organizations and make comments as I go along.

The American Association of Homes for the Aging; I think their interest is obvious.

The American Foundation for the Blind, the Community Council of Greater New York, and I would like to ask that the record include material prepared by the Community Council of New York, particularly their very interesting study of income and expenditures among the older group in the city.

Community Service Society of New York, the Council of Jewish Federations and Welfare Funds, that is the central body for all Jewish welfare agencies.

The Family Service Association of America. That includes all the voluntary family agencies throughout the country.

Laurin Hyde Associates, a management consultant firm.

The National Conference of Catholic Charities, central body of all the Catholic charities.

National Federation of Settlements and Neighborhood Centers and I have a statement I would like to file for them.

Senator HARTKE. Without objection it will be included in the record.

Mrs. WICKENDEN. Those organizations, the National Jewish Welfare Board, central body for the YMHA and community centers. The National League for Nursing which is the central organization for various purposes in the nursing field, but in this case particularly those organizations that are giving home nursing that are in a desperate situation because they are being urged to expand their services and then they find that these older people who desperately need home nursing have no money with which to pay for it.

The National Urban League which is filing a statement with you of its own, and has recently issued a study entitled "Double Jeopardy" in which they show the peculiar needs of the aged Negro.

The Synagogue Council of America, the United Seamen's Service, the Women's Division of the Board of Missions of the Methodist Church, the Young Women's Christian Association, National Board, and also one of our affiliates, the National Council of Churches of Christ in America is filing its own statement because it is not empowered to sign joint statements.

I would like to point out that this group includes all the major spokesmen of the three faiths as well as of the welfare field.

I am not going to read this statement because it will appear in the record, the formal statement.

Senator HARTKE. The entire statement will appear in this record at this time.

Mrs. WICKENDEN. Yes.

But I would like to indicate the three general reasons that seem to me to dominate the thinking of all these groups in advocating this type of benefit for the aged.

In the first place, I think that it is perfectly obvious to anyone who works with people who come to welfare agencies and those who seek out the advice of their church or religious body that there are large numbers of aged persons who simply are not now receiving any health care whatsoever or very inadequate health care.

I work with many of the groups of older people, and I think that it is impossible to measure the degree of discouragement which is in their hearts as a result of this long delay in any action on this compelling need.

In the second place, these organizations are all very strongly supportive of a very decent adequate public assistance, public welfare program, which can underpin existing other provisions for the needy.

One of the great difficulties at the present time is that the Kerr-Mills program, inadequate as it is, is already costing at present rates a billion dollars a year, and this figure is mounting constantly.

As a result of this pressure on the States they are totally unable to provide a decent cash level of benefits, so that you have at the present time an average old age assistance payment of about $61, the average payment for a needy child is under $30. It seems clear to me that you can't expect people to lift themselves out of poverty—when they can't even feed their children on $30 a month.

Now, one way in which this can be remedied or at least eased is to take this enormous cost, this billion dollars a year cost, and, of which a very substantial proportion is going now into hospital and nursing home care and put that under the social insurance system exactly as we have done with other types of need in the past.

The third point that I would like to make because I think it comes home so clearly to the religious organizations and those concerned with the family, is the tremendous family tension that is caused by the necessity for people in their middle years, Mr. Cruikshank already referred to this, being torn between their obligation to their parents and their other obligations.

The dilemma we have both in this family relationship and in the medical assistance for the aged is that the better job a family does the more conscientious it is, the more generous a State is in trying to meet these needs outside the social insurance system the more impossible it becomes for them because they are trying to do what cannot be done under these provisions.

I would say finally, that one thing that strikes me constantly, and I have been coming both to this committee and the Ways and Means Committee for many years, is the disposition to look upon these as alternative methods.

We do not by providing under social insurance that a person receive an entitlement as a matter of right, we have not destroyed the insurance industry, it has absolutely boomed in the scope of coverage, and level of profits.

We do not get rid of assistance because you still have to have something underpinning for unusual cases, nor do we destroy family solidarity. You simply make them all fit together.

But without this additional program there is not a one of them that is able to do its job properly.

I would say, as I have said, heard said so often, among the older people, that it has to be this year. They have waited so long. There is such a feeling that the needs of this huge group of people—19 million people—are somehow being passed over, and a hope too long deferred maketh sick the heart.

(The prepared statement of Mrs. Wickenden and attachments follow:)

TESTIMONY BY ELIZABETH WICKENDEN, TECHNICAL CONSULTANT TO THE NATIONAL SOCIAL WELFARE ASSEMBLY, INC., FAVORING THE ADDITION TO H.R. 11865 OF HEALTH BENEFITS FOR THE AGED UNDER SOCIAL INSURANCE

My name is Elizabeth Wickenden and I appear before you in behalf of a group of voluntary organizations in the social welfare field to urge you to recommend to the Senate the addition to H.R. 11865 of provision for hospital and related health benefits for the aged under the social insurance system. I am asked to make this group plea to you in my capacity as technical consultant in this field to the National Social Welfare Assembly, a coordinating body with which these organizations are directly or indirectly affiliated.

The following organizations have asked me to speak in their behalf:

American Association of Homes for the Aging.
American Foundation for the Blind.
Community Council of Greater New York.
Community Service Society of New York.
Council of Jewish Federations and Welfare Funds.
Family Service Association of America.
Laurin Hyde Associates.
National Conference of Catholic Charities.
National Council of Jewish Women.
National Federation of Settlements and Neighborhood Centers.
National Jewish Welfare Board.
National League for Nursing.
National Urban League.
Synagogue Council of America.
United Seamen's Service.
Woman's Division of the Board of Missions of the Methodist Church.
Young Women's Christian Association—National Board.

In addition, one of our affiliates, the National Council of Churches of Christ in the United States of America (which has a policy which precludes joint statements) is submitting testimony in its own behalf taking a similar position of support for health benefits for the aged under socal insurance.

The joint recommendation of these organizations is as follows:

"We wish to urge the Senate Finance Committee to amend H.R. 11865 to provide more adequately for the health needs of our aged population. It is evident to us that the present financing provisions available through public assistance, private insurance, voluntary philanthropy, and family resources are insufficient to cope with the disproportionately costly health needs that occur in a period of life when income is typically reduced.

"We, therefore, urge the Senate Finance Committee to include within the contributory social insurance system provision for hospital, nursing home, diagnostic, and home care benefits which will be available to persons over 65 years of age as a matter of right without regard to personal or family resources."

Some of these organizations are filing with the committee individual statements elaborating their particular point of view. In addition to these organizational signatories a large number of individual leaders in the social welfare field—including the three former Commissioners of Social Security, Arthur J. Altmeyer, Charles I. Schottland, and William L. Mitchell—signed a comparable statement submitted by the assembly at the time this issue was before the House Ways and Means Committee.

These organizations and individuals in the social welfare field have come to the conclusion that hospital and related benefits for the aged are a necessary supplement to the cash benefit provisions of the old-age survivors, and disability insurance program as a result of needs revealed in their own experience. Their perspective on these needs naturally varies to some extent with the nature and task of their own organizations but three points seem to me to be basic to this social welfare viewpoint and I would like to summarize them for you.

First: The inadequacy of existing provisions is everywhere revealed in the fact that large numbers of older people simply are not now receiving the health care they require. They do not have the money to buy it—whether through the advance payment methods of insurance or in actual payments at the time they need it—and other provisions under public assistance and private philanthropy are neither adequate nor satisfactory to people who have worked hard all their lives and deserve better of us in their later years.

Second: These voluntary social welfare agencies are strongly supportive of an adequate public welfare program which can place an effective floor under need not otherwise met. The levels of public assistance in a majority of States are shockingly low and one reason for this inadequacy is the mounting cost of trying to meet the health costs—particularly for hospitals and nursing home care—of the needy aged through welfare funds. Should these health costs be reduced by the insurance system it would not only provide a more satisfactory answer both for those needing and providing hospital and nursing home care, but it would also free State resources to make more adequate assistance and other welfare payments.

Third: Welfare and religious organizations are increasingly concerned about the difficulties created for families with older members who require costly or ex-

tended hospital or nursing home care. Naturally all persons of conscience and good will want their elderly parents, grandparents, and other relatives to have the care they require and many make every sacrifice to this end. But by reason of the same good will and conscience elderly people are extremely reluctant to see their children and grandchildren make these sacrifices. They will all too often hide their health needs in order to prevent this and will go to any length not to apply for welfare help under the Kerr-Mills or old-age assistance programs, which—in virtually all States—require that their children contribute in accordance with their resources. Many people do not seem to realize the extent to which the present system puts a burden on the middle generation, creates tensions within families, and inhibits older people from seeking the help they need.

In each of these cases there seems to be no satisfactory answer outside of a clear and universal entitlement for older persons under the social insurance system. Family help, public assistance, and private insurance all have their role to play but each of them is being asked at the present time to do the impossible. Only through the addition of social insurance entitlements can the health needs of older people be adequately met in a way that—with typical American ingenuity—combines all four approaches to the problem.

STATEMENT OF MISS HELEN HALL FOR THE NATIONAL FEDERATION OF SETTLEMENTS AND NEIGHBORHOOD CENTER, NEW YORK, N.Y.

The National Federation of Settlements and Neighborhood Centers is composed of 264 affiliates operating 356 neighborhood centers in 88 cities and 31 States and the District of Columbia.

The National Federation of Settlements and Neighborhood Centers supports S. 880, Hospital Insurance Act of 1963, on the basis of the resolution adopted at its delegates annual business meeting in Boston, June 1960, as follows:

"The National Federation of Settlements and Neighborhood Centers believes that communities must assure to all their citizens full access to the best possible preventive, treatment, and rehabilitative services known to modern health sciences. It therefore supports a comprehensive program of health insurance through the social security system with supplementary programs for nonparticipants in the social security system with no means test."

Letters and reports from staff members in our neighborhood centers all over the country show a clear unmet need for helping to finance a part of the health requirements of older men and women living in the neighborhoods we serve.

Since their founding, the settlement and neighborhood centers have been bringing their firsthand experiences in industrial neighborhoods to our lawmakers. Sometimes it is to city hall that they turn, somethimes to the State capital and sometimes to the Congress of the United States. Steadily throughout the years they have been asked for their firsthand experiences which have come from their close observation and close association with people in our poorest neighborhoods.

In April 1930, the National Federation of Settlements was asked by Senator Wagner and Senator Robert La Follette, to bring the results of their studies of unemployment to testify before a Senate committee.

Later in 1934, I served on the Advisory Council to the President's Committee on Economic Security and at that time it was hoped that our people's health needs would be a part of the comprehensive social security program, which included employment insurance, old-age insurance, child and maternal health service, accident compensation. Unfortunately, the opposition to health needs through social security was strong enough to keep health out of the social security coverage.

Before the Housing Act was passed, we took our part many times in presenting to the Congress the desperate need for decent housing in our slums.

Throughout these years and the years to follow, we have continued to bring to the public and to the Congress, the chaotic, wasteful and cruel lack of health services for low-income people in our country. In 1938, we made possible a study of the British experience, "Health Insurance With Medical Care," so that there would be a better understanding than was to be found current at the time. In 1946 we presented to a congressional committee the findings of a National Federation of Settlements study on "Medical Care in Settlement Neighborhoods."

In June 1949 we again brought our experience to bear before a subcommittee on health of the U.S. Senate on Labor and Public Welfare, in support of S. 1679, the national health bill.

A report issued in 1951 of the Henry Street Settlement's study of the health needs of 553 families living on the Lower East Side of New York, was included in "Building America's Health," a report to President Truman by a commission on the health needs of the Nation.

Again, in 1952, we brought the need for health care for the dependents of servicemen before the U.S. Senate Banking and Currency Committee.

In July 1961, we testified in favor of H.R. 4222, the "Health Insurance Benefits Act of 1961," which dealt only with care for the aged.

Throughout these years we have seen a fabric of security slowly being built to protect those of our lowest income neighbors. But the least progress is always in the field of health. We realize the power of the opposition but at the same time we see our neighbors still unsuccessfully struggling to meet the costs of catastrophic illness, inevitable sickness among children, the cost of the day-by-day emergencies, which, too often, take savings or food money. We see sickness rob the wage earner and his family of their independence.

Older members of our community have increased in proportion to the population. Medical science keeps people alive longer, but there is still insufficient provision for these added years to be borne with security. The fear of sickness and its costs is ever present in the minds and hearts of the aging who cannot afford to be ill.

The Hospital Insurance Act of 1963 only helps bear some of the burden of hospitalization and nursing care. But what is most important to the older people whom this bill is meant to protect, is that it comes to them as a right through their own payments to social security. There is no humiliating means test to add to the burdens of sickness and old age and the sense of comfort that at least this amount of care is theirs if they need it.

STATEMENT OF THE COMMUNITY COUNCIL OF GREATER NEW YORK PRESENTED AT THE MAYOR'S CONFERENCE ON MEDICARE AT CITY HALL, JANUARY 18, 1964

(By Judge Matthew J. Troy, chairman, Citizens' Committee on Aging, and Walter J. Lear, M.D., chairman, Public Health Committee)

My name is Matthew J. Troy. I am chairman of the Citizens' Committee on Aging, but I am speaking on behalf of the entire Community Council of Greater New York. As you know, this council is the planning and coordinating body in the health and welfare fields for over 1,000 official and voluntary agencies, including the three sectarian federations of New York City.

It is the fundamental conviction and belief of the Community Council of Greater New York that the socially desirable and fiscally sound approach to financing of health care of the aged is through the proven contributory system of social security. We feel that Federal legislation to enact such a program is urgently needed.

While we do not view any of the Federal legislative proposals as adequate in all respects, H.R. 3920 (King-Anderson) does embrace those principles we regard to be of fundamental importance: universal coverage; service benefits as a right versus pauperization and the means test; quality standards; economical administration by the Bureau of Old Age, Survivors and Disability Insurance.

The citywide picture of income levels of our older population is a sobering one. About 21 percent of New York City's large aging population had no money income in 1959, and an additional 49 percent had income of less than $2,000. In numbers, this totals, 560,148 or well over half a million older people, with income of less than $2,000, according to census data.

From the viewpoint of need for health services, there are two particularly vulnerable groups of elderly—those 75 years of age and older, and women living alone or with unrelated persons. Both groups had lower median income than males aged 65 to 74 years of age.

In 1960, New York City's aged 75 years and older comprised a larger group than the entire population of Staten Island, and is expected to total 330,000 people by 1970. A recent study indicates that medical expenditures for families headed by that age group were double that of families with heads 65 to 74 years

of age. However, this refers only to care actually purchased. The unmet need for preventive services to preserve health and independent living is a matter of deep concern to us.

It is a well-known fact that women live longer than men, but their disadvantaged economic status is less well known. The community council has recently published "A Family Budget Standard" which indicates that an elderly woman, not employed, living alone, requires $1,996 per year. Yet the median income of elderly women unemployed and employed, living alone or with unrelated persons, was only $982 in 1960. Furthermore, over half of women 65 years and older had income of less than $2,000. While the average monthly benefit for retired workers was about $80 in 1960, for the surviving spouse 62 years or older, it was $60 to $67 per month.

We know of your own commitment to medical care for the aged under social security and deeply appreciate your efforts to expedite this urgently needed legislation. Community council will continue to work for a Federal program of health care, as well as a liberalized State program of medical assistance to the aged.

Dr. Walter J. Lear, chairman of the community council's public health committee, will at this point present the Council's views on the inadequacy of the alternatives to the social insurance approach.

New York City has the largest MAA program in the Nation accounting for about 22 percent of the total expenditures and about 11 percent of the total number of MAA recipients. The scope of the program has been classified by the Bureau of Family Services of the Welfare Administration as comprehensive, a distinction shared by only three other MAA programs.

Despite this relatively extensive use of the MAA approach, New York City's program has been a disappointment. The community council and almost all concerned agencies and groups in New York City are agreed that the result falls far short of the intent of Congress—"a new and separate program" which provides a "wide range of medical services to low-income aged people who are not OAA recipients" and is "administered as simply as possible, with appropriate respect to the rights and dignity of the aged."

In New York City, the major effect of the MAA program has been to transfer to the State and Federal Governments a substantial part of the cost of the existing medical services previously paid for by the city department of welfare or furnished by the municipal hospitals. The limitations of the program have made it impossible to extend medical care to any significant additional number of the aged, or to improve in any significant way the medical services MAA recipients may use.

In fact, the medical services provided MAA recipients in New York City is no different from that provided without this legislation to all indigent patients. In addition, the MAA program has required the city department of welfare to engage in a costly and cumbersome administrative activity and has imposed on some of the medically indigent aged new indignities and pressures to become paupers.

The Blue Cross and Blue Shield plans covering New York City have offered a contract to older people on an individual basis. The combined premium is about $170 per year per person, and the principal benefits are 21 days of hospital care per admission and inhospital medical and surgical care. For most of New York City's aged, these premiums amount to 10 percent or more of their annual income. They cannot afford such an expenditure, particularly when the policy covers one-half or less of the average cost of medical care for people of their age.

New York City is also covered by one of three special statewide insurance programs for those 65 and over sponsored by the private insurance industry. "New York 65" offers a basic policy for $120 per year per person. Like policies from private insurance companies in general, comprehensive benefits are not the goal. Rather, they are intended to be of maximum help when the person is stricken by serious illness or accident. The sales literature gives the following example of how it would work in such a case:

"Suppose, for example, you broke your hip, then spent 41 days in a hospital where you required 38 doctor calls and 10 days of nursing care. Also assume that other major expenses included surgery, an anesthetist, and prescription drugs.

"Your total expense, according to serious cases of this kind, might be $2,910. Toward this bill, "New York 65" regular basic would pay $958, and "New York 65" major medical would pay $1,251—providing a combined benefit of $2,209. You would pay $701."

Clearly, this does not provide the kind of insurance protection that would be useful for the vast majority of the aged in New York. They do not need a policy costing $228 a year which at its best—when the costly medical problem occurs—still leaves the individual with hundreds of dollars of uncovered medical bills.

We would hope that the Congress, before acting on the King-Anderson bill would eliminate the confusing and undesirable hospital benefit options with "deductible" provisions. If options must be included, we strongly urge that the option providing 45 days of hospital care without a "deductible" be made the standard option which would apply to all except those persons who specifically requested one of the options with a "deductible."

Furthermore, we believe that experience under a social security health program for the aged would demonstrate the need for, and feasibility of, providing benefits more adequately related to health needs.

STATEMENT OF THE COMMUNITY COUNCIL OF GREATER NEW YORK, ON H.R. 3920

The Community Council of Greater New York is the planning and coordinating body in the health and welfare fields for over 1,000 official and voluntary agencies, including the three sectarian federations of New York City (app. C).

SECTION A. INCOME AND MEDICAL EXPENDITURES OF OLDER PEOPLE IN NEW YORK CITY (SUMMARY OF APP. A)

The plight of the aged

The 1960 census indicated that there were 813,827 people 65 years and older in New York City. We estimate that this age group may total 1½ million by 1970.

About 21 percent of those 65 and over had no money income in 1959 and an additional 49 percent had income of less than $2,000.

In 1960, the cost of hospital and related institutional care for New York City's aged was $222 million. This means almost one-third the total cost for all such care was incurred by only 10.5 percent of the population.

New York City's aged use almost three times as many patient-days in general hospitals as the younger age group and 27 percent of all ward service in general hospitals.

As overwhelming as these data are, they do not convey the full significance of the problem. Two vulnerable sectors of the aging population warrant special mentioning—the "older" aged group, that is, those 75 years and over, and the single person, particularly women, living alone.

The aged, 75 and over

Of special significance in relation to need for health services is the size of the group 75 years and older, almost 230,000 people in 1960. This group will increase at a proportionately faster rate, probably totaling 330,000 in New York City by 1970.

While there is no precise documentation available regarding the cost of the medical care they need, we know that expenditures for medical care by the group 75 years and older is double that of the group 65 to 74 years of age. A survey of budgets and spending patterns for a sample of New York City families in 1960 by age of head of family was undertaken by the U.S. Department of Labor, Bureau of Labor Statistics. ("Some Facts Relating to the Economic Status of the Aging.") This showed an average 1960 expenditure of $342 for medical care for families headed by persons 65 to 74 years, not in institutions, compared to $686 for families with heads 75 years and older, not in institutions.

The single aged person living alone

The 1960 Census of Housing indicates that nearly 150,000 New Yorkers 65 years and older were living alone in a "household." Of this particularly vulnerable group, 69 percent had 1959 incomes of less than $2,000.

It is a well-known fact that women live longer than men. Less well known is the lower income of elderly women, including adequate social security benefits. The Budget Standard Service of Community Council (based on October 1962 prices) indicates that an elderly woman, not employed, living alone requires $1,996 per year. Yet the median income of elderly women unemployed and employed living alone or with unrelated persons was only $982 in 1960.

SECTION B. INADEQUACY OF THE ALTERNATIVES TO THE SOCIAL INSURANCE APPROACH

MAA, no substitute for an effective solution

New York City has the largest MAA program in the Nation accounting for about 22 percent of the total expenditures and about 11 percent of the total number of MAA recipients. The scope of the program has been classified by the Bureau of Family Services of the Welfare Administration as comprehensive, a distinction shared by only three other MAA programs.

Despite this relatively extensive use of the MAA approach, New York City's program has been a disappointment. The community council and almost all concerned agencies and groups in New York City are agreed that the result falls far short of the intent of Congress—"a new and separate program" which provides "a wide range of medical services to low-income aged people who are not OAA recipients" and is "administered as simply as possible, with appropriate respect to the rights and dignity of the aged."

In New York City, the major effect of the MAA program has been to transfer to the State and Federal Governments a substantial part of the cost of the existing medical services previously paid for by the city department of welfare or furnished by the municipal hospitals. The limitations of the program have made it impossible to extend medical care to any significant additional number of the aged, or to improve in any significant way the medical services MAA recipients may use.

In fact, the medical services provided MAA recipients in New York City is no different from that provided without this legislation to all indigent patients. In addition, the MAA program has required the city department of welfare to engage in a costly and cumbersome administrative activity and has imposed on some of the medically indigent aged new indignities and pressures to become paupers.

Private insurance, inadequate benefits, and high cost

The Blue Cross and Blue Shield plans covering New York City have offered a contract to older people on an individual basis. The combined premium is about $170 per year, per person and the principal benefits are 21 days of hospital care per admission and in-hospital medical and surgical care. For most of New York City's aged, these premiums amount to 10 percent or more of their annual income. They cannot afford such an expenditure, particularly when the policy covers one-half or less of the average cost of medical care for people of their age.

New York City is also covered by one of three special statewide insurance programs for those 65 and over sponsored by the private insurance industry. "New York 65" offers a basic policy for $120 per year, per person, and a major medical policy for $108 per year, per person. Like policies from private insurance companies in general, comprehensive benefits are not the goal. Rather they are intended to be of maximum help when the person is stricken by serious illness or accident. The sales literature gives the following example of how it would work in such a case:

"Suppose, for example, you broke your hip, then spent 41 days in a hospital where you required 38 doctor calls and 10 days of nursing care. Also assume that other major expenses included surgery, an anesthetist, and prescription drugs.

"Your total expense, according to serious cases of this kind, might be $2,910. Toward this bill, New York 65 regular basic would pay $958, and New York 65 major medical would pay $1,251—providing a combined benefit of $2,209. You would pay $701."

Clearly this does not provide the kind of insurance protection that would be useful for the vast majority of the aged of New York. They do not need a policy costing $228 a year which at its best—when the costly medical problem occurs—still leaves the individual with hundreds of dollars of uncovered medical bills.

SECTION C. POLICY STATEMENT ON HEALTH CARE OF THE AGED

The following statement was prepared by the Citizens' Committee on Aging and the Public Health Health Committee of the Community Council of Greater New York, and was unanimously adopted by the board of directors of the community council on May 3, 1962.

Health care of the aging has become a matter of grave national concern. The average aged person is unable to meet, out of his own resources, the high cost of health services required. The facts regarding income and medical costs have been amply documented and do not require repetition.

While there is general agreement as to the extent and nature of the problem and the need to deal with it on a broad-scale basis, there is no universal agreement on a desirable social remedy. Many suggestions have been put forward by various groups concerned with this problem. While they differ in approach and reflect at times diverging, if not strongly conflicting, concepts as to the nature of community responsibility and the methods for discharging that responsibility, they are in agreement that a socially acceptable way must be found to meet this imperative need.

It is the fundamental conviction and belief of the Community Council of Greater New York that the socially desirable and fiscally sound approach to financing health care of the aged is through the proven contributory system of social security and that Federal legislation to enact such a program is urgently needed.

Needs created by reason of health problems are no less important than the needs created by reason of total and permanent disability, or because of unemployment due to age. They should have an equal claim to coverage by our Federal social insurance system. Such inclusion would entitle beneficiaries to health benefits as a matter of right. There would be no room for a means test just as there is none now when an insured person qualifies for receipt of old-age or disability benefits under Federal social security.

In the consideration of the various legislative proposals which have been urged on the Congress we believe there are certain fundamental principles which should govern the enactment of relevant Federal legislation.

Eligibility

Coverage should be extended to all persons 65 years of age and older. While inclusion of health benefits under the Federal social security system would assure coverage to those who are now receiving, or will subsequently qualify for old-age insurance benefit payments, we believe some provision should be made to blanket-in all other persons 65 years and older. This will provide universal coverage and will reduce the need for supplemental medical assistance to the aging programs based on a means test.

Benefits

From a medical point of view it is difficult to evaluate one segment of medical care as being more important than another. Comprehensive medical care embraces care at home and in medical facilities. It includes professional services, hospital and nursing home care, diagnostic procedures for ambulatory patients, such as X-rays and laboratory tests, home health services, dentistry, and prescribed drugs.

In recognition of the high cost of institutional care it is estimated that this receive priority consideration. No less compelling from both a humanitarian and economic standpoint is the need for early diagnosis and preventive medicine. Therefore, the program should include initially at least diagnostic and home health services in addition to hospital and nursing home care.

The elimination of all economic barriers to medical care benefits is essential if the aged are to use them when they will do the most good, that is, when illness first becomes evident or even earlier. Deductible and limited cash indemnity provisions encourage delay in seeking medical care and in the long run, result in increased cost because of the greater amount of care required by neglected illness. Thus the special value of medical benefits is diminished when the patient is required to pay an initial deductible or the balance above a scheduled benefit.

Unlike the existing provisions of the old-age, survivors, and disability insurance program which provide for payment of cash benefits directly to the eligible insured beneficiaries, the medical insurance benefits should be on a basis of payment to providers for services rendered. It has been demonstrated that cash benefits are both medically undesirable and economically unsound. Instead of rationalizing the costs of medical care, cash benefits invariably promote their inflation.

Quality of care

Adequate safeguards to insure high quality of medical care should be an integral part of the program. There should be an advisory council which should include persons outstanding in the health professions. There should be standards for all classes of participating medical care facilities and health service personnel. These should be no less than minimum standards to be prescribed by the

Secretary of Health, Education, and Welfare. Where empowered by State law to do so, State health departments should be utilized in the determination of initial and continuing eligibility of participating facilities and personnel. There should be encouragement, and financial support of demonstrations, administrative studies, consultations, established certification and accreditation bodies, and measurements of the medical care needs of the aged.

Administration

Responsibility for administering the medical insurance benefits program should be lodged with the Bureau of Old-Age, Survivors, and Disability Insurance of the Social Security Administration of the U.S. Department of Health, Education, and Welfare. This will facilitate administration of the new program since utilization of existing social insurance mechanism would assure uniformity of benefits throughout the country, would entail the lowest possible administrative costs, and would promote the prompt initiation of the program.

This statement was circulated to many New York City organizations and was officially endorsed by 69. These included:

Schools of social work	2
Homes for the aged	10
Hospital social service department	14
Recreation centers	13
Neighborhood councils and civic associations	8
Other agencies and organizations	22

These agencies are listed in appendix B.

SECTION D. RECOMMENDATIONS CONCERNING H.R. 3920

While none of the current Federal legislative proposals meet the fundamental principles which we advocate (sec. C) in all respects, H.R. 3920, commonly known as the King-Anderson bill, comes closest to it because it embraces the principles of universal coverage, service benefits as a right, quality standards, and administration by the Bureau of Old-Age, Survivors, and Disability Insurance.

However, we would hope that the Congress before enacting this legislation would eliminate the confusing and undesirable hospital benefit options with "deductible" provisions. If options must be included, we strongly urge that the option providing 45 days of hospital care without a "deductible" be made the standard option which would apply to all except those persons who specifically requested one of the options with a "deductible."

Furthermore, we believe that experience under a social security health care program for the aged would demonstrate the need for, and feasibility of, providing benefits more adequately related to health needs.

APPENDIX A

OLDER PEOPLE IN NEW YORK CITY: FACTS AND YARDSTICKS

Dimensions and growth of the city's aging population; income of New Yorkers aged 65 years and older; health status and institutional care

(Citizens' Committee on Aging, Community Council of Greater New York, New York, N.Y.)

DIMENSIONS AND GROWTH OF THE CITY'S AGING POPULATION

Dimension

By 1960, 813,827 New Yorkers were 65 years old or older. If this age group were "a city," it would rank as the ninth largest in the United States—exceeding the total population of Washington, D.C., and also of St. Louis and San Francisco. By 1970, it is estimated there will be about 1½ million New Yorkers in this age group.[1]

Although in 1960, 10.5 percent of the city's total population were aging, this proportion ranged from a little less than 6 percent in some communities to 15 or 16 percent in others, and to 18 percent in one area of Manhattan.

[1] Mayor Robert F. Wagner, inaugural dinner of 1962–63 maintenance campaign, Federation of Jewish Philanthropies.

Growth in relation to total population[2]

During the 60 years of the 20th century, the city's total population grew by 126 percent, while the aging segment grew by 749 percent. In 1900, the aging were less than 3 percent of all the residents. As late as 1930, they were only 3.8 percent. In 1960, however, 1 in every 10 New Yorkers was 65 years of age or older.

Age range of older people[2]

The significant fact in relation to health and welfare services is the rapid increase in the group 75 years old or over between 1930 and 1960. Its share of the total in the age group is shown in the tabulation, but the actual number of the "older aged" is the most impressive fact.

New York City's aging population, 1930–60

Age group in years	Number		Percent of total	
	1930	1960	1930	1960
Total	264,502	813,827	100.0	100.0
65 to 69	127,350	344,063	48.2	42.3
70 to 74	77,327	240,101	29.2	29.5
75 to 84	52,375	197,215	19.8	24.2
85 and over	7,444	32,448	2.8	4.0

Source: U.S. Bureau of the Census, decennial census of population.

While the number of men and women from 65 years of age through 74 years increased from 204,683 to 584,164, or 185 percent, the group 75 years and over rose by 284 percent from only 59,819 in 1930 to 229,663 in 1960—a figure larger than the entire population of Staten Island. This older group is expected to grow at a proportionately faster rate, probably totaling 330,000 by 1970.[3]

INCOME OF NEW YORKERS AGED 65 YEARS AND OLDER[4]

Unquestionably, the income of most of the city's older population is low:

The 1960 Census of Population found that about 21 percent of the individuals (7 percent of the men and 32 percent of the women) who were 65 years of age or older in 1960 had no money income during 1959 and another 49 percent had incomes of less than $2,000.

From the 1960 Census of Housing it is known that nearly 156,000 of these older residents were living alone in "a household"—not in an institution or other "group" quarters. Of this particularly vulnerable group, 69 percent had 1959 incomes of less than $2,000.

Families with heads 65 years or older also had 1959 incomes below the general population's. The 1960 census reveals that the median family income during 1959 for all families in the city—without regard for size or composition—was $6,091. For families headed by a person 65 years old or older, the 1959 median family income was much lower—$4,304 for families in which both the husband and wife were present, $5,504 for other families with a male head, and $4,595 for families with female heads.

For older men living alone or with unrelated persons—excluding those in institutions—the median income was $1,133; for women in this category the median income was only $982.

In 1960, close to three-fifths of the New York City population 62 years old or older were receiving social security benefits.

For some 433,000 retired workers the average monthly benefit was under $80 but in about 97,670 instances the wife or husband received an additional benefit of about $43 a month.

For surviving spouses or parents, however, the average benefits were lower—$60 to $67 a month per beneficiary.

[2] Bureau of Community Statistical Services, Research Department, Community Council of Greater New York.

[3] Klarman, Herbert E.: "Background, Issues, and Policies in Health Services for the Aged in New York City," Interdepartmental Health Council, March 1962.

[4] Bureau of Community Statistical Services, Research Department, Community Council of Greater New York.

In the spring of 1963, about 12,430 elderly residents of the city who were beneficiaries of old-age, survivors, and disability insurance were receiving supplementary public assistance under old-age assistance.

These insurance beneficiaries constituted almost 40 percent of the department of welfare's total OAA caseload.

Most older people live on fixed incomes, with little opportunity to earn, although more than a fifth were in the labor force in 1960. Of the total of 188,452 older persons in the labor force, 14,600 were unemployed.

About 71 percent of the employed men were working full time; only 56 percent of the women in jobs were employed full time.

HEALTH STATUS AND INSTITUTIONAL CARE

National and local studies indicate that most older people are functioning well, physically and mentally. However, older people are particularly vulnerable to catastrophic illness, and four-fifths have one or more chronic conditions.

Recent studies of community need across the country show that most of the chronically ill aged live in their own homes and receive either no health services or totally inadequate care.[5]

In New York City, public agencies are making vigorous efforts to upgrade medical care for the indigent, and for elderly residents of public housing projects. For the much larger group of marginal income aged, health care remains sparse and spotty, despite numerous new pilot projects.[6]

Within present-day knowledge, much physical and mental illness and crippling disability could be prevented through early diagnosis, treatment, and rehabilitative service. Moreover, the provision of home health services could enable many elderly now institutionalized to live in the community or to avoid prolonged hospital stays.

Analyses of general hosptials show that from 20 to 30 percent of the extended stay patients have been retained because of social rather than medical reasons.

Similarly, studies of nursing homes, homes for the aged and mental hospitals indicate that many do not require institutional care and could live at home if community resources were available to meet their medical and social needs.

Older people comprising 10.5 percent of New York City's total population use almost three times as many patient days in general hospitals and 30 to 40 percent more physicians' services than the younger population. They also use 27 percent of all ward service in general care hospitals.

In New York City, at least 8,000 older people are in general hospitals on any given day and, in addition, at least 37,000 are in long-term institutions. Almost half of the latter (17,000) are in State mental hospitals.[7]

In addition to our major consideration—the welfare and dignity of the individual—there are compelling economic reasons for expanding services to preserve health and prevent needless institutionalization.

The cost of hospital and related institutional care for the aging is high. In 1960, it was $222 million, almost one-third of the total for all such care, for only 10.5 percent of the population.[7]

Moreover, by 1970 New York City will require 15,000 new long-term institutional beds for the aged at a cost of about $180 million for construction only.

APPENDIX B

ENDORSEMENTS OF THE COMMUNITY COUNCIL'S POLICY STATEMENT ON HEALTH CARE OF THE AGED

Schools of social work (2):

Fordham University School of Social Service.

Hunter School of Social Work.

Homes (10):

Beth Abraham Home.

Bronx Home for Sons & Daughters of Moses.

Evangelical Home for the Aged.

First United Lemberger Home for the Aged.

Hebrew Convalescent Home.

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[5] "Facilities for Long-Term Treatment and Care," American Hospital Association-Public Health Service, February 1963, U.S. Department of Health, Education, and Welfare.

[6] Interim report: "Preventive Home Care and Health Maintenance Programs," Subcommittee on Health, Citizens' Committee on Aging, March 1963.

[7] Klarman, Herbert E.: "Background, Issues, and Policies in Health Services for the Aged in New York City," Interdepartmental Health Council, March 1962.

Hebrew Home for the Aged.
Home for Aged & Infirm Hebrews of New York.
Providence Rest Home.
Sephardic Home for the Aged.
Workmen's Circle Home for the Aged.

Hospitals (14):
Beth El Hospital Social Service Division.
Bronx Municipal Hospital Center, Social Service.
Columbus Hospital.
Gouverneur Ambulatory Care Unit Social Service Division.
Grand Central Hospital.
Hebrew Home & Hospital for Chronic Sick.
Home & Hospital of the Daughters of Israel.
Jamaica Hospital, Social Service Department.
Mount Sinai Hospital Women's Auxiliary Board.
New York Eye & Ear Infirmary.
New York Infirmary, Social Service Department.
Queens Hospital Center, Social Service Department.
St. John's Queens Hospital.
St. Mary's Hospital, Social Service Department.

Recreation centers (13):
Brooklyn War Memorial Recreation Center.
Bronxdale Community Center.
East Harlem Day Center for Older People.
East Side House Settlement, Mill Brook Center.
East Tremont YM–YWHA.
Forest Neighborhood House.
Golden Age Club of the Jewish Center of Kew Garden Hills.
Howard Houses Golden Age Club.
Hudson Guild.
Owen F. Dolen Park, Golden Age Center.
Red Hook Day Center.
The Salvation Army Senior Citizens' Club.
YM & YWHA of Williamsburg, Senior Adult Division.

Neighborhood councils and civic associations (8):
Brownsville Neighborhood Health & Welfare Council.
Coney Island Community Council.
East Harlem Council for Community Planning, Committee on Aging.
Kingsview Community Association.
Kissena Flushing Homeowners Association.
Red Hook Neighborhood Council.
Sheepshead Bay Civic & Community Council.
Wavecrest Civic Association.

Other (22):
Alpha Kappa Alpha Sorority.
Bronx County Society for Mental Health.
Central Bureau for the Jewish Aged.
Childville, Inc.
Church of All Nations, Board of Directors.
Clinical Services of the William Alanson White Institute of Psychiatry, Psychoanalysis, and Psychology.
Italian Welfare League.
Jewish Community Services of Long Island.
Jewish Family Service.
Musicians Aid Society.
National Association of Social Workers, New York City Chapter.
National Council of Jewish Women, New York Section.
New York Clinic for Mental Health.
New York Hotel Trades Council, AFL–CIO.
New York State Psychological Association.
Optometric Center of New York.
The Salvation Army, Social Welfare Department.
Self-help of Emigres from Central Europe, Inc.
Sidney Hillman Health Center.
Society of St. Vincent De Paul.
Tolstoy Foundation Inc.
United Help, Inc.

APPENDIX C

CORPORATE MEMBERS OF THE COMMUNITY COUNCIL OF GREATER NEW YORK

American Red Cross in Greater New York.
Brooklyn Bureau of Social Service and Children's Aid Society.
Brooklyn Tuberculosis and Health Association, Inc.
Catholic Charities, Diocese of Brooklyn.
Catholic Charities of the Archdiocese of New York.
Children's Aid Society.
Citizens' Housing and Planning Council of New York, Inc.
City of New York.
Commerce and Industry Association of New York, Inc.
Community Service Society of New York.
Federation of Jewish Philanthropies of New York.
Federation of Protestant Welfare Agencies, Inc.
The Greater New York Fund, Inc.
Hospital Council of Greater New York, Inc.
New York Academy of Medicine.
New York Chamber of Commerce.
New York City Central Labor Council AFL-CIO.
New York Tuberculosis and Health Association, Inc.
United Hospital Fund of New York.
United Neighborhood Houses of New York, Inc.
Urban League of Greater New York, Inc.
Visiting Nurse Association of Brooklyn.
Visiting Nurse Service of New York.

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Executive secretary: Irma Minges

Senator HARTKE. Thank you, ma'am, for a very fine statement.

That concludes the list of witnesses to be heard this morning, and the committee will adjourn until 10 o'clock tomorrow morning.

(Whereupon, at 12:30 p.m., the committee adjourned, to reconvene at 10 a.m., Tuesday, August 11, 1964.)

SOCIAL SECURITY; MEDICAL CARE FOR THE AGED AMENDMENTS

TUESDAY, AUGUST 11, 1964

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

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

Present: Senators Byrd (presiding), Smathers, Douglas, Gore, Talmadge, McCarthy, Ribicoff, Carlson, Bennett, and Dirksen.

Also present: Elizabeth B. Springer, chief clerk; and Fred Arner and Helen Livingston of the Education and Public Welfare Division, Legislative Reference Service, Library of Congress.

The CHAIRMAN. The Chair wants to apologize for the fact that there are not more Senators here but we have a vote in the Senate at 11:15 and I think we had better start now.

The first witness is Mr. Karl Schlotterbeck of the U.S. Chamber of Commerce.

Take a seat and proceed, sir.

STATEMENT OF KARL SCHLOTTERBECK, MANAGER, ECONOMIC SECURITY DEPARTMENT OF THE CHAMBER OF COMMERCE OF THE UNITED STATES

Mr. SCHLOTTERBECK. Mr. Chairman, my name is Karl Schlotterbeck. I am manager of the Economic Security Department of the Chamber of Commerce of the United States. I am testifying on behalf of the national chamber.

I want to emphasize that the national chamber endorses the basic principles of social security. Those principles, which have been enunciated repeatedly by both the House Ways and Means Committee and this committee of the Senate, are:

1. Social security cash benefits should be wholly financed by equal taxes on employees and employers, taxes on self-employed, and interest on the trust funds.

2. The benefits should serve as a floor of protection so that the vast majority of elderly beneficiaries would not have to seek additional help through public assistance.

3. Benefits should be wage-related, with some weighing in favor of those at the low end of the benefit scale.

4. Benefits are a partial replacement of income loss, wage loss, due to retirement or from permanent and total disability, or from premature death of the family breadwinner.

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5. Benefits should be paid in cash so this will preserve for each beneficiary his freedom of choice.

And finally, social security benefits should be paid without a needs test.

Now, turning to the bill passed by the House (H.R. 11865), there are four provisions in the House bill which we regard as of major importance.

First and foremost is the provision for additional financial support to the social security disability benefits program. The national chamber endorses this provision.

Another major provision in the bill is a 5-percent across-the-board increase in social security cash benefits. We recognize, of course, that Congress will decide whether there must be some increase in benefits to preserve benefits as a "floor of protection."

In arriving at this decision we would again urge you to look at those people whose benefits are minimal or slightly larger. Many of these are widows of advanced age with very modest incomes and also less likely to be able to afford health insurance. I might mention, Mr. Chairman, that the national chamber in 1958 and again in 1961 urged the Congress to raise the minimum benefit. We believed it might not be adequate to serve as a floor of protection.

Another major proposal in the House bill is to increase the employee, employer and self-employed tax rates and also to increase the taxable wage base.

We recommend that whatever cost increases are finally approved by Congress should be financed wholly by an increase in the tax rate.

Turning now to the various medicare proposals, we have analyzed them carefully, and have concluded that:

1. Medicare is not needed.
2. There is an inherent disadvantage in medicare.
3. There are inherent advantages in social security protection provided as benefits in cash.

Now, I would like to take up why we believe medicare is not needed. We have brought together in this table figures showing the health care protection of the elderly through private and public programs in 1952 and compared them with 1962, and then we have projected these figures to 1970.

The estimates below show that 15.4 million persons, approximately 90 percent of the elderly in 1962, had health care protection through one or another of these four broad programs as compared with only 4.5 million or 35 percent of the 1952 elderly population.

The figures also show that in 1962 less than 2 million elderly were without health care protection under these plans as compared with 8.5 million of the 1952 elderly population.

Looking forward to 1970, the projections indicate that virtually the entire elderly population will have protection against health care costs through private voluntary arrangements or through one or another of these three major public programs.

We had a similar transition experience between 1940 and 1960 in providing health care protection for those under 65, a much larger part of our total population. And, no one today seriously contends we need a Federal compulsory program for those under 65.

This experience demonstrates that we do not need social security medicare for the elderly established in perpetuity to deal with this transitional situation.

Now I'd like to discuss the disadvantage of medicare. There is a serious and fundamental disadvantage in medicare. This disadvantage to beneficiaries and to all social security taxpayers, workers, and employers, arises out of the fact that hospital costs have been rising rapidly in recent years and are expected to continue to do so in the future.

In consequence, any medicare proposal will cost more than initially anticipated. Social security beneficiaries and all social security taxpayers, workers, and employers, will be compelled to make a choice from a number of unhappy alternatives. These are:

First, the taxpaying workers and employers would have to pay more social security taxes.

Second, should workers and employers be unwilling to pay still more in taxes the beneficiaries might find that the medicare protection had to be reduced.

Third, as an alternative, beneficiaries might find their cash benefits reduced in order to continue the same level of medicare protection.

Fourth, to avoid any of these courses of action Congress might conceivably attempt to control the cost of hospital services. I might mention—I am sure I don't need to remind you, Mr. Chairman—in passing, our experience during World War II, where the price line for many commodities and services was held reasonably well but only at the expense of quality.

A last choice might be for Congress to finance the rising cost of medicare protection by drafts on the general funds of the Treasury. This would involve using means test money, and there is no place in social security for the means test.

Perhaps these choices explain an observation by the chairman of the House Ways and Means Committee when he said, and I am quoting here:

> I would not think that the Congress would be justified in launching a new program (medicare) knowing as we launched it that the tax that we are providing for that program will not be sufficient but that we face the inevitable situation of having to raise that tax in the future.

Now, I'd like to discuss the advantage of social security benefits in cash. When Congress makes commitments for cash benefits, the benefit costs and the tax burden can be estimated with reasonable reliability. All covered workers and employers thus can know what their tax liabilities are likely to be for the next few years.

Should Congress consider changes in social security, workers and employers would have the opportunity to decide whether they would be willing to pay more in social security taxes.

There is another advantageous feature in the cash benefit protection arrangement. This is the safety factor built into the system by the method employed in projecting benefit costs and in determining the needed tax rates and taxable wage base.

This safety factor provides a cushion in the event that subsequent experience should result in unanticipated cost increases.

The net effect of this safety factor is that covered workers and employers can have more assurance about their future liabilities for social security taxes than would be possible under any medicare arrangement, that pays for services.

In conclusion, we urge Congress to reject all medicare proposals and thus protect:

1. All social security taxpayers against the inevitable situation of having to raise that tax in the future.

2. All beneficiaries against any possibility of reduction in social security protection.

This reaffirmation of the superiority of social security protection in the form of benefits in cash will help preserve for every beneficiary his freedom and right to make all his own decisions.

That completes my statement, Mr. Chairman.

(The prepared statement of Mr. Schlotterbeck follows:)

STATEMENT OF KARL SCHLOTTERBECK FOR THE CHAMBER OF COMMERCE OF THE UNITED STATES

My name is Karl Schlotterbeck. I am manager of the Economic Security Department of the Chamber of Commerce of the United States. I am testifying on behalf of the national chamber.

I want to emphasize that the national chamber endorses the basic principles of social security. Those principles, which have been enunciated repeatedly by both the House Ways and Means Committee and this committee of the Senate, are.

1. Social security cash benefits should be wholly financed by equal taxes on employees and employers, taxes on self-employed, and interest on the trust funds. On a longrun basis, the income and outgo should be about equal.

2. The benefits should serve as a floor of protection so that the vast majority of elderly beneficiaries would not have to seek additional help through public assistance.

3. Benefits should be wage related, with some weighting in favor of those at the low end of the benefit scale.

4. Benefits, chiefly for the elderly, should be restricted to those who have retired or have substantially done so.

5. Benefits should be paid in cash so that each beneficiary can make his own free decisions on how best to use this and other income to satisfy his needs.

6. Social security benefits should be paid without a needs test.

We have carefully studied H.R. 11865, as well as S. 880, S. 2431, and similar proposals for initiating social security medicare. Because H.R. 11865 has been passed by a House vote of 388 to 8, we will give our views first on provisions of this bill.

H.R. 11865—THE HOUSE-PASSED SOCIAL SECURITY BILL

There are four provisions in the House bill which we regard as of major importance. First and foremost is the provision for additional financial support to the social security disability benefits program. This program is now seriously out of balance and one provision in the bill (sec. 7) would virtually eliminate this financial deficiency. The national chamber endorses this provision.

A second provision of major importance is the extension of benefit coverage to a limited group of elderly 72 and over. Any step in the direction of providing benefit protection for all the elderly will help achieve the objective of social security.

This is especially meritorious because those of such advanced age are known to have smaller incomes on the average than, say, those 65 to 74. They are also less likely to have insurance protection because they reached retirement a decade or more ago when voluntary health insurance for the elderly was in its infancy.

We question the merit of establishing a new minimum benefit amount less than the existing minimum primary old-age benefit. If the present $40 monthly

minimum benefit is the necessary amount to serve as a floor of protection, the reasonableness of anything less is questionable.

A third major provision in H.R. 11865 is a 5-percent across-the-board increase in social security cash benefits. While the cost of living has increased some 6 to 7 percent since the last general benefit increase in 1958, we do not believe that the present benefits as a whole, are failing to provide a floor of protection. Certainly, there is no rise in the percentage of aged beneficiaries who are having to seek additional help through old-age assistance.

However, Congress will decide whether there must be some increase in benefits to preserve the floor of protection. In arriving at this decision, we would again urge you to look at those people whose benefits are minimal, or slightly larger. Many of these are widows, of advanced age, with very modest incomes and also less likely to be able to afford health insurance.

The fourth major proposal in the House bill is to increase the employee, employer, and self-employed tax rate effective in 1965, with a stretchout of needed additional tax rate increases and, also, an increase in the taxable wage base from $4,800 to $5,400. Whatever cost increases are approved by this Congress, they should be financed by an increase in the tax rate. Because the various liberalizations proposed in the bill are broadly distributed, the added costs should be borne by all those working. This can be achieved only through an increase in the tax rate.

Among other provisions is one which would lower from 62 to 60 the age at which a widow could get old-age benefits, with an accuarial reduction in the benefit amount. Under existing law, a widow's benefit is equal to 82½ percent of the primary benefit amount her husband would have received. Congress apparently regards this reduced amount to be adequate as a floor of protection benefit. Thus, any further reduction would mean that a widow would receive less than a floor of protection. Moreover, it would establish a still lower age for retirement—a step in the wrong direction. The national chamber urges Congress to reject this proposal.

Another provision of the bill would extend coverage to a minor degree. For some 20 years, the national chamber has endorsed the extension of coverage to all occupations. In this kind of program, all who work should share the tax burden of financing benefits, chiefly for those who, because of age, no longer can support themselves by working. The national chamber urges Congress to extend coverage to the largest single group now excluded, some 2 million employees of the Federal Government under staff retirement programs.

MEDICARE PROPOSALS

The national chamber realizes there is a problem for some of the aged to obtain health care protection through private voluntary plans. For a number of years, the chamber has been deeply interested in, and helped promote the growth of, private arrangements through which people may obtain protection against the major costs of illness. The vast majority of people are now obtaining such protection through private voluntary individual and group programs.

Everyone, young and old alike, should get needed health care, regardless of ability to pay. There is a public responsibility to help those who have extremely costly health needs and cannot meet them through their own income and resources. The national chamber has supported the vendor payments arrangements in old-age assistance and, when the Kerr-Mills Act was passed in 1960, we encouraged businessmen to take leadership in their States to determine the needs and, also, the kind of plan best suited to meet these needs.

There are several bills before this and other congressional committees designed to help the elderly meet some health care costs. These proposals would initiate in social security an entirely new type of protection—payments by social security for selected health care services. These proposals are commonly called "medicare."

We have carefully analyzed all such "medicare" proposals and have concluded that:

1. Medicare is not needed in view of the tremendous progress already achieved in protecting the elderly against health care costs.
2. Medicare has an inherent disadvantage to beneficiaries, and to all workers and employers who pay taxes to support social security.
3. There are inherent advantages in social security protection provided as benefits in cash.

We urge the Congress to reject all proposals for initiating social security protection through "paid-for services."

Medicare is not needed

In sharp contrast with the situation 10 years ago, a very large part of our elderly population today has protection against costly illness through one or more of several programs. Outstanding is the performance of the health insurance industry and other private voluntary organizations, such as Blue Cross and Blue Shield, in extending protection to an increasing proportion of our growing elderly population.

There no longer can be any dispute that private enterprise can extend insurance protection to a large majority of our elderly. This insurance coverage on a broad scale is attributable in large part to the experimentation and innovation by insurance companies and other private agencies. These innovations have been made not only in marketing techniques but also in the variety of specific protection made available through such programs.

The mass enrollment of persons 65 and over is a new marketing device which has been used successfully by two well-known companies and by the American Association of Retired Persons. The same technique has also been employed in certain States by associations of insurance companies, enabling the participating companies to pool their resources and thus provide low-cost, comprehensive individual health insurance policies to State residents.

This areawide technique is in operation in seven States, including North Carolina, Massachusetts, Texas, California, Connecticut, and New York. Enabling legislation has been passed in eight others—Maine, Michigan, Mississippi, Nevada, New Mexico, New Hampshire, Oregon, and Washington.

Another innovation will contribute materially to future growth of health insurance protection for the aged. This is the provision in most group policies now being written or modernized which enables a worker with health insurance to carry this protection into retirement. A recent study by the Health Insurance Institute shows that in new group policies:

"Four out of every five employees have the right to retain their health insurance protection upon retirement, either by conversion to an individual policy or by continuation under a group policy." [1]

This year, the national chamber conducted a survey of its 32,000 member firms to determine the extent to which their employees may continue their health insurance protection when they retire. We received returns from more than 25 percent of these firms of varying sizes, and found that more than 9 out of 10 of them had health insurance in force for their employees. Three-fourths of these plans contained a provision whereby the employee could continue this protection on retirement. Of the remaining firms without this provision, about one-third said they were carefully examining various proposals for extending this opportunity to their employees.

The health insurance industry is also offering a variety of policies—not only hospital insurance, but also protection for surgical, regular medical, and major medical expense. Adequate insurance protection, already a fact for the younger population, is becoming more readily available to the aged.

Another factor in the rapid growth of health insurance coverage has been the rising income position of the elderly. The median income of aged families was $3,204 in 1962, as compared with $1,956 for their counterparts in 1951. This trend of rising money incomes has also been true for the nonmarried elderly, both men and women.[2]

In part, the much better income position in 1962 was the result of various amendments to social security. Congress has increased monthly benefits four times during the past 12 years.

In substantial part, the better income position of today's elderly is explained by the fact that millions of "newcomers" have joined the elderly population. Many of these newcomers—people becoming 65—had been working regularly at rapidly rising wages and salaries during the decade preceding retirement. The income position of these new elderly, of course, was substantially better than that of those who had retired many years earlier when pay levels were lower.

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[1] See: Health Insurance Institute, "Group Health Insurance Policies Issued in 1962," p. 6.

[2] See: U.S. Bureau of the Census, Current Population Reports, "Consumer Income," series P–60, No. 12, table 8, p. 22; and No. 41, table 3, p. 26.

This movement of people from the "under-65" to the "65-and-over" group is a continuing process. For example, the aged population in 1960 was about 16.6 million, and by 1970 it will be roughly 20 million.[3] Of these 20 million, 13 million will join the aged population during the 1960's. Most of them—families and single individuals—will enter retirement after 20 to 25 years of quite regular employment at rising levels of pay. Thus, there is every reason to expect that the income positions of these successive elderly populations will progressively be higher—and likewise their ability to afford health insurance will improve in the years ahead.

Despite the marked improvement indicated by the data on the median money incomes of elderly people, there are many whose incomes are more modest, and even meager. All these, however, are not without protection against the costs of needed health care. Two million in 1962 were receiving old-age assistance. Through the vendor payments part of this program they have health care protection. Another million[4] were elderly people receiving veterans' compensation or pensions, and they have their health needs all met.

Some elderly are able to get along on their own incomes and resources so long as they are in good health. However, if they are faced with a costly illness, they may not be able to pay for all needed health care. Just how many elderly couples and single individuals have such modest incomes and resources is not known. For such people, Congress established in 1960 a new program (Kerr-Mills) of Federal grant-in-aid to the States, known as medical assistance for the aged. This Kerr-Mills program had been set up in 28 States by the end of 1963, and 8 more will be in operation by the close of this year.

It is most significant that, with a substantially bigger aged population in 1962 than in 1952, a much larger proportion of the elderly in 1962 had protection against health care costs under private health insurance or through one of these three public programs.

The estimates below[5] show that 15.4 million persons—approximately 90 percent of the elderly in 1962—had health care protection through these four programs, as compared with only 4.5 million, or 35 percent of the 1952 elderly population.

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[3] See: U.S. Department of Health, Education, and Welfare, "Illustrated U.S. Population Projections," actuarial study No. 46, May 1957, table 9–V, p. 29.

[4] See: Hearings, "Operation of Non-Service-Connected Pension Program," House Veterans' Affairs Committee, 87th Cong., 2d sess., p. 2638.

[5] The data for 1952 and 1962 were obtained from various sources. The figures for health insurance coverage of the elderly are from: The Health Insurance Association of America, "Financing Health Care for the Aged," a release dated Oct. 28, 1963.

For old-age assistance, the data are for the number of cases receiving monthly payments in those States which had vendor payments programs. For 1952, the January 1953 caseload data were the first available, and include the caseloads for Connecticut, Hawaii, Illinois, Indiana, Massachusetts, Minnesota, New Hampshire, New Mexico, New York, North Carolina, and Rhode Island. By 1962, all 50 States had vendor payment programs in connection with old-age assistance, and thus, OAA recipients had health-care protection. The OAA caseloads in Texas and Colorado were eliminated, since they are included in the figures for private insurance coverage. See: U.S. Department of Health, Education, and Welfare, "Social Security Bulletin," Annual Statistical Supplement, 1961, table 133, p. 107; and "Social Security Bulletin," May 1963, table 7, p. 36.

For veterans, the data include the number of World War I veterans receiving either compensation or pensions. As of June 30, 1962, there were about 2.5 million living World War I veterans in civilian life. Of this total, approximately 147,000 had service-connected disabilities and were receiving compensation. Their average age was 68 years. Another 1,006,533 veterans had nonservice incurred disabilities and were receiving pensions. More than 90 percent of the pensioner group are 65 years of age and over. The remaining 1.3 million World War I veterans are not receiving either type of benefit. They were not included in this table. However, those who could not afford needed health care could also receive it through the Veterans' Administration: See: Hearings, "Operation on Non-Service-Connected Pension Program." House Veterans' Affairs Committee, 87th Cong., 2d sess., p. 2638.

For medical assistance for the aged, the data are from the 1965 Federal budget estimate of 338,000 individuals who received care sometime during fiscal 1963. This figure was expanded by six to allow for the other aged who had the protection through MAA had they needed care during that period. See: "Appendix to the Budget of the United States," for fiscal year ending June 30, 1965, p. 462.

The projections for 1970 were developed as follows:

Health insurance coverage was estimated at 68 percent of the aged. This percentage was the low estimate given by the witness for the Health Insurance Association of America in testimony before the House Ways and Means Committee on Nov. 22, 1963.

Veterans benefits is a rough estimate making allowance for a slight decline in aged population in 1970 as compared with 1962.

Old-age assistance was projected on basis of the present decline in the caseload averaging 50,000 per year.

Medical assistance for the aged was projected on the basis of experience for fiscal 1963. In addition, we assumed all 50 States will have such programs by 1970.

Aged with protection against health care costs in 1952, 1962, and estimated for 1970

[In millions of persons 65 and over]

	1952	1962	1970
Protection through:			
Health insurance	3.4	10.3	13.6
Veterans benefits	.6	1.1	.9
Old-age assistance	.5	2.0	1.6
Medical assistance for the aged		2.0	4.1
Total	4.5	15.4	20.2
Other aged without protection under these programs	8.5	1.9	0
Total aged population	13.0	17.3	20.1

The figures also show that in 1962 less than 2 million elderly were without health care protection under these plans, as compared with 8.5 million of the 1952 elderly population.

Looking forward to 1970, the projections indicate that virtually the entire elderly population will have protection against health care costs through private voluntary plans or through the three major public programs. It would thus appear we are approaching the end of a transition period in providing protection for our elderly people through a combination of private and public programs.

We had a similar transition between 1940 and 1960 in providing health care protection for those under 65—a much larger part of our total population—and no one today seriously contends we need a Federal compulsory program for those under 65.

This experience demonstrates that we do not need social security medicare for the elderly established in perpetuity to deal with this transitional situation.

Disadvantage of medicare

The evidence is clear that if a very small medicare program is established in social security, it will be expanded over the years—in amount of care as well as the range of different kinds of care. Moreover, there is good reason to expect that such protection, no matter how modest initially, would not be restricted to elderly beneficiaries.

However, there is a serious and fundamental disadvantage in medicare. This disadvantage to beneficiaries, and to all social security taxpayers—workers and employers—arises out of the fact that hospital costs have been rising rapidly in recent years and are expected to continue to rise. In consequence, any medicare proposal will cost more than initially anticipated. For example, the first medicare bill introduced by Congressman Forand in 1957 provided for an increase in the combined social security tax rate of one-half of 1 percent. The social security chief actuary informed the Ways and Means Committee last November that, in the light of subsequent experience, the cost of this program would now be 50 percent higher (making no allowance for amendments in 1958, 1960, and 1961).[6]

The chief actuary further told the committee if allowance is made for subsequent changes in social security, the cost of this original medicare proposal would be about 100 percent greater.

Turning to the original Kennedy-Anderson bill of 1960, the chief actuary admitted to the Ways and Means Committee that today—less than 4 years later—that program would be 30 percent underfinanced.[7]

If H.R. 3920 (the King-Anderson bill) should be adopted as drafted less than 2 years ago, a combined tax rate of 1 percent would be needed—rather than one-half of 1 percent as provided in the bill.[8]

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[6] See hearings, "Medical Care for the Aged," House Ways and Means Committee, 88th Cong., 1st and 2d sess., pt. 1, p. 141.
[7] The same, pp. 141–142.
[8] The same, p. 145.

Obviously, if any commitment is now made for social security to pay for selected health care services, and the costs of these services continue to rise as expected, social security beneficiaries and all social security taxpayers—workers and employers—will be compelled to make a choice from a number of unhappy alternatives. These choices are:

1. The taxpaying workers and employers would have to pay more social security taxes. It is now generally recognized, however, that there are limits to the willingness of workers to be taxed more. A combined tax rate of 10 percent on employees and on employers is generally regarded as a ceiling. For various reasons, the ceiling on the amount of earnings which may be taxed is not an unlimited one either. Many workers look forward to the time when they will have some of their earnings tax-free—that is, social security tax-free. Most of them have real, urgent family needs and wants that have a greater priority to them.
2. Should workers and employers be unwilling to pay still more in taxes to finance rising costs of medicare, the beneficiaries might find that the medicare protection had to be reduced—either the number of days stay in the hospital would be reduced, or larger deductibles would be initiated.
3. As an alternative, beneficiaries might find their cash benefits reduced in order to continue the same level of medicare protection.
4. To avoid any of these courses of action, Congress might conceivably attempt to control the costs of hospital services. Experience with price control during World War II showed the price line for many commodities and services could be held reasonably well—but only at the expense of quality. If this course of action were chosen, all would find the quality of health care services declining—and that is out of the question.
5. A last choice might be for Congress to finance the rising cost of medicare protection by drafts on the general funds of the Treasury. This would involve using "means test" money, and there is no place in social security for the means test.

Perhaps these choices explain an observation by the chairman of the House Ways and Means Committee when he said:

"* * * I would *not* think that the Congress would be justified in launching a new program [medicare] knowing as we launched it that the tax that we are providing for that program will not be sufficient but that *we face the inevitable situation of having to raise that tax in the future.*"[9] [Italic supplied.]

The advantage of social security benefits in cash

There are inherent advantages to providing protection solely through the cash benefits arrangement. These are advantages not only to Congress, but most especially to the beneficiaries on the one hand, and to the taxpayer workers and employers on the other.

When Congress makes commitments for cash benefits, the benefit costs and the tax burden can be estimated with reasonable reliability. All covered workers and employers thus can know what their tax liabilities are likely to be for the next few years.

Should Congress consider changes in social security, workers and employers would have the opportunity to decide whether they would be willing to pay more in social security taxes.

There is another advantageous feature in the cash benefits protection arrangement. This is the safety factor built into the system by the method employed in projecting benefit costs and in determining the needed tax rates and taxable wage base. By this method, when levels of pay advance, those whose earnings are below the taxable wage base ceiling—$4,800 today—will pay more in social security taxes. So will the employers. Hence, social security tax receipts rise.

Likewise, benefit costs will be higher in the long run—in consequence of the higher average monthly earnings of these workers. But, owing to the weighting in the benefit formula, the added tax revenues will exceed the increase in benefit costs.

This safety factor thus provides a cushion—in the event that subsequent experience should result in unanticipated cost increases. The net effect is

[9] The same, p. 146.

that covered workers and employers can have more assurance about their future liabilities for social security taxes than would be possible under any medicare arrangement.

In conclusion, we urge Congress to reject all medicare proposals and thus protect all social security taxpayers against "the inevitable situation of having to raise that tax in the future," and also protect all beneficiaries against any possibility of reduction in social security protection. This reaffirmation of the superiority of social security protection in form of benefits in cash will help preserve for every beneficiary his freedom and right to make all his own decisions.

The CHAIRMAN. Thank you very much, sir. Any questions? Thank you.

Mr. William C. Fitch was scheduled to testify today in behalf of the American Association of Retired Persons and National Retired Teachers Association. Unfortunately he was called out of town but his prepared statement is inserted in the record in lieu of testifying in person.

(The statement of Mr. Fitch follows:)

STATEMENT OF WILLIAM C. FITCH, EXECUTIVE DIRECTOR, AMERICAN ASSOCIATION OF RETIRED PERSONS, NATIONAL RETIRED TEACHERS ASSOCIATION

On behalf of the 850,000 members of the National Retired Teachers Association and American Association of Retired Persons, I appreciate this opportunity to present the views of our nonprofit, nonpartisan organizations on social security bill H.R. 11865 and related amendments.

Purpose

We are in accord with the expressed purpose of H.R. 11865 to improve the benefit and coverage provisions and the financial structure of the Federal old-age, survivors, and disability insurance (OASDI) system. However, we are deeply concerned that the legislation under consideration has omitted or only partially deals with areas of vital importance to the Nation's older citizens.

Benefit increases

Our members are all too well aware that the last across-the-board adjustment in social security insurance benefits and the last adjustment in the amount of annual earnings that is taxed and credited toward benefits were enacted in 1958. This in itself is one of the major complaints of the older American, that the present social security system does not recognize the changes in the economy and usually 4 or more years may elapse before the benefit is adjusted to bring it somewhere within the cost-of-living increase. This does not compensate for the hardship of the diminishing dollar value of the benefit during the interim periods.

A 5-percent increase in the insurance payment benefits for all persons now on the rolls or for future beneficiaries appears minimal to say the least. It is doubtful that this percentage fully represents the cost of living increase since 1958. In terms of additional dollars for most, it falls short of an increase that might have been used to pay a health insurance premium under an insurance option on a voluntary health insurance program.

To make the increase in the benefit more practical and meaningful, it would seem that a 5-percent increase or a flat $5 increase across the board would provide the financial basis for a realistic health insurance option through social security.

The $5,400 earning base is reasonable but should also be raised to a level that will support a 5-percent or $5 increase in benefits.

Child's insurance benefits

Payment of child's benefits until the child reaches age 22 as a full-time student after age 18 is a much-needed amendment and will make it possible for children to continue their education without placing a further burden on the widow who cannot qualify for benefits until age 60 or 62.

Benefits for widows

Reduced benefit payments to widows at age 60 will help to overcome one of the major gaps in the insurance program.

Payment of benefits to cerain aged persons

The recommendation that special insured status provisions be adopted under a "transitional insured status" creates a further injustice for those individuals over age 72 who were too old to qualify for even three-quarters of coverage. These individuals retired before the social security program went into effect or before their positions were covered under the law.

In no sense can the benefits based on "transitional coverage" be considered wage related. To also qualify wives and widows under this provision and to deny others who are equally in need of the benefits is to penalize a very deserving though diminishing number of older Americans.

We would urge that minimum insurance benefits be extended to all persons 72 years of age or older without attempting to create an impression of "qualifying" under a wage-related formula that in truth has no valid basis.

Actuarial estimates have shown that to extend the coverage to all persons over age 72, paying from the general fund over a period of time actually shows a saving and places the payments in a category that can be justified. It would give fair and equal treatment to a group that has already been denied a decent retirement income because they were too old to render service under the system and who have struggled to maintain their independence and dignity in a period of incrased costs of living, and spiraling medical expenses.

The failure to include these individuals in the provisions of H.R. 11865 is indeed a grave weakness that might easily be overcome by a recognition of all the equities involved.

Earning limitations

In spite of the fact that more than 70 Members of Congress have introduced bills to increase the amount of earning permitted without loss of benefits, H.R. 11865 makes no reference to this problem. This is difficult to understand.

In an attempt throughout the bill to recognize the changes in the economy, it would seem reasonable and feasible to raise the present limitation on earnings to $2,400 a year without loss of insurance benefits.

This would create an incentive for older persons to continue to contribute to the national economy as well as make a more satisfying life for themselves and for their families.

This increase would help to offset an inequity that has been a part of the Social Security Act from the beginning. The discrepancy denies insurance benefits to workers in employment covered by the law, but permits unlimited interest or dividend income without reduction in benefits to others. This discrimination should be eliminated.

Health and hospital insurance

Medical or hospitalization insurance for the elderly is inevitable and desirable. It is no longer a question of whether but how to enact legislation that does not deprive the individual of his right of free choice or place an undue burden on the economy.

The policy of our associations over the years has been consistent and positive.

Before the platform committees of both parties in 1960 we called for a medical care program within the reach of retirement incomes, available as a matter of right on a voluntary, not a compulsory, basis.

Delivered before the Republican resolutions committee last month in San Francisco, and scheduled for presentation next week before the Democratic platform committee is the resolution of our associations "favoring health care for the aging and the aged available on a voluntary basis to all persons 62 years of age or older." This resolution was unanimously endorsed at the biennial conventions of both of our associations held in June of this year.

In hearings before the House Committee on Ways and Means in July 1961, considering H.R. 4222, we testified in favor of the bill with two modifications: (1) The elimination of the compulsory feature and (2) extending the provision to older persons not currently covered by social security.

Health legislation that provides an option to the individual, through acceptance of a health plan or its cash equivalent, would be endorsed by our associations if the option were a fair choice.

Under the present proposal to increase social security by 5 percent, the additional amount for most of the beneficiaries would be so small that accepting a Federal health plan could be the only practical choice. That is why we favor an across-the-board dollar increase in an amount that could cover the premium for private health insurance.

In reply to those who question whether an increase in the amount of social security or health insurance is the more important, we would repeat that the two need not be separate. The increase should be large enough to pay a health insurance premium, either public or private, and offered as an option at the time of filing for social security benefits.

We believe this is a satisfactory alternative to millions of persons who resist the compulsory Government principle inherent in previous proposals. We would encourage favorable action before Congress adjourns on the option or voluntary approach to health care for the aged.

(At the request of the chairman, the following are made a part of the record:)

STATEMENT ON BEHALF OF MEMBER STATE CHAMBERS OF THE COUNCIL OF STATE CHAMBERS OF COMMERCE

This statement is made on behalf of the 25 member State chambers in the Council of State Chambers of Commerce that are listed at the end of the statement.

We appreciate this opportunity to submit our views on H.R. 11865 to your committee, and particularly so since no hearings on the bill were held by the House Ways and Means Committee. We think it is unfortunate that this bill is before you for consideration during a national election year and when time is so short in this session. Rather than consider the bill at this time we would suggest that you defer action until next year.

The organizations for which this statement is made are opposed to the enactment of H.R. 11865 in its present form. If Congress is determined, however, to enact a bill this year, we strongly urge you to amend H.R. 11865 with respect to its financing provisions as recommended herein.

These organizations also are unalterably opposed to the creation of a new Federal program of health care benefits in conjunction with the OASDI program or otherwise, whether or not participation in such a new program is to be on a voluntary basis.

FINANCING PROVISIONS OF H.R. 11865

The financing provisions of H.R. 11865, as approved by the House July 29, are intended to pay the cost of the additional benefits provided in the bill and to improve the actuarial status of the trust fund. These provisions would raise the taxable wage base from $4,800 to $5,400 and would revise the existing tax rate schedule for both employee and employer as follows: For 1965 the tax rate would be increased from the existing rate of 3.625 percent to 3.8 percent. But the rate would be decreased from the scheduled rate of 4.125 percent for 1966 and 1967 to 4 percent for those years. The rate would also be reduced for 1968 through 1970 from 4.625 percent to 4.5 percent. Finally, for 1971 and later it would be increased from the scheduled 4.625 percent to 4.8 percent.

These provisions constitute a marked shift toward further progression in the OASDI tax. If enacted, they would have the effect, over the next 8 years (1965–72), of saddling covered workers who earn more than $4,800 a year with all the costs of the added benefits in the bill and a larger share of the cost of existing benefits than under present law. We question the equity of this shift in the OASDI tax burden.

Except for the increase in the tax rate for 1965, H.R. 11865 will roll the existing rate schedule back to approximately that of the 1958 law for the years 1966 through 1970. The effect of this rollback is to provide a tax rate in each of the years 1966 through 1970 of one-eighth percent less on employee and employer than is provided under existing law.

Under the financing provisions in the bill, a covered worker would have to earn $4,814 a year over the next 8 years to have his OASDI tax liability equal what it would be under existing law. Over the same period, those workers earning more than $4,814 a year would have their tax liabilities increased.

For example, the worker earning $5,400 a year during these 8 years would pay over 12 percent more in OASDI taxes than he would under existing law.

Social Security Administration records indicate that 70 percent of all wage and salary workers in covered employment earned less than $4,800 in 1962, the most recent date for which information is available. Thus, if H.R. 11865 is enacted, it will result in Congress having provided additional benefits and, at the same time, having reduced the OASDI tax burden on a substantial majority of covered workers for the next 8 years.

We urge you to reject the proposal to expand the taxable wage base to $5,400. To the extent that benefits are to be increased, we recommend that you finance those changes through increases in the tax rates. This certainly would be more equitable and proper than an expansion of the taxable wage base.

MEDICAL CARE FOR THE AGED

During the House Ways and Means Committee hearings earlier this year on H.R. 3920, the "Hospital Insurance Act of 1963," we presented testimony strongly opposing enactment of that bill or any similar proposal for old age health care where control is vested in the Federal Government. We have not changed our views with respect to such legislation.

And our opposition to a program of this type also extends to the administration's alternative proposal which has been reported in the news media as one that would permit the aged to choose either the increased cash benefits of H.R. 11865 or a part of the increased benefits in cash and the balance in the form of hospitalization. We view this alternative program as a "foot in the door" proposal which would result eventually in a full-blown national health care program.

To this statement we are attaching a copy of our testimony of last January 22 to the House Ways and Means Committee with respect to H.R. 3920. Briefly, the testimony sets forth factual information establishing that private health insurance, the Kerr-Mills Act of 1960 and other existing programs either do or can provide adequate health care protection for the aged. Our testimony recognized that the extent of benefits and the eligibility rules under the Kerr-Mills Act may need to be adjusted in some jurisdictions. It also expressed the belief that the Kerr-Mills program could be made more fully operative if the administration, through the Secretary of Health, Education, and Welfare, showed the same enthusiasm for Kerr-Mills that it has for an OASDI-financed health care program.

We urge you to reject all efforts to attach a health care program to the provisions of H.R. 11865. Instead, we suggest that Congress reaffirm the principles of the Kerr-Mills Act.

The chamber of commerce organizations endorsing this statement are:

Alabama State Chamber of Commerce.
Arkansas State Chamber of Commerce.
Connecticut State Chamber of Commerce.
Delaware State Chamber of Commerce.
Florida State Chamber of Commerce.
Georgia State Chamber of Commerce.
Idaho State Chamber of Commerce.
Indiana State Chamber of Commerce.
Kansas State Chamber of Commerce.
Kentucky Chamber of Commerce.
Maine State Chamber of Commerce.
Michigan State Chamber of Commerce.
Mississippi State Chamber of Commerce.
Missouri State Chamber of Commerce.
Montana Chamber of Commerce.
New Jersey State Chamber of Commerce.
Empire State Chamber of Commerce (New York).
Ohio Chamber of Commerce.
Pennsylvania State Chamber of Commerce.
South Carolina State Chamber of Commerce.
Greater South Dakota Association.
Lower Rio Grande Valley Chamber of Commerce (Texas).
West Virginia Chamber of Commerce.
Wisconsin State Chamber of Commerce.

STATEMENT OF LESLIE J. DIKOVICS ON BEHALF OF MEMBER STATE CHAMBERS OF THE COUNCIL OF STATE CHAMBERS OF COMMERCE

My name is Leslie J. Dikovics. I am assistant controller of Walter Kidde & Co., Belleville, N.J. I am chairman of the Social Security Committee of the New Jersey State Chamber of Commerce and a member of the Social Security Committee of the Council of State Chambers of Commerce. I appear before you on behalf of the 32 State chamber organizations listed at the end of my statement.

The organizations for which I speak are vigorously opposed to the creation of a new federally controlled program of health care benefits in conjunction with the OASDI program. Consistent with our position we oppose the enactment of H.R. 3920 or any similar proposal for old-age health care where control is vested in the Federal Government.

Let me emphasize at this point that the organizations on whose behalf I am speaking today believe that adequate health care should be available to all the aged. This is a sound and desirable goal which we believe is accepted by everyone. Thus it seems to us that the differences in viewpoint revolve about the best method or methods of attaining that generally accepted goal.

We believe that the Congress in 1960 provided the best public means to supplement private efforts toward that end when it enacted the Kerr-Mills bill. On the other hand, we are more than ever convinced that a drastic modification of the social security system is neither necessary nor desirable to assure reasonable health care protection for the aged.

The American system of voluntary health insurance has done and is doing much to reduce the health care cost problem for millions of our aged citizens. According to a July 1963 report of the Health Insurance Association of America, 60 percent of the 17.2 million aged, or 10.3 million persons, are covered by private health insurance. And this coverage will continue to grow.

Several million additional aged persons are provided medical assistance by means other than insurance. These include the Federal-State old-age assistance program veterans health programs, and the growing Federal-State programs under the Kerr-Mills Act.

KERR-MILLS ACT, THE ANSWER TO THE PRIMARY PROBLEM

When the medical assistance for the aged program (Kerr-Mills) became effective in October 1960, five States had authorized participation in the program and, in fact, began making payments for medical care in November 1960.

According to the Department of Health, Education, and Welfare, there are at present 28 States and 4 other jurisdictions in which the MAA program is in effect. Ten additional States have authorized participation but have not yet begun making medical care payments. For one reason or another, the remaining 12 States have not adopted the MAA program to date.

Thus, there are 42 States and other jurisdictions, with 81 percent of our total aged population, which are already participating in the MAA program or will be doing so soon.

To give the committee some idea of the growth of the MAA program, there were 12,791 claimants who received benefits of $2,441,000 in November 1960, the first month in which the program was operative. In November 1961 there were 71,650 claimants who received $15,051,000. That represents an increase of 460 percent in claimants and 517 percent in benefits paid over November 1960. In November 1962, 111,828 claimants received $22,712,000 in benefits, or an increase over November 1961 of 56 percent in claimants and 51 percent in benefits. For June 1963 claimants totaled 136,393 and they received benefits of $26,612,000. These figures represent increases over November 1962 of 22 percent in claimants and 17 percent in benefits.

On an annual basis, there were 280,000 persons in fiscal 1962 who received medical assistance for the aged under the MAA program, as distinguished from the old-age assistance program. That number rose to an estimated 421,800 persons in 1963 and is expected to rise to 523,500 in 1964. Total benefit payments under this program in the same years were $190 million in 1962, $295 million in 1963, and are estimated at $380 million for 1964. The source for these figures is the appendix to the 1964 Federal budget.

One of the frequent complaints against the MAA program is that it is still not effective in all States after 3 years of existence. This should not be too

surprising. It is typical of the growth of many major new Federal spending programs. A good recent example is the area redevelopment program. The original authorization for that program for 4 years was $451 million. In spite of the fanfare with which the program was launched and the promotion which it has been given, the actual expenditures in the first 2 years of its operation totaled only $38 million, or 8 percent of the 4-year authorization. The MAA program, however, is now moving rapidly and we expect that it will continue to grow until it fully accomplishes the purposes of the Kerr-Mills Act.

The charge is made that less than 1 percent of the aged population is benefiting from the MAA program. That charge is used by proponents of OASDI-financed medical care to draw the conclusion that the program is inadequate. But the charge is based on an invalid use of arithmetic to justify a preconceived conclusion. The "less than 1 percent" allegation is the result of relating the number of persons using MAA in the single month of July 1963 to the total aged population of the United States.

This is a completely misleading means of relating the coverage under the program to the scope of the problem. What are the facts?

(1) Out of the 17.2 million aged population, over 10.3 million have private plan benefits.

(2) Another 2.3 million aged persons are eligible for benefits under the old-age assistance program.

(3) Another 1.5 million persons are otherwise provided for. They include over 1 million veterans, medical practitioners, certain religious groups, the well to do, etc.

Thus, there are approximately 3.1 million aged persons whose basic medical needs are not provided for through other sources and who might be expected to resort primarily to MAA for assistance.

An estimated 523,500 aged persons will call on MAA for assistance in the current fiscal year according to the 1964 budget estimate. This total is 16.8 percent of the 3.1 million who may need MAA assistance. Is this percentage of benefit claimants low or a mark of failure? No, it is not. Data from experience with the private New York 65 program indicate that the claimant ratio under MAA is closely comparable with the ratio under the New York program. A report of the New York 65 Health Insurance Association in October 1963 stated that of the 116,305 individuals participating in the program, 15,872 claimed benefits in 11 months of operation. If this claimant total were projected to 12 months, the claimant figure would be 17,315. This projected total is 14.9 percent of the number participating and compares with the 16.8 percent claimant ratio under MAA.

The charge is also made that the administrative costs of the MAA program are exorbitant. This charge does not stand up either. The total Federal-State administrative costs of $12.7 million for the program in 1962 were 6.7 percent of the benefit total of $190 million. Is this an excessively high administrative cost ratio? Actually, it is quite close to the ratio for the comparable disability program under OASDI. Administrative costs for that program, exclusive of its share of general administrative costs of OASDI as a whole, were $65 million in 1962 or 6.3 percent of the $1,011 million benefits paid. Moreover, the budget estimates for 1964 indicate that the administrative cost ratio for MAA will be better than the ratio for the OASDI disability program, with the MAA ratio being 6.4 percent and the disability program ratio being 6.7 percent.

The MAA program has been attacked on the ground that the duration levels, and types of benefits vary widely from State to State. The fact that each State may initiate and then administer its own program within the broad common framework of the Kerr-Mills Act is, in our view, the major advantage of MAA. It is well known that costs of medical care and needs for providing assistance to meet such costs vary widely in different areas of the country. Adjustment to these varying factors can best be accomplished by the development of individual State programs.

We see no merit to the charge that the MAA program is wrong because benefit eligibility is based upon need. Historically, many private and public programs providing assistance for a wide range of purposes have incorporated some form of means test to determine eligibility. Some examples include most private and public college scholarship and student loan programs, most church and church-related assistance programs, many private foundation grants, veterans pensions and hospitalization, free school lunches, public assistance, public housing, and most recently the Federal area redevelopment program.

While we support the Kerr-Mills theory based on need and State control, we recognize that the extent of the benefits and the eligibility rules in some jurisdictions may need to be adjusted. This, however, does not mean that the basic approach of the Kerr-Mills program, which is now law in 38 States and 4 other jurisdictions, is wrong. We would welcome congressional reaffirmation of the principles contained in the 1960 legislation.

We also believe that the Kerr-Mills program could be made more fully operative if the administration, through the Secretary of Health, Education, and Welfare, showed the same enthusiasm for Kerr-Mills that it has for the King-Anderson bill.

COMMENTS WITH RESPECT TO H.R. 3920

We think enactment of H.R. 3920 or any similar legislation would be a serious mistake for the following reasons:

It would constitute the first provision for services, as distinguished from cash benefits, under the Social Security Act. This is a sharp change in philosophy. In effect Congress would be deciding how a part of each social security beneficiary's monthly benefit should be spent.

A federally controlled program under social security would violate and alter the basic concept of OASDI. OASDI covers three risks—old age, death, and total and permanent disability—that occur only once, are easily identified and involve substantial but fixed liabilities. The need for medical care can recur innumerable times, cannot be easily determined and the liability, therefore, is almost without limit. Accordingly, it is patently untrue and unsound to say that OASDI provides a tried and true precedent for the socialization and federalization of medical care. It is significant that other recurring risks such as workmen's and unemployment compensation, temporary disability insurance and medical care under categorical assistance programs are provided under State programs rather than a federally controlled program. Also, in connection with recurring risks of medical care there is a vast range of individual preference as to desirable coverage and the way it is obtained. A federally controlled program would stifle such individual preferences.

A federally controlled program has been advocated on the ground that the cost of health services contemplated are modest, predictable, and controllable. The initial benefits suggested under H.R. 3920 are modest—understandably so—because the immediate objective is to establish such a program. In fact, after it was demonstrated in 1959 that the costs of the principal medical care bill of that year, H.R. 4700, would materially exceed the revenues from increasing the social security tax by one-half percent of covered payrolls, the proponents of the legislation were willing to diminish the benefits in order to more nearly match costs with revenues from the one-half percent of payrolls tax increase. This reduction of benefits appeared in H.R. 4222 in 1961 and again in H.R. 3920 in 1963. But even with their diminished benefits H.R. 4222 and H.R. 3920 called for increased OASDI tax revenues, not by increasing the rate more than one-half percent of payrolls but by increasing the wage base to $5,000 in H.R. 4222 and then to $5,200 in H.R. 3920.

It is understandable that proponents of OASDI-financed medical care have been willing to amend their proposals to make the initial costs as low as possible because, once the program were enacted, it could be easily expanded.

Despite the diminished benefits and increased OASDI tax revenues provided in H.R. 3920, it is still highly questionable whether costs of the program could be financed by the new tax once the program got underway. Competent actuaries in the insurance industry believe that both the initial full-year costs and the longer range costs of H.R. 3920 would substantially exceed the proponents' estimates.

It must also be recognized that the proponents' $1.6 billion estimate for the first full year (1966) cost of H.R. 3920 relates only to institutional-type care; that is, primarily care provided in hospital and hospital-related nursing facilities. Accordingly, the cost estimates relate only to a portion of the full medical care costs which an aged person might incur and which can now be provided by MAA.

If H.R. 3920 should actually provide the full range of medical services that many of the aged believe it would provide, its costs would be about four times its stated cost. In other words, the $1.6 billion 1966 cost which has been attributed to H.R. 3920 by its proponents would in fact be about $6.4 billion. Likewise, the insurance company actuaries' far higher cost estimates of the

benefits provided by this bill would have to be multiplied by 4 to show the cost of the full range of services many believe it would provide.

We do not consider it idle speculation to project the costs of the limited benefits in H.R. 3920 to determine the probable costs of complete medical and hospital services for the aged. We are convinced that if this bill is enacted, the program eventually will be expanded to cover the benefits now authorized under MAA. As a matter of fact, many of the bill's proponents have indicated that H.R. 3920 is intended to be only a starting point for a more comprehensive program. They recognize that the tremendous costs of a full medical care program would probably prevent its enactment. But, if the principle of an OASDI medical program were once approved by Congress, it would be comparatively easy to expand the program to attain the intended objectives.

It seems incongruous to us that the Congress might enact this legislation in the light of all the existing facts and probabilities. There is now a broad consensus in the Nation among economists, business leaders, and labor leaders that the Federal tax burden has been a serious drag on the economy in recent years. It is a consensus with which your committee agreed in writing the tax reduction bill.

But there is one tax, OASDI, which the committee well knows is still headed upward under existing law. Even with the additional scheduled rate increases, however, there seems to be some question as to whether OASDI tax revenues will be adequate to meet outgo. The impovement of this situation seems to be the principal purpose of the chairman's bill, H.R. 6688, which would raise the taxable wage base to $5,400. The effect of this bill would, of course, be to offset in part the relief from the present tax burden provided by the tax reduction bill.

Enactment of H.R. 3920 would have a further contra effect to the economic purpose of the tax reduction bill. And if its costs should materially exceed the proponents' estimates, as many believe they would, the bill would defeat the fiscal purpose of H.R. 6688.

As we stated earlier, adequate health care should be available for the aged. Voluntary health insurance, the MAA State programs, and other assistance programs now cover a substantial majority of the aged. The continuing expansion of private plans and the MAA programs, in our view, make it unnecessary and unwise to finance another medical care program in conjunction with OASDI under Federal control.

The chamber of commerce organizations endorsing Mr. Dikovics' statement are:

Alabama State Chamber of Commerce.
Arkansas State Chamber of Commerce.
Colorado State Chamber of Commerce.
Connecticut State Chamber of Commerce.
Delaware State Chamber of Commerce.
Florida State Chamber of Commerce.
Georgia State Chamber of Commerce.
Idaho State Chamber of Commerce.
Indiana State Chamber of Commerce.
Kansas State Chamber of Commerce.
Kentucky Chamber of Commerce.
Maine State Chamber of Commerce.
Michigan State Chamber of Commerce.
Mississippi State Chamber of Commerce.
Missouri State Chamber of Commerce.
Montana Chamber of Commerce.
New Jersey State Chamber of Commerce.
Empire State Chamber of Commerce (New York).
North Dakota State Chamber of Commerce.
Ohio Chamber of Commerce.
Oklahoma State Chamber of Commerce.
Pennsylvania State Chamber of Commerce.
South Carolina State Chamber of Commerce.
Greater South Dakota Association.
East Texas Chamber of Commerce.
South Texas Chamber of Commerce.
West Texas Chamber of Commerce.

Lower Rio Grande Valley Chamber of Commerce (Texas).
Salt Lake City (Utah) Chamber of Commerce.
Virginia State Chamber of Commerce.
West Texas Chamber of Commerce.
West Virginia Chamber of Commerce.
Wisconsin State Chamber of Commerce.

STATEMENT OF JAMES A. MANN FOR THE ILLINOIS STATE CHAMBER OF COMMERCE

My name is James A. Mann. I am personnel manager for Wyman-Gordon Co., Ingalls-Shepard Division, Harvey, Ill., producers of drop-forgings for the automotive aircraft, truck and tractor industries. Currently, I am chairman of the Social Security Committee of the Illinois State Chamber of Commerce.

This statement is presented on behalf of the Illinois State Chamber of Commerce, a statewide civic organization with a membership of over 20,000 businessmen, representing over 8,000 individual business enterprises in Illinois. Since 1952, I have been a member of the Illinois State Chamber's Social Security Committee which is comprised of 91 individuals, representing all types of business in our State, ranging from the self-employed to some of the Nation's largest corporations.

Our committee has constantly studied and reviewed matters relating to social security, and the policies which we recommend are approved by the State chamber's 71-member board of directors. Thus, my presentation and the viewpoints expressed in this statement, I am sure, are broadly representative of Illinois business.

On November 21, 1963, representing the Illinois State Chamber of Commerce, I appeared before the House Committee on Ways and Means in opposition to the King-Anderson proposals (H.R. 3920 and S. 880) which would provide limited hospital benefits for the aged under the social security program. The House Ways and Means Committee, as you know, rejected proposals to provide hospital and medical care for the aged through the social security system. Rather, in favorably recommending H.R. 11865, which your committee is now considering and which expands social security and increases benefits and taxes, the House committee recognized the actuarial deficiencies in the social security program. Today, with the apparent need to improve the financing of social security as indicated in H.R. 11865, there appears more reason than ever to reject any proposal that would place an additional tax burden on social security taxpayers and further threaten the solvency of the system with unpredictable future costs.

In this statement, I will not attempt to present, in great detail, reasons for the Illinois State chamber's opposition to a medical and hospital care program under social security. Volumes of testimony are already available to your committee. However, I would like to point out, in general, our basic objections to the King-Anderson proposals as I indicated in my presentation before the House Committee on Ways and Means. They do, I believe, apply to the various similar proposals that are now being presented to your committee.

HOSPITAL AND MEDICAL CARE FOR AGED UNDER SOCIAL SECURITY UNNECESSARY

It is our firm conviction that at present there are sufficient Federal and State statutes to provide medical and hospital care for the aged who need it. Combining these Federal-State programs with voluntary insurance coverage precludes the need for a compulsory system under social security.

Kerr-Mills—Public assistance

The Illinois State Chamber of Commerce urges the continued improvement and expansion of the Kerr-Mills program, public law 86-788, which became effective on October 1, 1960. This program provides an essential working partnership between local, State, and Federal Governments to provide help to all who need help and it has had a remarkable degree of success where it has been given a chance to operate. However, it is disturbing to us to note an apparent laxity on the part of the Federal administration to encourage implementation of this program to the fullest extent. We suggest that the Federal administration encourage the development of this program in all States and expansion of the services provided in these programs. The experience of some 40 States that are providing medical assistance under Kerr-Mills will encourage expansion of this

program and it can be safely expected that the States will continually improve its operation by developing eligibility rules and benefits that will match the need of older people.

This program which provides local administration, local determination of benefits, and local designation of eligible beneficiaries places administration with those who are most familiar with local conditions and local needs and gives greater assurance that medical care will be provided for those financially unable to pay for it themselves.

As an example, let me refer you to Illinois. Here, the State chamber has encouraged the development of the Kerr-Mills program. The Illinois law provides for medical services that correspond to the full spectrum authorized under the Kerr-Mills law. The department of public aid is to determine which of these services will be provided. At present the department has authorized the following services: (1) Hospital care, (2) care by a physician during hospitalization, (3) care by a physician for 30 days after the patient's release from the hospital, and (4) necessary drugs for 30 days after the patient's release from the hospital, (5) 90 days of convalescent care or rehabilitative treatment in a nursing home, if necessary after release from the hospital, with continued payment of drugs and physician's services as needed. These services, as you can see, exceed those provided in the King-Anderson proposals.

For the current biennium ending June 30, 1965, the Illinois General Assembly approved $20.8 million to cover anticipated medical needs of the aged under the Kerr-Mills program. In addition, it is estimated that nearly $60 million will be paid for medical costs of old-age recipients under the Federal-State old-age assistance program. Improvements can be made in this program but it is questionable what will happen if a similar program under Social Security is enacted.

Voluntary insurance

No doubt your committee will receive conflicting testimony on the extent to which our elderly are now covered by health insurance. It is not my intention to enter into this battle of national statistics. It is undeniable, however, that private insurance has made tremendous progress in providing protection to the aged. In 1952, a Social Security Administration study reported that 3.4 million persons over age 65 had health insurance. This was 26 percent of the noninstitutionalized aged. In 1962, the Health Insurance Association of America reported that 60 percent of noninstitutionalized persons over 65 were so insured.

Without question, increasing numbers of self-reliant Americans are choosing voluntary self-protection as opposed to compulsion under a Government program. This protection for the aged is provided in a number of ways—through individual policies, extension of Blue Cross-Blue Shield plans, group insurance plans and individual employer plans, many of which have come about through the collective-bargaining process between unions and management. Under these programs, individuals and groups of individuals can determine the types of policies they wish to buy, the benefits they desire, and the premiums they can afford. This growth and expansion under private enterprise clearly indicates the lack of need for further Federal legislation such as the proposed King-Anderson bills—legislation that would disrupt and confuse present plans and most certainly discourage their further expansion.

I have mentioned the growth of individual employer plans where, through collective bargaining, specific plans particularly suited to the employer and employee have been developed. At present there are many Illinois-based firms providing both hospital and medical care protection for their retired workers and many new plans are being developed every day. I am sure this Illinois experience is representative of the Nation as a whole. Here is an area which I sincerely believe deserves your committee's deep concern. You, I am sure, will want to encourage the continued growth of this type of hospital and medical care protection for retired workers rather than discourage it with passage of legislation compelling what in many instances would be less favorable protection under the social security system.

As an example of what is occurring in this field, may I relate what has happened in my own company?

Through the process of collective bargaining with three international unions—namely, the International Association of Machinists, the International Brotherhood of Electrical Workers, and the International Brotherhood of Boilermakers—retired employees and participants of the Wyman-Gordon benefit plan, a voluntary plan, are provided with 365 days of Blue Cross protection, $375 maximum

Blue Shield, and major medical expense benefits for the duration of their retirement at no cost to the pensioner. The same coverage is provided, at no cost, to the dependents of pensioners. At the death of the pensioner, Blue Cross-Blue Shield and major medical benefits are provided the spouse until her death or remarriage, and again at no cost. In addition, group life insurance is provided the pensioner at no cost to him.

Pensioners of the Employees' Independent Union are provided 120 days Blue Cross, $375 maximum Blue Shield, and major medical coverage at no cost to them. That same coverage is extended to dependents of the pensioner at no cost to the pensioner.

Pensioners of our fifth union, the International Die Sinkers Conference, are provided with 120 days Blue Cross and $375 maximum Blue Shield coverage at no cost to them. These same benefits are extended to dependents of the pensioner, and again at no cost to the pensioner.

Identical coverages are also provided nonunion employees, retiring under our retirement program.

COSTS AND TAXES

Social security should not be considered an insurance program. Essentially, it is a tax program wherein today's workers pay for the benefits of today's retired workers. Increasing this tax to provide the limited hospital benefits your committee is considering would place a new and onerous burden on already overburdened taxpaying workers, workers who have homes to buy, automobiles to pay for, children to educate, along with real estate, sales and income taxes to pay. It is indeed surprising and alarming to us that serious consideration is being given to legislation that would place an additional tax burden on the working population after our Government in the interests of spuring our economy and increasing purchasing power recently enacted an income tax reduction.

H.R. 11865, alone, will about cancel out the decrease in income taxes most employees are to receive in 1965. For example, the present law calls for a social security tax of $174 for the worker who earns $5,400 in 1965. H.R. 11865 will increase that tax to $205.20. Of course, the employer will pay a like amount and the self-employed tax will be increased from $259.20 to $307.80. It should also be pointed out that under this bill, a worker earning $5,400 in 1971 will pay $259.20 in social security taxes compared to a presently scheduled tax of $222. This, by the way, represents about a 17 percent increase in taxes, for which the individual is promised a 5-percent increase in benefits.

To impose an additional social security tax for hospital care might well jeopardize the entire social security system. Will not these workers begin to ask the question, "Who's getting the benefits?" Will they not rebel when they realize that thousands of individuals well able to provide this care for themselves will be the beneficiaries of their tax dollars?

Experience with social security here and abroad shows that costs are invariably underestimated. The costs of medical and hospital care under the social security program are almost impossible to predict and could rise to staggering proportions. When Great Britain began its medical care program, costs were estimated at $475 million a year. But for 1959, the costs had soared to over $2 billion annually.

Proposals before your committee would provide only limited hospital care. It is estimated that the King-Anderson bills would pay about 25 percent of the medical and hospital costs for an elderly benficiary. Even for this limited care, it is fair to question if the costs have been forecast with any degree of accuracy. It can be forecast that the future costs would not be confined to these limited benefits. Once a hospial or medical care program is established, the unrelenting pressure for more and greater benefits could not be resisted. The way would be open to expansion and extension of benefits not only to the elderly but to the development of a national health program to cover every man, woman, and child in the Nation.

SUMMATION

Everyone agrees that hospital and medical care should be provided the elderly who need it. The question is, "How shall this care be financed?" In the American tradition, this responsibility should first fall on the individual, then his family, then on voluntary community agencies and finally on local, State,

and Federal governments. In line with this philosophy, the Illinois State Chamber of Commerce urges rejection of legislation to establish a compulsory program of hospital and medical care benefits under social security for the following reasons: (1) This legislation is unnecessary. Such care is now available through private health insurance plans and voluntary programs which have shown remarkable growth in recent years and through the Federal-State public assistance and Kerr-Mills programs which provide superior protection for those who need it. (2) This legislation is a "foot in the door" providing limited benefits which would be expanded with a "snowballing" of costs. While the initial costs are staggering, the unpredictable potential costs might well jeopardize the entire social security program. The recognized limit of a 10-percent social security tax may soon be levied (H.R. 11865 provides for a 9.6-percent combined employer-employee tax by 1971). (3) This legislation is unfair to our working generations who will be taxed to pay benefits for millions who do not need them. (4) Inclusion of hospital and medical care benefits under social security would endanger the ability of the social security system to pay higher future cash benefits that might be required. (5) Such a mandatory program would destroy individual initiative and would promote development of a philosophy contrary to the traditional American philosophy of letting government do only what the citizens cannot do better for themselves.

INDIANA STATE CHAMBER OF COMMERCE,
Indianapolis, August 6, 1964.

HON. HARRY FLOOD BYRD,
Chairman, Senate Finance Committee,
Washington, D.C.

DEAR SENATOR BYRD: Since H.R. 11865, the Social Security Amendments of 1964, is now in the Senate Finance Committee, I would appreciate your considering the following views of the Indiana State Chamber of Commerce concerning this bill.

The Indiana State Chamber of Commerce recognizes the need for improving the actuarial soundness of the old-age and survivors insurance phase of the social security program. Such improvement should be based on careful appraisal of experience with the actual operation of the program, including the still unsolved problems that (1) no consistent relationship exists between amounts of tax contributions of individuals and the amounts of benefits they ultimately may receive; (2) the program is one of sharply rising costs and a major portion of costs of pension rights being earned now is being postponed for future generations to bear, and (3) the cost-deferment characteristic hides from public consciousness the future cost impact of obligations being incurred currently.

H.R. 11865, the Social Security Amendments of 1964, while increasing and extending benefits under the program, attempts to finance these provisions by rolling the tax rate schedule back for the years 1966 through 1970 and expanding the taxable wage base from $4,800 to $5,400. These financing provisions of the bill would result in a substantial discrimination against these persons earning more than $5,000 and would have the effect of making this class of workers and their employers shoulder the costs of the 5-percent across-the-board benefit increase and other liberalizations provided in the bill for the next 8 years. In other words, Congress would be providing additional benefits and at the same time reducing the taxes (which already are insufficient to meet the benefit schedule) on more than one-half of covered workers.

The Indiana State Chamber urges that any increasing OASI costs should be accomplished directly by commensurate tax rate increases in order to create a clear public understanding of the cost impact, rather than through the hidden method of an expansion of the taxable wage base. Since under the bill all beneficiaries would get bigger benefits, needed additional financial support should be provided by all who work, through a higher tax rate.

Cordially yours,

JOHN V. BARNETT.

GREENSBORO CHAMBER OF COMMERCE,
Greensboro, N.C., July 28, 1964.

Hon. HARRY F. BYRD,
Washington, D.C.

DEAR SENATOR BYRD: Attached is a copy of the action taken by our board o directors and this is how the business community feels toward medicare. W would appreciate your efforts on behalf of the business community in seein that this measure is not passed.

Very truly yours,

ROBERT VIDAL,
Chairman, Congressional Action Committee.

GREENSBORO CHAMBER OF COMMERCE,
Greensboro, N.C., July 20, 1964.

REPORT OF CONGRESSIONAL ACTION COMMITTEE

COMMITTEE ON TAX REVISION AND SPENDING CONTROL—BILL NO. H.R. 3920

Subject: Medicare.

Basic provisions

Although the House Ways and Means Committee moved to defer action on legislation establishing health care for the aged financed by increased social security taxes, it is believed that House passage of any legislation dealing with social security could provide a vehicle for medicare amendments in the Senate.

Impact of bill locally

(1) The administrative expenses involved would be extremely burdensome and would only serve to increase the already rising costs in the present socia security program.

(2) According to statistical surveys, at the present 60 percent of the public is covered under private health insurance plans, and it is projected that within a relatively short period of time, this coverage would increase beyond 90 percent. There seems every likelihood of success for programs such as Virginia-Carolina 65 Plus plan.

(3) The Kerr-Mills plan is already existent and has proven successful in States that have adopted the plan.

(4) Evidence from other countries which have had experience with socialized medicine in one form or another seems to indicate that the results are less than satisfactory.

Committee recommendation

The committee recommended to the board of directors that the Greensboro Chamber of Commerce oppose medicare. The board of directors did oppose medicare at its July 16 meeting and asked that the committee alert the membership on this issue, asking them to state their views to the following: Senator Sam J. Ervin, Jr., Senate Office Building, Washington, D.C., 20025; Senator B. Everett Jordan, Senate Office Building, Washington, D.C., 20025.

Please let your public affairs department know that you have written by sending carbon copies or a statement of the number of letters written on this bill.

The CHAIRMAN. The next witness is Dr. Ira Leo Schamberg, committee on social security for physicians.

Take a seat Doctor, and proceed.

STATEMENT OF DR. IRA L. SCHAMBERG, CHAIRMAN OF THE COMMITTEE ON SOCIAL SECURITY FOR PHYSICIANS, PHYSICIANS FORUM, INC.

Dr. SCHAMBERG. Mr. Chairman, and members of the committee, my name is Ira Leo Schamberg. I am a physician. With me is Mrs. Gertrud Rost, the wife of a physician in Orange, N.J. I am in the

private practice of dermatology in Elkins Park, Pa., a suburb of Philadelphia.

I have been in private practice since getting out of the service in 1946. I am a member of the Venereal Disease Subcommittee of the Philadelphia County Medical Society. I was recently a member of the legislative committee of this society, and from 1961 to 1963 I was a delegate to the Pennsylvania State Medical Society from the Philadelphia County Medical Society.

My statement is as follows: As chairman of the committee on social security for physicians, which represents many thousands of doctors from every State of the Union, I respectfully urge the Senate Finance Committee to approve a proposed amendment to the Social Security Act which would extend coverage to self-employed physicians.

The House Ways and Means Committee, as you know, approved this provision, and it was subsequently adopted by the entire House, with other amendments, by a rollcall vote of 388 to 8. I am encouraged to believe that the evidence which persuaded Members of the House, both Democrats and Republicans, to vote so overwhelmingly in favor of extending social security to self-employed physicians will likewise convince this committee of the justice and wisdom of this action.

As evidence that a majority of physicians want social security coverage, I offer exhibit A, which gives the results of official polls conducted by State medical societies of the American Medical Association, as well as three surveys by the Honest Ballot Association.

These reveal that social security coverage is favored by a substantial majority of doctors in 19 States and is opposed in only 8 States.

Moreover, the 19 States which registered a majority sentiment for social security have a private practitioner physician population of approximately 87,000, slightly more than 60 percent of the physicians in private practice in this country.

In addition, separate national polls by two independent and highly respected medical publications—Medical Economics (October 1958) and Medical Tribune (July 1961) show that the medical professors favor inclusion under social security by majorities of 56 percent and 57.7 percent, respectively.

It is therefore clear that, when the House of Delegates of the American Medical Association annually rejects resolutions approving physician coverage, it does not represent the viewpoint of the Nation's practicing physicians on this issue.

The AMA has never offered any evidence to substantiate its repeated assertion that physicians don't want social security.

Indeed, if the members of the AMA house of delegates voted in accordance with the wishes of physicians in their State, as expressed in official polls, a resolution favoring social security coverage would command a clear majority. Figures to support this statement are contained in exhibit A.

Repeated requests for a national poll on this issue have been made to the AMA by the Utah, New Jersey, New York, Pennsylvania, and other State medical societies, as well as by county medical societies and individual members.

These requests have been turned down by the AMA house of delegates on the grounds that a poll—

would be subject to great error in that it presupposed equal knowledge on the part of all polled——

and

it would create inflexible policy statements and would endanger the usefulness of the house of delegates.

There is no reason why physicians should be the only self-employed professional group which should be excluded from social security. Lawyers, dentists, osteopaths, bankers, and corporation executives are included, and they and their families receive its protection and benefits. Even in the medical profession, approximately 35 percent of our colleagues are covered by social security by virtue of their employment in group practice, in the Armed Forces, or as salaried employees.

Why is only the self-employed physician subjected to discrimination? The proposed amendment to the Social Security Act, approved by the House and now being considered by your committee, would remedy this gross injustice to members of my profession.

(Exhibit A referred to follows:)

EXHIBIT A. RESULTS OF STATE MEDICAL SOCIETY SOCIAL SECURITY ROLLS

States for social security (19)

State	In favor	Opposed	Number of votes in AMA House of Delegates
California [1]	635	372	21
Connecticut	1,391	504	3
Delaware	135	85	1
District of Columbia	550	192	2
Florida	957	714	5
Maine	369	210	1
Massachusetts	3,253	988	6
Michigan	1,781	1,048	7
Missouri [2]	277	148	4
New Jersey	2,174	916	6
New York [3]			24
Ohio	4,095	2,737	9
Pennsylvania	5,605	3,335	11
Rhode Island	[4] 70	[4] 30	1
South Dakota	155	104	1
Utah	322	188	1
Vermont	[4] 65	[4] 35	1
Washington State	[4] 60	[4] 40	4
West Virginia	436	237	2
Total			[5] 110

[1] A 1-in-10 poll by Honest Ballot Association.
[2] A 1-in-5 poll by Honest Ballot Association.
[3] Based on county society polls and State society resolutions.
[4] Percentage.
[5] A clear majority of the 202 votes in the AMA House of Delegates.

States against social security (8)

State	Opposed	In favor	Number of votes in AMA House of Delegates
Arkansas	1,167	596	2
Georgia	539	496	3
Illinois	3,301	2,790	11
Indiana [1]	246	181	5
Minnesota	1,030	817	4
Oklahoma	761	446	2
Virginia	[2] 62	[2] 38	3
Wisconsin	870	854	4
Total			34

[1] A 1-in-5 poll by Honest Ballot Association.
[2] Percentage.

NOTE.—The remaining State medical societies, which represent 58 votes in the AMA House of Delegates, have not held social security polls.

Dr. SCHAMBERG. I would like to stop now and ask Mrs. Rost to present her statement as the wife of a physician.

STATEMENT OF GERTRUD SANDER ROST, WIFE OF ORANGE, N.J., PHYSICIAN

Mr. ROST. My name is Gertrud Sander Rost and I am the wife of Dr. Adolf S. Rost, a physician with a private practice in Orange, N.J.

We have a married son with three children, who is a physician in Freeport, Long Island—Dr. Michael S. Rost. I therefore know, from firsthand experience, why the families of both young and older physicians want and need social security.

Certainly, on an issue of this kind, the wives of physicians have as much, if not more, at stake as the physicians themselves. It makes quite a difference to the widow of a young physician, who is left with two or three small children, whether or not she gets social security benefits. That difference may amount to many thousands of dollars over a period of years. As for the older physician and his wife who contemplate retirement, social security benefits could assure them of a financial cushion. I know that many physicians' wives take jobs to build up some social security coverage of their own, guaranteeing them at least some small protection.

At this point I would like to read to you an excerpt from a letter that our committee on social security for physicians received only recently. It comes from Kentucky and is dated July 16, 1964.

I have been a widow for 1½ years. I have no income whatsoever. My husband was in the hospital so many times the last year of his life that we were left broke and with a lot of noncollectible medical accounts. I am 57, and I have not been able to find work as I have no special skills or college degrees.

I am tired of living off relatives. I would like to see my 16-year-old son have an education. If the social security bill for physicians passes how will a physician's widow and children fit? I have no money to send for promotion for the passage of this bill but if I can give of my time or service in any way I will be glad to do so.

Dr. Schamberg has provided you with evidence that a majority of physicians are in favor of social security insurance. I am convinced that if the wives of physicians were polled, there would be virtually unanimous approval of this legislation.

What I—and many physicians' wives I have spoken to—cannot understand is why we are denied social security coverage while the families of lawyers, dentists, businessmen, and other self-employed people are included. What is the reason for this injustice? Doctors are just as vulnerable to the hazards of life as anybody else. They are subject to chronic illness and death; they have accidents and economic reverses.

Why shouldn't they and their families be protected against these calamities by receiving social security as most American families do?

Our New Jersey medical societies have charitable organizations similar to those Dr. Schamberg told you about.

There is, for instance, the Society for the Relief of the Widows and Orphans of Medical Men of New Jersey. The name alone is a slap in the face: why must we, and only we, turn to charity in case of need?

We, the physicians' wives, are at a loss to understand the opposition of the AMA to this legislation. We are absolutely appalled that a relative handful—some 200 members of the AMA House of Delegates, many of whom are acting contrary to their mandates—should be able to block a law of such vital importance to their colleagues. This cruel and callous opposition to social security has caused unnecessary hardship to the wives of retired physicians and has made the lot of widows more painful and difficult. Surely, it is time that this gross and senseless injustice is ended.

All of us were tremendously heartened by the action of the House Ways and Means Committee in extending social security coverage to self-employed physicians and its subsequent, near-unanimous approval by the House. We were particularly happy that this provision was passed with bipartisan support. I pray that we may receive similar approval in the Senate Finance Committee and on the Senate floor.

I can assure you that the expectations of the wives of physicians all over the country are running high, and they believe that at long last, after many, many years of waiting, they will now be eligible for the protection and benefits of old-age, survivors, and disability insurance.

I confess to you that while I am as hopeful as they are, I cannot help feeling some anxiety. I well remember the shock and bitter disappointment when, in 1960, I read that the Senate Finance Committee deleted, upon the urging of the AMA, a similar provision to extend social security coverage to physicians.

If this should happen again, we would feel utterly crushed, helpless, and abandoned. We are counting desperately on your sense of justice to retain the House-approved provision on physician coverage. You will gain the everlasting gratitude of countless physicians and their families all over the country by including them under social security.

Thank you.

Senator TALMADGE. Dr. Schamberg, do you have any further testimony?

Dr. SCHAMBERG. I would like to offer additional evidence, if I might, which is included in the annual report of the Aid Association of the Philadelphia County Medical Society for the years, 1959, 1960, 1961, and 1962.

The object of the aid association as stated on the first page of each annual report is to afford aid to needy physicians and their families.

Senator TALMADGE. The reports will be included in the committee files for the information of the members.

Senator TALMADGE. Any questions, Senator Douglas?

Senator DOUGLAS. I would like to deal with the statement that Mrs. Rost made or rather with a rhetorical question which she had.

She says:

> What I cannot understand is why we are denied social security coverage while the families of lawyers, dentists, businessmen, and other self-employed people are included.

I can tell you, Mrs. Rost, why this is so. Stated very briefly, the American Medical Association is the reason why you are not included. They have opposed inclusion of doctors.

Mrs. ROST. They have never polled—the AMA suggested to have polls taken a few years ago, which were taken by the medical societies, but then later the American Medical Association discouraged taking the polls when they saw how the polls were turning out, because we have—that is why—I think as I see it is very simple to explain.

The medical, the American Medical Association considers social security charity, and not an insurance, and they feel that charity leads to a welfare state and a welfare state would mean socialized medicine. They are, of course, as my husband is, for instance, too, opposed to socialized medicine, and that is why they do not want to have social security for physicians.

Senator DOUGLAS. Well, I don't quite understand. Are you saying that the American Medical Association is in favor of the inclusion of doctors?

Mrs. ROST. No, no, strictly opposed.

Senator DOUGLAS. They are opposed to it?

Mrs. ROST. Strictly opposed to it.

Senator DOUGLAS. What I am trying to say is that it has been the opposition of the American Medical Association which has prevented the Congress from including doctors.

Mrs. ROST. Yes. But what we are trying to prove is that in this case the American Medical Association does not represent the majority of physicians.

Senator DOUGLAS. And you cite these polls as an illustration?

Mrs. ROST. We have the polls, which we taken in many, many States of the Union.

Senator DOUGLAS. I would like to see doctors included. The American Bar Association for a long time opposed the inclusion of lawyers but finally the younger lawyers changed the opinion of the bar association. They were then included.

The dentists and the American Dental Association for a time opposed the inclusion of dentists, and when public opinion inside the profession changed, they were included. But now here you have the

American Medical Association, with its representatives in the house of delegates selected by the membership in the various States, adopting very strong resolutions against this.

How can you ask Congress to go out ahead of the official representatives of the profession?

Mrs. ROST. Well, I was explaining in a conversation with Senator Case that the bar association was just as strictly opposed to inclusion of the lawyers, but that they followed and obeyed the results of the polls which were taken, whereas the American Medical Association ignores these polls.

We have proof that after the polls were taken, and it was absolutely clear that if the majority of delegates would have been bound to testify in favor of social security coverage, we read in the American Journal of Medicine a small paragraph where it said that the house of delegates unanimously opposed the inclusion of doctors under social security.

That was after the polls were taken, and after the majority of delegates should have been bound to vote in favor of it.

Senator DOUGLAS. Would you suggest that your recourse is to change your representation in the house of delegates?

Dr. SCHAMBERG. Senator Douglas, that is a very difficult thing to do because our delegates to the American Medical Association are not elected by the grassroots in the counties.

Senator DOUGLAS. How are they elected?

Dr. SCHAMBERG. They are elected by the delegates from the counties to the State medical societies.

Senator DOUGLAS. Indirect election.

Dr. SCHAMBERG. Yes, correct.

Senator DOUGLAS. What prevents change at the grassroots level?

Dr. SCHAMBERG. Well, as a delegate to the State Medical Society of Pennsylvania, I introduced a resolution suggesting just such a change in the method of selecting delegates to the AMA, so that the AMA's delegates would be more democratically elected.

Senator DOUGLAS. What happened to your resolution?

Dr. SCHAMBERG. This was turned down by the reference committee.

Senator DOUGLAS. I'm sorry I couldn't hear you.

Dr. SCHAMBERG. This was turned down by the reference committee of the Pennsylvania State Medical Society to which it was referred by the Pennsylvania State Medical Society House of Delegates.

Senator DOUGLAS. You see, it is very hard for us to go behind the official declarations of the various professional bodies.

Dr. SCHAMBERG. Senator Douglas, I do not recall whether it was the lawyers or the dentists, but I do have in my files back at home the statement that the chairman of either the American Dental Society or the American Law Association, I forget which, stood up and said:

> I realize the polls favor inclusion under social security. But I in my official position as president of this group will continue to oppose it.

The American Medical Association shows the most unbelievable arrogance. I attended a reference committee meeting of the AMA meeting some years ago where this question was brought up, and the point of view of the members of the reference committee was that the

fact that most doctors who were polled wanted social security simply was evidence of their ignorance, that they just didn't realize what a vicious Communistic thing social security is and, therefore, the answer of the AMA should be to launch an educational campaign to teach these foolish ignorant physicians what is what.

I had another curious experience at the meeting of the Pennsylvania State Medical Society in Pittsburgh.

I guess I shouldn't be talking against my fellow physicians this way, but I feel so strongly about this that I am going to.

I introduced a resolution favoring social security coverage of physicians. This was referred to a reference committee, and the reference committee turned it down despite the fact that I think it was 67 percent of Pennsylvania physicians favored social security in the most recent poll.

When the chairman of the reference committee stood up and advised rejection of this resolution, I stood up and said:

Mr. Speaker, if 670 out of every thousand physicians in Pennsylvania want social security I feel sure that there must be physicians, other physicians than myself in this room full of delegates who want social security. I would like to ask the men who voted for social security coverage in the privacy of a mail ballot to show the courage of their convictions by having a standing vote.

And I sat down. The speaker said, well, this would require a motion. Immediately someone stood up and said, "I move we have a voice vote."

There were seconds from all over the room and it was overwhelmingly moved that there be a voice vote. I hate to think that my fellow physicians do not, will not stand up for what they want, but I know, I can't see any other conclusion to reach from this occurrence.

Senator DOUGLAS. In other words, what you say is that the house of delegates is really unrepresentative of the body of medical opinion, at least on this matter?

Dr. SCHAMBERG. I don't know how many of those delegates wanted social security, I am sure some of them must have.

Senator DOUGLAS. But you are saying the House of Delegates of the American Medical Association does not represent the majority opinion of the doctors themselves?

Dr. SCHAMBERG. Exactly.

Senator DOUGLAS. Do you think this might apply to health care for the aged, too?

Dr. SCHAMBERG. Yes. I feel that the men who are at the reins of the American Medical Association are for the most part older physicians and I believe, although I don't think I could document this, that they tend to be more conservative than the average physician.

Senator DOUGLAS. Thank you, Mr. Chairman.

The CHAIRMAN. Thank you very much.

(At the request of the chairman, the following are made a part of the record:)

GLASGOW CLINIC,
Glasgow, Mont., August 3, 1964.

HON. HARRY F. BYRD,
Chairman of the Senate Finance Committee,
Washington, D.C.

DEAR SENATOR BYRD: A strong majority of the physicians in the United States have earnestly fought to stay out of the Social Security Act coverage. A majority of physicians in certain "overdoctored" areas are in favor of this inclusion, but the majority in the United States are heavily opposed to it.

In the State of Montana, a poll of our members showed that a minority opinion for this inclusion was most prevalent in the middle-aged group physician and the opposition was even stronger among the younger and among the elder physician.

Because of our working into later years and our economic situation, almost without exception, physicians provide for their own coverage, for their own protection of themselves and of their families, and we feel that these self-employed physicians should be allowed this independence.

I wonder how an increase in my income taxes to the scheduled 7.2 percent of the first $5,400, which I will have to pay by 1971, is going to aid me in any way having, by that time, 5 children in college. Must we then have more Federal scholarship programs to pay for bright children who do need and can profit by college education? I don't see how this compulsory inclusion of the self-employed and reasonably independent physicians is going to further allow them to care for their families and to educate their children.

I have written you before that I have always regretted not being able to cast a vote for you in an election. I feel your voting record in Congress has been one I can most heartily endorse with my limited knowledge of the situation, and I am sure that you will give this request the same consideration that you have used on other matters.

It's a sad thing in this country when things have come to the point where you have to write letters to Senators asking them to protect you from bureaus of the Government that want to do something for you. A revolution has certainly come a long way.

Sincerely yours,

DAVID GREGORY, M.D.

THE FREDERICK C. SMITH CLINIC,
Marion, Ohio, July 28, 1964.

Senator HARRY F. BYRD,
Senate Office Building,
Washington, D.C.

DEAR SENATOR BYRD: I hope you will do everything in your power to strike out that portion of H.R. 11865 which has to do with including physicians under social security. This diabolical action was taken in the House Ways and Means Committee in executive session with no one present to speak for the doctors.

As a practicing physician, I don't expect to retire, just as most physicians do not expect to retire, but if I did I would certainly plan on taking care of myself, just as most other physicians would do. Indeed, if we are unable to take care of ourselves in our old age, for God's sake who is left in this world that can?

It is obvious that the inclusion of physicians is only a means of extracting additional tax dollars from them in order to help finance a program which is fiscally unsound to begin with. It is taxation without representation and it is a change from voluntarism for physicians to compulsion. This action of the House Ways and Means Committee is morally indefensible.

Since the bill cannot be amended in the House, and in an election year will undoubtedly pass the House, the only chance we have of stopping it is in your committee. I beg of you to do everything you can to strike down this devilish attempt.

I have written to you before on other matters, because you are one of the few remaining people in the Senate who have any conscience remaining regarding their country. Fortunately here in Ohio we have one other Senator, Frank J. Lausche, not a member of my party, but a man whom all physicians respect, and I sincerely hope he will help you in whatever way he can in this action. Senator Lausche once voted for a bill which would provide hospital care for the elderly under social security. I sincerely hope he will reverse himself in this position because it is obvious that this matter will come up again in the Senate. Of course, such a step, too, cannot be reconciled with the position that you and he have taken on other matters involving the same principles. I deeply appreciate your kind attention to this matter, and I remain,

Very sincerely yours,

PHILIP W. SMITH, M.D.

ATLANTIC CITY, N.J., *August 10, 1964.*

Senator HARRY F. BYRD,
Senate Committee on Finance,
Washington, D.C.

DEAR SENATOR BYRD: The proposed medicare amendment to H.R. 11865 would destroy private practice in such medical specialties as radiology.

It would do this through the provision which provides payment for diagnostic X-ray studies in hospital outpatient departments but not in the offices of physicians specializing in this field.

Under the free enterprise system, patient flow has tended to go to those who offer better medical service. The proposed medicare would change this by using the economic power of the Federal Government to force patients to hospital outpatient departments for X-ray examination rather than to physicians who practice this specialty under their own names.

I regret that the schedule of the committee did not permit my appearing before it and request therefore that this statement be included in the printed record of the hearings.

Very respectfully,

LEONARD S. ELLENBOGEN, M.D.

The CHAIRMAN. The next witness is John C. Lynn, American Farm Bureau Federation.

STATEMENT OF JOHN C. LYNN, LEGISLATIVE DIRECTOR, AMERICAN FARM BUREAU FEDERATION

Mr. LYNN. The stated objectives of the proposals before your committee are to (1) modify the existing social security laws to increase OASI benefits, (2) extend coverage, (3) improve the actuarial status of the trust funds, and (4) provide for payment for hospital and related services to the aged.

These proposals are embodied in the House-passed bill, H.R. 11865; the King-Anderson bill, S. 880; and the Javits amendments to H.R. 11865.

The American Farm Bureau Federation represents 1,628,295 farm families in 2,764 organized counties in 49 States and Puerto Rico.

Farm Bureau believes that the most pressing need is to improve the actuarial status of the trust fund. We believe that this can best be done through a modification of the existing programs so that no further tax increase will be required. Rather than approve a 17-percent tax increase and a 5-percent across-the-board benefit as authorized in H.R. 11865, we recommend that benefits be adjusted to improve the status of the trust funds without a tax increase.

We are opposed to all of the other provisions of the bill now under consideration, as indicated in points 1, 2, and 4 above.

Farm Bureau policy of the last decade was reaffirmed last December in our latest annual meeting:

> Social security programs should be designed to supplement rather than replace individual thrift and personal responsibility. The increasing costs of liberalized benefits are a serious financial burden. We therefore recommend that existing programs be modified so that no further tax increases will be required.

Farmers' opposition to increasing social security taxes to pay for medical costs in any of their various forms is of long standing. When proposals of this nature were made in the 1940's, we took vigorous exception to them and have continued to do so.

This opposition is founded on the philosophy that America's unparalleled progress is based on freedom and dignity of the individual. We oppose the trend toward centralization of power and responsibility in the Federal Government. In the words of a resolution adopted by the elected voting delegates of member State Farm Bureaus at our last annual meeting:

Social security taxes should not be increased to pay medical costs for any portion of the population. The need for medical insurance should be met by expansion of existing private insurance programs without Federal subsidy.

Farm Bureau opposes S. 880, the King-Anderson bill, for the following principal reasons:

1. It would make radical changes in our present system in transferring to an already overcentralized, overobligated Central Government responsibilities that can be handled better in other ways.

Farm Bureau believes that the financing of medical care is essentially the responsibility of the individual and the family. If such needs cannot be met by the individual—either through private savings or through prepaid private health insurance—and if the members of his family are unable to assist him, then church and private welfare agencies have a role to perform.

In the relatively limited number of cases that cannot be satisfactorily dealt with by individuals and through private agencies, participation by local or State government is justified.

As a last resort—and only to share in the medical costs of the medically indigent—should the Federal Government enter into the financing of medical care for individual citizens with aid such as the Kerr-Mills bill?

The operations of the States under the Kerr-Mills law enacted in 1960, coupled with the increased activity of private insurance groups in providing health insurance to the aged, are demonstrating that the Congress was wise in enacting the Kerr-Mills bill and rejecting the legislative proposals providing for medical care through the social security tax.

There is every indication that private, non-Federal insurers can provide adequate coverage for medical care for all groups.

Latest reports indicate that some 170 insuring organizations are now offering voluntary health insurance on an individual basis. In addition, there are several hundred companies who write group policies which include those over 65. The plans offered include a wide range of individual choices to fit the individual's needs. Many plans accept all ages, regardless of health, without physical examination. It is estimated that more than 60 percent of the aged already have health protection. The number covered has increased more than three times in the past 10 years, and the trend is still upward.

According to figures published by the Health Insurance Institute in 1962, more than 141 million persons, representing 76 percent of the civilian population of the United States, were covered by some form of health insurance.

2. Enactment of legislation as proposed in S. 880 would impose immediate Federal control in certain areas and would undoubtedly lead to extension of Government controls to other services.

The Government, under this bill, would impose additional control on personal income through an additional tax.

Under the bill before this committee, hospitals and nursing homes would be required to have "utilization review" plans as a condition for participating in the proposed Federal program. These plans, of necessity, would have to be in harmony with the philosophy of the Secretary of Health, Education, and Welfare, or the Federal funds would be withheld.

Admittedly, the control is indirect, but it is there and extends further to the relationship between doctor and patient. Theoretically this is to avoid abuses, but it could create injustices. The recipient of Federal medical care would be limited in his choice of hospital and nursing care to those institutions having an agreement with the Federal Government.

3. Financing medical care for the aged through a tax and the mechanism of social security would not provide "prepaid insurance" in the usual meaning of the term.

The title of the proposed act, "The Hospital Insurance Act of 1963," is a misnomer. The program bears no resemblance to insurance.

The Supreme Court has ruled (*Flemming* v. *Nestor*, 1960) that social security is not an insurance program.

The Internal Revenue Service of the U.S. Treasury Department has proceeded in its cases on the valid assumption that social security is a tax and not insurance.

The bill would impose a tax on the present generation to provide services for the untaxed and with little guarantee that such services would be available when the taxpayers reach age 65.

4. Increasing the social security tax to provide medical assistance would be burdensome to the self-employed farmer and impose additional controls which he resents. Farmers are jealous of their independence and are little disposed to spend money on such Government programs. They want freedom to choose their insurer, and freedom implies diversity. The trend in this bill is toward conformity and control.

The social security tax rate on the self-employed has risen six times since 1953 and will go up again in 1966 to 6.2 percent and in 1968 to 6.9 percent. Under the provisions of S. 880, the social security tax would be increased an additional two-fifths of 1 percent, and the base would be raised from $4,800 to $5,200.

It is generally conceded that, if the provisions of S. 880 were added to the House-passed bill, it would be necessary to eventually raise the base to $6,600 or a combined tax rate in excess of 10 percent. It seems incredible that serious consideration would be given to such a proposal.

The result of the application of the increased tax rates to various levels of annual earnings as they would affect the taxes to be paid by self-employed under current legislation and the House and Senate proposals is shown in the following tables:

Present: $4,800 maximum earnings base

Annual earnings	5.4 percent, 1963-65	6.2 percent, 1966-67	6.9 percent, 1968 and after
$2,000	$108	$124	$138
$3,000	162	186	207
$4,000	216	248	276
$4,800 (ceiling)	259	298	331

House-passed bill tax: $5,400 maximum earnings base

Annual earnings	5.7 percent, 1965	6 percent, 1966-67	6.8 percent, 1968-70	7.2 percent, 1971 and after
$2,000	$114	$120	$136	$144
$3,000	171	180	204	216
$4,000	228	240	272	288
$5,000	285	300	340	360
$5,400 (ceiling)	308	324	367	389

Present tax, plus House bill, plus King-Anderson: $5,400 maximum earnings base

Annual earnings	6.3 percent, 1965	6.6 percent, 1966-67	7.4 percent, 1968-70	7.8 percent, 1971 and after
$2,000	$126	$132	$148	$156
$3,000	189	198	222	234
$4,000	252	264	296	312
$5,000	315	330	370	390
$5,400 (ceiling)	340	356	400	421

The tables already referred to show the heavy burden which would be imposed on farmers and the self-employed. There is a wide difference in tax burden between employees and self-employed farmers. Many employees regard their take-home pay as their real wages and are oblivious to the payment of the Federal insurance contribution tax as a result of the withholding by the employer. On the other hand, farmers pay this tax along with their Federal income tax in a lump sum at payment time.

The farmer is already burdened with capital investment and operating problems. This would only compound his problem. In this connection, it my be asked: Out of what earnings is a self-employed farmer going to provide for the purchase of a farm or the livestock, machinery, and equipment needed for his operations? The farmers of America have not asked for the proposed benefits and are opposed to any extension to cover health benefit costs.

Finally, may we cite additional reasons and comment briefly as to why the American Farm Bureau Federation has taken a strong position against the proposed legislation. We believe this legislation, if adopted and implemented, would bring about substantial and far-reaching changes within a very short period in our system of private medical services to our society.

It is our belief that American medicine would soon lose its enviable position as the finest in the world. This measure extends a new type of Federal support and control to a substantial segment of our society. With this beginning, we fear it would be only a matter of time until

other groups would be brought under the program, and eventually our system of medicine in this country would be changed beyond recognition.

This proposal brings Americans face to face with what could be a historic decision between voluntary medical care, unmatched in its excellence in the entire world, and a Federal program, which we believe would alter this fine system beyond the hope of recall. Once the principle of providing for health care on a compulsory basis has been established, the "point of no return" will have been passed. The history of similar programs supports this statement.

We fear that, with the inroads which would be made by this legislation, before many decades we would witness in America a situation which other nations, and particularly Great Britain, are witnessing at the present time. Recent reports tell of callousness in treatment of the ill at outpatient clinics, long waiting lines, and physicians handling almost 3,500 patients. This has weakened the services rendered to such an extent that there is an almost wholesale migration away from the medical profession in Great Britain.

As a responsible farm organization, representing the largest segment of our farm population, we are concerned with the health of our people. In our local county and State organizations, we take an active part in promoting better health services and in working with voluntary groups to provide medical care wherever it is needed. We stand ready and willing to continue in this role and much prefer to do so rather than to turn to the Federal Government.

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

Our next witness is Mr. Arthur J. Packard of the American Hotel & Motel Association.

STATEMENT OF ARTHUR J. PACKARD, PRESIDENT OF THE PACKARD HOTEL CO., AND CHAIRMAN OF THE GOVERNMENTAL AFFAIRS COMMITTEE OF THE AMERICAN HOTEL & MOTEL ASSOCIATION

Mr. PACKARD. Mr. Chairman and gentlemen of the committee, I am Arthur J. Packard, president of the Packard Hotel Co., with headquarters in Mount Vernon, Ohio. I am chairman of the governmental affairs committee of the American Hotel & Motel Association. I am also president of a chain of small hotels and motels.

I appear before this committee today as the official spokesman of the A.H. & M.A. on H.R. 11865, the Social Security Act Amendments of 1964.

We deeply appreciate the opportunity to present testimony on this legislation which would require an employer to pay a Federal tax on a transaction which occurs between one of his employees and an outside or third party. As you gentlemen know, the language in section 9 of the bill, requiring an employer to withhold the tax on employees' tips for social security purposes was inserted in H.R. 11865 without industry being afforded an opportunity to testify. The insertion of this language in the bill has created nationwide concern in the innkeeping business.

Let me say at the outset, that we have never objected to paying our share of the social security tax on payroll. The point is, however, that tips received directly by an employee are not and should not be considered payroll. Neither in theory nor in practice can we justify an arrangement between two separate parties who have nothing to do with an employer's payroll, but which imposes a Federal tax on an entirely separate party; namely, the employer.

My association is keenly aware of its responsibilities to its employees in finding ways by which the vicissitudes of life can be more adequately met for older persons or for widows or orphans. We are anxious to see our employees enjoy the "golden years." In this connection, we are constantly attempting to improve and expand our retirement and pension policies. This we will make every effort to do regardless of your decision on H.R. 11865, although every increase in payroll taxes necessarily limits our ability to do so.

The bill proposes a system based on voluntary reporting by the employee. From a practical standpoint, we believe that a young man, scarcely thinking of social security benefits, will report little, if any, tip income. On the other hand, an older citizen looking forward to imminent retirement may be inclined to enlarge upon his declaration. In either case, the employer must pay a tax which may be based on the whim and fancy of the employee. We must object to a law which would require an employer to accept an employee's statement as to the amount of tips he receives. This is tantamount to asking an employer to incur a responsibility which he cannot budget and to pay taxes on a base of which he has no accurate knowledge and over which he has no control.

May I say with all due respect to those who drafted this bill that section 9 of H.R. 11865 shows a complete lack of knowledge of the operation of service employees in the hotel-motel industry. Let me tell you briefly how tips are sometimes distributed in our industry.

In an ordinary dining room a waiter collects the tip from the table. Often by agreement or custom, he then gives a share to the captain because the captain has given him some special consideration in seating guests at the table served by the waiter who received the tip. He may also pay a share to the busboy so that the busboy will give special attention to the table in keeping the water glasses filled with ice and water and in removing the dishes quickly so that the waiter can serve more parties at his assigned tables during the course of a day. Also, the waiter might give a share of his tip to the cook and other kitchen help with the expectation that they will give him quicker service. In other words, the waiter frequently distributes some of the tips to a large number of other persons who help him to serve more quickly and thereby produce a larger tip.

Banquet tips are frequently distributed in exactly the same manner. The hotel does not know exactly how it is handled in each case, but those concerned frequently designate a particular employee to receive the tip from a banquet. He then pays over a specified amount to the headwaiter, to each of the other waiters, the busboys, the kitchen help, and to all other persons who participated in making the function a success. Probably the captain receives the largest share, waiters probably get slightly less, on down to busboys and kitchen helpers. The amount that each is to receive is agreed upon among the people

who participated, or is governed by custom, but the hotel has no way of knowing what amount each receives.

The situation is complicated even further by the fact that the percentage amounts vary from time to time and from function to function.

Whenever a large banquet is being served most hotels and motels are obliged to hire casual waiters. Immediately after a banquet these people are paid and the hotel may not see them again for a month or two until another large dinner is scheduled. Casual waiters are employed for other than banquet business. Again, this type of employee may work on 1 or 2 occasions for 1 or 2 nights a month for 1 hotel employer and during the course of that month may work for as many as 10 or more different employers. You can readily visualize the complications which will be compounded by the presently proposed bill, H.R. 11865. The employee will be expected to keep a record of the tips received at each affair and from each employer and report to those employers where the tips total $20 a month or more. It is hardly likely that such records will be kept. The employer will be placed in the awkward and untenable position of accepting whatever the casual employee decides to report to him in the nature of taxable tip income. These casual employees are ofttimes here today and gone tomorrow. It would not be difficult for such an employee to make one employer whom he disliked responsible for a disproportionate part of the social security tax.

Likewise, a different situation would be noted in resort and seasonal hotels which have a very fast turnover of employees. This type of establishment engages many young people, schoolteachers, or even housewives during the summer months when the resort is operating. Many of these folks never work as long as 3 months at a time. But here again, I can visualize a person who left the hotel's employ, after only a brief period of his employment. He would have no wages coming from which the hotel could make a deduction.

The 10-day provision contained in H.R. 11865 does not afford the employer any measure of protection. For example, an employee who has suffered in 1 month an illness in his family, or an added increase in expenditures in his household, or a bad day at the races, could very easily declare a minimum of tip income. The next month with reduced household expenditures or a good day at the races, he could double or triple the amount of tip income in his declaration to his employer.

Under a ruling given in 1958 by the Treasury Department, hotels must pay social security and withhold income tax on tips which are distributed through the hotel. This is the case where the customer or the hotel adds a percentage to the bill to cover gratuities. Under these circumstances, the employee must keep a separate account of the tips which he gets directly from the customer so that he can report them under the proposed bill. However, he must omit from the statement the tips upon which social security has already been paid under the distribution system. It is obvious that few employees will be able to keep such accurate records.

A hotel-motel employer has no more knowledge of what his employee receives in total tip income than you or I know as to how much a minister of the gospel gets "in gratuities" over a year's period; than a shoeshine boy receives "in tips" in a day; than a barber receives

"in tips" in a week's time; or that a taxicab driver receives "in tips" in a period of an hour. It just doesn't seem right under these circumstances to place an employer in the position of accepting a statement of tips received from an employee and at the same time require the employer to accept such a declaration as gospel. Technical and administrative difficulty in the proposal contained in section 9 of H.R. 11865 is that there is no way to insure accuracy in reporting. The employer has no way of knowing whether the employee's report is real or phony.

Additional work required by section 9 in making up payrolls would be astronomical. After completing the payroll and making the regular payments to employees, the employer would be required to wait for 10 days for any reports which the employees might make and then compute the social security tax on the tips reported. This would mean a complete extra payroll computation for every employee in the tip category.

H.R. 11865 does not provide for withholding of income taxes based on tip income. However, H.R. 11865 now provides that tips are wages. Section 3403 of the Internal Revenue Code specifically makes the employer liable for withholding taxes on wages. Under this section, if an employer requires an accounting from an employee for tips these may become wages for all purposes and the employer is required to withhold on them or face liability for payment himself. Query: Does the language in H.R. 11865 indirectly require the withholding of income taxes based on tip income?

Tip employees perform a personal service to patrons of hotels and motels and are compensated accordingly.

We strongly believe that if a tax on tips is to be imposed for social security purposes, the most practical, beneficial, and least complicated way of handling the matter is to consider such tips as true self-employment income. This would avoid disputes between employer and employees; avoid disputes between unions and put the employees on their own to pay taxes and to receive benefits based on the taxes that they pay.

There would be no difficulty in the computation of tax. The employer would pay his share of the social security tax on the employee's regular wages. Annually, the employee would declare his "tips" as self-employed income. The employee's tax on self-employment income for social security purposes would only apply to the extent that regular wages did not reach the base of $4,800 per year.

It is obvious that a proposal which would permit such manipulation is a disservice to the welfare of a community and an unwarranted interference with sound business practices. The amount of tip income that an employee receives should be a matter between him and his Government. Nothing can be gained and only discord and confusion can follow by inserting a third party between the said employee and his Government.

Gentlemen of the committee, you have always accorded the American Hotel & Motel Association's spokesman full and adequate hearings and we have been gratified by the interest you have manifested in our problems. We appreciate the opportunity to appear before you this morning and earnestly request that a detailed study be made on how best to handle the tax on tips for social security purposes before the

proposal contained in H.R. 11865 is approved by Congress. We are cognizant of the thorough manner in which this committee considers tax legislation and feel certain that upon further consideration you will disapprove this potentially damaging piece of legislation.

Thank you.

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

Senator CARLSON. Mr. Chairman, may I ask permission to insert in the record a letter that I have from the Kansas Hotel & Motel Association signed by C. H. Nanson, Jr., secretary, endorsing the position which has just been taken by Mr. Packard?

Mr. PACKARD. Thank you, Senator.

(The letter referred to follows:)

KANSAS HOTEL & MOTEL ASSOCIATION,
August 4, 1964.

Senator FRANK CARLSON,
Senate Office Building, Washington, D.C.

DEAR SENATOR CARLSON: As a member of the Senate Finance Committee you will be called upon very soon to review H.R. 11865, which relates to the taxing of tips that people give varies from State to State, city to city, day to day, meal law. As one can readily ascertain without much study, the great variation in the amount of tips received by employees in different localities, and the amount of tips that people gives varies from State to State, city to city, day to day, meal to meal, and trip to trip. How there can be any continuity, or any justification for the employer deducting for these tips is beyond our comprehension. It would appear that almost every employee would be in constant hot water with the Internal Revenue people, and it would be a very difficult job to adequately police such a matter.

It would seem to me that perhaps the bill should be remodeled, and if tips are to be a part of social security, then there should be self-employment income. What I mean by this is if a bell boy or waitress or any individual who receives tips wish to consider it as self-employment income, he could report it, pay the tax, and get the benefit of it in his social security benefits. No doubt some employees would be happy to do this, and would appreciate the opportunity to do so. When you place a burden on the employers to determine tips, or to report on tips, then you are asking them to do something that is almost impossible.

Won't you please use your influence to straighten out this matter?

When the rules of Government become too oppressive that employers are constantly harassed by the Internal Revenue Service, and social security services, then you are creating a situation which breeds discontent, and eventually you will have almost a revolt on the payment of taxes. Just look what they are doing again by raising the limits to $5,400. This is strictly a revenue-producing situation when this is done and it doesn't seem quite right.

We must be constantly on the alert.

Kindest personal regards.

Yours truly,

H. C. NANSON, Jr., *Secretary.*

The CHAIRMAN. The next witness is Mr. Leslie W. Scott of the National Restaurant Association.

Senator DOUGLAS. Mr. Chairman, I would like to say the representatives of the National Restaurant Association are men of high character and well represent the progressive spirit in their industry.

STATEMENT OF LESLIE W. SCOTT, CHAIRMAN, GOVERNMENT AFFAIRS COMMITTEE, NATIONAL RESTAURANT ASSOCIATION; ACCOMPANIED BY IRA H. NUNN, ATTORNEY

Mr. SCOTT. Mr. Chairman, my name is Leslie W. Scott. I am president of the Fred Harvey Co., a corporation with headquarters in Chicago which operates restaurants in various cities across the country, at airports, on railroads, and in some of our national parks.

I appear today on behalf of the National Restaurant Association of which I am a director, as well as chairman of its Government affairs committee.

I am also representing the American Motor Hotel Association, a trade association affiliated with our National Restaurant Association; and Mr. S. Cooper Dawson, Jr., a past president and chairman of the Governmental Affairs Committee of the AMHA will file a separate statement for inclusion in the record.

The National Restaurant Association is the trade association of the food service industry. Through direct membership and affiliation with 135 State and local restaurant associations, it represents over 100,000 restaurants in the United States.

We have filed our statement with the committee, Mr. Chairman, and I will attempt to summarize it here in the interest of conserving your time.

While the House Committee on Ways and Means held extensive public hearings on the subject of medical care for the aged it did not hold any public hearings on the contents of H.R. 11865. The legislation was brought to the floor of the House under a closed rule which prevented the offering of any amendments on the House floor.

Neither the National Restaurant Association nor any other interested employer group were notified that a proposal to base social security covering tip income as well as wages would be considered as part of the proposed Social Security Act of 1964.

Our first notice of this matter came only after the Ways and Means Committee had included section 9 in the bill.

We were then told we would be permitted to suggest technical amendments but would not be permitted to direct our attention to the problem of including tips as wages for social security purposes because the subject was no longer at issue having already been approved by the committee.

The potential harm of this legislation, in our opinion, is very great and if enacted it would create many new problems for restaurant operators and would serve to impair or destroy our good employer-employee relationships in an industry where even now almost half of the owners are reporting no taxable income.

The National Restaurant Association is not opposed to social security protection for restaurant employees. It is not opposed to the principle of basing social security payments and benefits on the tip income of employees. It is not opposed to matching and withholding the employee's contributions providing a satisfactory solution can be discovered which would limit the employer's bookkeeping burden and would not be harmful to employee morale and would not adversely affect the already serious problem of recruiting employees.

The National Restaurant Association is opposed to section 9 of H.R. 11865 because we believe it was conceived in haste, without adequate time being made available for interested groups to consider solutions and present them to both Houses of Congress.

Section 9 is not a satisfactory solution to this problem. Therefore it should be removed and the matter of basing social security benefits and payments on tip income should be considered on its own merits, preferably at some time during the 89th Congress.

Section 9 requires that all employees in any business or industry who receive more than $20 per month in tips report these tips to their employer within 10 days following the calendar month in which the tips were received. The employer must make a record of the tip income reported, withhold the social security contribution due thereon for any unpaid wages, match the employee's contribution, and provide the employee with a record of the amount reported and the contribution made to the Treasury.

The employee is given the option of paying such money as may be due to meet the social security payment should sufficient wages for withholding not be available.

The employer's liability for matching his employee's payment extends to all tip income reported by his employees even though the tip income may not have been acquired while in his employ.

The nature of restaurant employment is such that all of our employees work in close contact with each other. They must cooperate and communicate continuously with each other if they are to do their jobs successfully, and this close contact causes these employees as a rule to be quite frank and they discuss with each other many personal problems.

They know the wages being paid, and other things that might not be known to fellow employees in other industries.

However, our employees do not know the tip income of their fellow employees, and the reason for this is that the tips are almost never discussed and they are certainly never disclosed.

The employee's tip income arises from his very personal relationship with his customer or guest. He feels this makes tips his business and that of no one else. Often the families of tipped employees are not aware of the extent of the tipped income.

Many employees feel that their employers would attempt to decrease wages if their true tips were known. Therefore, they feel their employer has an adverse interest in this matter.

In certain union agreements, including some of those of our company, employers are even forbidden to question employees about their tips. Tips are never considered part of compensation in any agreement. It is certainly difficult to evaluate tips, and just recently in California, where my company operates, the industrial welfare commission of that State ruled that tips cannot be considered part of compensation.

The question also must be raised as to who is the tipped employee. The Senate itself has tipped employees. The barbers in the various congressional barbershops are salaried employees who also receive tips. They are eligible for retirement based on their wages, but Congress has not seen fit to require them to report their tip income other than directly to the Internal Revenue Service.

The employer never sees the tips his employees receive and, therefore, he has no knowledge of the amount of the tip income.

There is thus no way of knowing the average or normal tip situation.

Under the House-passed bill the employer must simply take on faith the employee's statement concerning his tip income. The employer is given no right to challenge the tip figure reported. Many employees might adjust their reported tip income to fit their personal needs and situations. The young employees, for example, who are not

concerned with retirement and pensions might understate their tip income as a means of limiting their income tax liability.

On the other hand, the older employee near retirement might overstate his tip income feeling that the added income tax liability would be worth the increased pension he would thereby obtain.

Also, our industry employs many casual employees, particularly among the tipped employees.

Many work for 10 or more restaurants in a month as they shift from weekend to weekend work or banquet work in establishments.

The House-passed bill requires reporting within 10 days after the end of the month. It is possible for an employee to require the entire social security contribution for the month to be paid by the employer for whom he was working at the month's end or, for that matter, any one of the employers he might select during the month.

Many service employees in our industry actually work to obtain supplementary income for specific purposes. Thus the primary sources of waitresses are housewives or high school or college students working part time or during holiday periods. They are not seeking social security coverage, but rather are working for specific purposes, quite frequently such as tuition for themselves or for their children.

Tip splitting, also a part of our restaurant industry pattern, is a common practice and this results when busboys or bartenders are given a portion of the waiters' or waitresses' tips.

Section 9 of this—of H.R. 11865 is not clear as to whether employees who share tips would be covered by this bill.

Another major problem is that many of our larger restaurants operations have introduced automated bookkeeping as a means of reducing costs.

But the introduction of such a widely fluctuating daily variable as tip income into this machinery would force an extensive return to manual bookkeeping. The increased cost of doing so in my opinion might even outweigh the direct social security costs.

This is a very complex subject, and I believe the problems are not adequately solved by the House-passed bill. Several industries are involved and many different types of employees. Not only would hotels and motels and restaurants be affected but also barbers and bootblacks and beauty shop operators, and beauticians and taxi drivers and others. The problems can be solved, and the defects corrected, but this cannot be achieved in the haste which has surrounded this legislation.

This provision was rushed through the House and yet there was no need for haste for even under present law tips can be treated as income for social security purposes.

Section 1329 of the Social Security Handbook published by the Department of Health, Education, and Welfare, makes this clear.

At the present time banquet or club employees tips when charged as part of the bill are already used in determining wages for social security purposes, and all other restaurant employees may avail themselves of this under present law if they desire to do so.

Actually under a more liberal interpretation of the Social Security Administration, a labor agreement in New York City has just been concluded between the Joint Council of the Hotel Trades and the New York Hotel Association where a combination of wages and tips

of $70 per week for service employees was established as the base for reporting income for social security purposes.

In other negotiations this matter is being considered and this opportunity is available for social security coverage.

The very fact that the effects of section 9 can be achieved under present law is reason enough for deferring action on this provision until all interested parties can be given an opportunity to appear and suggest such changes as they see fit.

Tip income is self-employment income. The cost of recognizing it as such is not necessarily prohibitive to an employee. We believe it should be so recognized.

Section 9 of H.R. 11865 was not adequately considered by the House before it acted. Time has not been permitted all interested groups to appear before the Senate. This is a complicated, costly, and morale-destroying problem for which no clear solution has yet been proposed.

This problem of basing social security on tip income should be considered as an independent issue at some time during the next Congress when adequate time may be provided to give the matter the consideration it deserves.

I respectfully urge you to eliminate section 9 completely in the 1964 social security bill.

Thank you, Mr. Chairman.

(Mr. Scott's prepared statement follows:)

STATEMENT OF LESLIE W. SCOTT, CHAIRMAN, GOVERNMENT AFFAIRS COMMITTEE, NATIONAL RESTAURANT ASSOCIATION

Mr. Chairman, my name is Leslie W. Scott. I am president of Fred Harvey, Inc., a corporation with headquarters in Chicago, which operates restaurants in various cities across the country, on railroads and in several national parks. I appear today on behalf of the National Restaurant Association, of which I am a director and the chairman of the Government affairs committee. I am also representing the American Motor Hotel Association, a trade association affiliated with the National Restaurant Association. Mr. S. Cooper Dawson, Jr., a past president and chairman of the Governmental Affairs Committee of the American Motor Hotel Association will file a statement for inclusion in the record.

The National Restaurant Association is the trade association of the food service industry. Through direct membership and affiliation with 135 State and local restaurant associations, it represents over 100,000 restaurants in the United States.

I am, as I have stated, now associated with the restaurant industry as president of Fred Harvey, Inc. Prior to that I served for 10 years as a member of the faculty of Michigan State University as director of the School of Hotel and Restaurant Management, as assistant dean of the College of Business and as director of continuing education.

THE POSITION OF THE RESTAURANT INDUSTRY

I appear in opposition to section 9 of the bill H.R. 11865 and urge that section 9 be eliminated from the bill. No public hearings were held by the Committee on Ways and Means on section 9 of this bill. The legislation was brought to the floor of the House under a closed rule which prevented the offering of amendments on the House floor. This is our first opportunity to testify to the merits of the bill.

The potential harm of this legislation is great. If enacted, it would impose burdens and liabilities on employers as the direct result of income of their employees over which the employer cannot exercise either custody, possession, or control. Knowledge of the amount of tip income lies exclusively within the knowledge of the employees receiving the tips. The employer would be completely at the mercy of the employees as to the amount of tip income reported.

The employer has a very real interest in the amount of tip income reported because he would be required to pay the social security tax thereon. Without knowledge of the average tip or the right to challenge the employee's report the employer is left to pay a tax based on an inestimable figure the fluctuations of which lie completely outside his control.

Section 9 is not a satisfactory solution to this problem. Therefore, it should be removed and the matter of basing social security benefits and payments on tip income should be considered on its own merits at some time during the 89th Congress. When adequate time is available to hear all interested parties in full.

SECTION 9 OF H.R. 11865

Section 9 requires that all employees in any business or industry who receive more than $20 per month in tips report those tips to their employer within 10 days following the calendar month in which the tips were received. The employer must make a record of the tip income reported, withhold the social security contribution due thereon from any unpaid wage due the employee, match the employee's contribution, and provide the employee with a record of the amount reported and the contribution made to the Treasury. The employee is given the option of paying such money as may be due to meet the social security payment should sufficient wages for withholding not be available. The employer's liability for matching his employee's payment extends to all tip income reported by his employees.

THE MORALE PROBLEM OF SECTION 9 OF H.R. 11865

The nature of restaurant employment is such that all our employees work in close contact with each other. They must cooperate and communicate with each other to do their job successfully. This close contact causes the employees as a rule to be quite friendly with each other. They discuss with each other personal family problems. They know the wages everyone is paid and many other things which might not be known by fellow employees in other industries. However, our employees do not know the tip income of their fellow employees. The reason is that tips are almost never discussed and are never disclosed. The employee's tip income arises from his personal relationship with the customer. He feels this makes tips his business and that of no one else. Often even the families of tipped employees do not know the extent of their tip income.

Some stations in a restaurant are better tip areas than others. Forcing disclosure of tip income would cause employees to vie for the most desirable posts. This would present a new headache to management.

If employees won't tell fellow employees the extent of their tip income, they will certainly be all the more reluctant to tell their employers.

Many feel that their employers would attempt to reduce wages if true tip income were known. Therefore, they feel that the employer has an adverse interest in this matter.

The employer never sees the tip. The employees feel that the employer has nothing to do with determining the amount of the tip. They feel it is none of the employer's business and the resentment they will feel if they have to disclose their tip income to their employer will seriously impair or destroy good employer-employee relations. Since our business is one which depends on good service for continued success, good employee morale is vital. Most employers would not want to inquire into the extent of their employees' income because of the morale problem. The Senate itself has tipped employees. The barbers in the various congressional barbershops are salaried employees who also receive tips. They are eligible for retirement based on their wages, but the Congress has not seen fit to require them to report their tip income other than directly to the Internal Revenue Service. Numerous industries have tipped employees, but I know of none which as a practice, requires the reporting of tips.

FURTHER DEFECTS OF SECTION 9 OF H.R. 11865

The employer never sees the tips his employees receive. Therefore, he has no knowledge of the amount of tip income. There is thus, no way of knowing the average or normal tip situation. Under the House passed bill, the employer must simply take on faith the employee's statement concerning his tip income. The employer is given no right to challenge the tip figure reported. Many employees might adjust their reported tip income to fit their personal situation and needs.

The young employees who are not concerned with retirement and pensions might understate their tip income as a means of limiting their income tax liability. The older employee near retirement might overstate his tip income feeling that the added income tax liability would be worth the increased pension he would thereby obtain. No safeguards are provided the employer in this matter. While our primary objection is not its cost, it must not be overlooked that this proposal could prove very expensive to an industry with an already poor profit picture. In my company, we have approximately 2,000 employees receiving tips. If their average tip income reported were 50 cents an hour, it would cost my company $100,000 per year. If the average hourly reporting were $1, the cost would be $200,000 per year. The restaurant industry does not object to paying more to its employees, but we do object to having a significantly increased labor cost over which we would be given absolutely no control.

This bill ignores requirements for State income tax withholdings, union check-off dues, and the employee cost of IRS approved pension plans.

Our industry employs many casual employees particularly tipped employees. Many work for 5 or more restaurants in a month. The House-passed bill requires reporting within 10 days following the end of the month. It is possible for an employee to require the entire social security contribution for the month to be paid by the employer for whom he was working at the month's end, or for that matter, any one of the employers during the month.

In the restaurant industry, many employees receive tips from other of our employees. This results from the common practice known as tip splitting. Busboys or bartenders are often given a portion of the waiter's or waitress' tips. Section 9 of H.R. 11865 is not clear as to whether employees who share tips would be covered.

Many of our larger operations have introduced automated bookkeeping as a means of reducing costs. Introduction of such a widely fluctuating variable as tips into the wage determining payroll machinery would force an extensive return to manual bookkeeping. The increased cost of doing so will perhaps outweigh the direct social security cost.

THE PROBLEM CAN BE HANDLED BY PRESENT LAW

H.R. 11865 proposes extensive changes in social security. Covered for the first time would be doctors of medicine. Changes would be made with respect to the farm community, policemen, and firemen. The rate and benefits would be raised. Changes would be made with respect to widows and children. The primary attention of the Senate to date has been whether to include provisions for medical care for the aged. The House did not hold hearings on the tips proposal. The Senate has been forced by the short time available to severely limit the time available for industry witnesses to present their views. This is a very complex subject and I believe one which has problems not solved by the House-passed bill. Several industries are involved and many different types of employees. Not only would hotels, motels, and restaurants be concerned. Also affected would be barbers, bootblacks, beauticians, taxi drivers, and others.

There is no need for haste in handling this legislation. Social security in much its present form has been a part of our law since 1935. Congress in that time has not seen fit to include tips for social security purposes. A few more months will cause no harm.

Furthermore, existing law and the regulations of the Social Security Administration allow tips to be a part of wages for social security if the parties agree (sec. 1329, Social Security Handbook, 1963).

Actually, as an example, the Social Security Administration has recently taken a much more liberal approach than that proposed by section 9 of H.R. 11865. The Administration has approved an agreement of the New York Hotel Association and the Hotel Trades Council that wages and tips shall be assumed to be equal to $70 per week. This is a recent example to show that even estimated tips can, under present law, be used to provide social security coverage for tip income.

Banquet employees' tips when charged as part of the bill are already used in determining wages for social security purposes. All other restaurant employees may avail themselves of this under present law if they desire to do so. The vast majority do not desire to do so because they don't want their employers to know the extent of their tip income.

The very fact that the effects of section 9 of H.R. 11865 can be achieved under present law is reason enough for deferring action on this provision until all interested parties can be given an opportunity to appear and suggest such changes as they see fit.

TIPS ARE REALLY SELF-EMPLOYMENT INCOME

The waiter or waitress in our industry is really a concessionaire. His tips are primarily the result of his own industry and skill in serving the customer. The customer rewards the waiter or waitress and not the employer with a tip. The employer has no interest in this. His concern is that the customer be satisfied. If tip income should be included for social security purposes, it should be done on a self-employment basis. Present law permits people receiving wages and self-employment income to have social security protection for both. Sharecroppers and tenant farmers are employees who are treated as self-employed for social security purposes. Federal court reporters are treated as employees, but income from the sale of transcripts to interested parties is treated as self-employment income.

Tip income is genuinely self-employment income. The cost of recognizing it as such will certainly not be prohibitive to an employee. The man who earns $1.25 per hour in tips under the self-employment treatment would pay only $49.40 more per year next year.

Ministers of the Gospel often receive gratuities for performing weddings, baptisms, etc. This is much the same as the gratuity given a waiter or waitress, yet the congregation does not expect the minister to reveal that gratuity. Between the congregation and the minister as between the restaurant owner and the waiter, the gratuity is solely the result of the individual's personal effort. The minister may report the gratuity as self-employment income. The waiter should be required to do the same.

CONCLUSION

Tip income is self-employment income. It should be so recognized. Section 9 of H.R. 11865 was not adequately considered by the House before enactment. Time has not been permitted all interested groups to appear before the Senate. This is a complicated, costly, and morale destroying problem for which no satisfactory solution has been proposed. The problem of basing social security on tip income should be considered as an independent issue at a later date when adequate time may be available to give the matter the consideration it requires.

I respectfully urge you to eliminate section 9 completely.

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

Senator BENNETT. Mr. Chairman, may I ask one question?

There are self-employed people who receive tips, the taxi driver would be in that class.

Mr. SCOTT. That is correct.

Senator BENNETT. So we are now facing the dilemma of having part of the tip income considered self-employed income and part of it if this bill goes through considered wage income.

Mr. SCOTT. That is correct.

Senator SMATHERS. Mr. Chairman, may I ask one question.

I noticed where Mr. Scott says the administration has approved the agreement with the New York Hotel Association and the Hotel Trades Council that wages and tips should be equal to $70 per week.

You say the administration has approved it. For what purpose have they approved it, not for tax purposes?

Mr. SCOTT. No, for social security purposes.

Senator SMATHERS. For social security purposes?

Mr. SCOTT. Yes, sir.

Senator MCCARTHY. Can I ask at this point does that include tips?

Mr. SCOTT. Yes, sir; this is a combination of wages and tips.

Senator McCarthy. I see. This applies not only to employees who receive wages and tips but is just a flat $70.

Mr. Scott. This is for the tip employees.

Senator McCarthy. Only for those who are tipped.

Mr. Scott. Yes sir.

Senator McCarthy. Do all of these employees—do all of them, receive tips or do some——

Mr. Scott. This would only apply to the tipped employees.

Senator McCarthy. Those who receive tips directly or those involved in tip splitting?

Mr. Scott. I am not aware of how they handle the tip splitting.

Senator Smathers. As I gather, this is the kind of thing you are not particularly in favor of, is that correct?

I don't understand why you put this illustration in your statement.

Mr. Scott. We submitted this to show that there are opportunities at the present time for workers to have this type of coverage. This was a new development in the city of New York.

Senator Smathers. Most of your argument has been that it is impossible to administer, there is no way to have an agreement, there is no way for it to be worked out equitably, and yet you point to this illustration of how it could be done.

Mr. Scott. This can be done over the bargaining table.

Senator Smathers. All right.

Senator Douglas. Mr. Chairman——

Senator Ribicoff. Would somebody yield for one question?

What puzzles me in this could be a way out. But I am just wondering how you would do this with a general rule when you have waiters working in New York in Tweaty One and Horn & Hardart. I mean it is obvious that you have got a difference here. How do you reconcile that?

In other words, certainly the way they are working at Twenty One they get more than $70 a week, and a waiter working at Horn & Hardart probably earns less than $70 a week.

How do you do this?

Mr. Scott. I think this would be a very great problem and I am not aware, because I do not operate in New York City, as to how they negotiate their contracts, as to whether they negotiate them for the hotel group separately or for the restaurant group separately.

But I believe their contract was only for hotel waiters in hotel restaurant operations and would, therefore, not include the Bickfords or the Schraffts or companies of that type.

Senator Douglas. Mr. Chairman, may I ask a question?

The Chairman. Proceed, Senator Douglas.

Senator Douglas. Mr. Scott, what would you think of the possibility of the tip employee making the same statement for social security purposes that he now makes for tax purposes, so that it would be a unified statement which would be made quarterly rather than monthly?

I don't think that there would be any danger under this provision that the amount of the tips would ever be overstated, which I understand is one of your fears in the later years of an employee's life.

I have thought that this might be a constructive way out. Have you had a chance to think about that, Mr. Scott.

Mr. SCOTT. I haven't had a great deal of opportunity to think about it because of the time element that was involved. This could be a possible approach to this solution, and there have been others that some of our members have asked to discuss with us but time has not permitted us to really probe this matter and come up with a solution that would be fair to the employer as well as to the employee.

Senator DOUGLAS. It seem a possibility to you at least?

Mr. SCOTT. I would think this would have a possibility.

Senator DOUGLAS. Thank you.

Senator SMATHERS. May I ask one further question on this point.

Do you have any estimate as to how many of the employees who work in restaurants throughout the Nation, how many of them belong to unions and how many of them do not? What is the percentage of them?

Mr. SCOTT. I do not know the answer to that question, Senator. I could only tell you for our own company, where about 75 percent of our 5,000 employees are members of unions. I can't answer that for the industry.

Senator DIRKSEN. Mr. Scott, when did you first become aware that this item might be inserted in the House bill?

Mr. SCOTT. I don't have the date. Mr. Nunn, do you have the date?

Mr. NUNN. Senator, we became aware of it, first of all, when the Committee on Ways and Means proposed to report the Social Security Amendments of 1964. Not before that date.

Senator DIRKSEN. In other words, they were already preparing their report.

Mr. NUNN. Yes, sir. They were.

Senator DIRKSEN. At that point the——

Mr. NUNN. We found out about it and pointed out some of the difficulties, and they told us that, "Well, you may send us a letter in which you will describe your technical difficulties, the burdens of this thing, but you need not address yourself to the philosophy because we have determined about this."

We sent a letter up, and they incorporated it as well as they could, some of the minor matters that we pointed out. But we first knew about it after the decision had been made, Senator.

Senator DIRKSEN. And the hearings were closed?

Mr. NUNN. Hearings were closed, sir.

Senator DIRKSEN. Had there been any testimony on this in prior years?

Mr. NUNN. Some years ago, I believe there had been, Senator, not in my time, not within my memory.

The CHAIRMAN. Any further questions?

It is now 11:10, so I assume we won't have time for the next witness and we will recess until 2:30 this afternoon.

(At the request of the chairman, the following are made a part of the record:)

STATEMENT OF S. COOPER DAWSON, JR., CHAIRMAN, GOVERNMENTAL AFFAIRS COMMITTEE, AMERICAN MOTOR HOTEL ASSOCIATION

Mr. Chairman and members of the Senate Finance Committee, my name is S. Cooper Dawson, Jr., owner and operator of a motel and restaurant in Alexandria, Va. I am filing this statement as chairman of governmental affairs of the American Motor Hotel Association, after our request for oral testimony in opposition to section 9 of H.R. 11865 was denied at the hearing held today.

The American Motor Hotel Association has been the spokesman for the motel industry since motels came into being. No other organization speaks for the motel industry as a whole.

We are opposed to section 9 of the proposed social security bill (H.R. 11865) because it is ill conceived, unjust, and unworkable and was drafted without hearing of those who would be most vitally concerned.

This section 9 is asking me to be a new kind of tax collector. I don't want to be this kind of tax collector and those I speak for feel the same way.

Most of the employees in motels and restaurants are people with minimum skills and limited business dealings. They are always scared stiff in any dealings or involvement with (1) the policeman and (2) the Internal Revenue man.

It is hard enough to explain to them that their pay is, say $60 a week, and after present taxes the take-home portion is $40 a week. It would be next to impossible to explain to them that they must now report the amount of their tips to us, so we can take out another big slice of their take-home pay for the Federal Government.

I don't want to further jeopardize my employee relations by becoming another nasty type of tax collector. The others I represent think likewise. We do not feel that this section is right or fair to either the employer or the employee.

From 32 years' experience in this business, I know of no practical way to determine the amount of tip income of an employee. It is his money and it is paid to him directly by the customer or guest he serves. Only tips of record, or those that are collected by the management, can be accurately pinned down for taxing purposes. We have no quarrel with taxing tips of record and this can be handled with reasonable efficiency. This type of tip deduction by management is understood by most employees.

Tips not of record, those given direct to the employee by the customer or guest, are the big problem. Any deductions from this type of tip income will cause much friction and ill will between employee and employer. This loss of this proper relationship can and will be costly to motel and restaurant operations. In our estimation, it will be of such magnitude, in many instances, as to cause business failures.

Disgruntled employees, in the service industries, often pass their grievances along to the customer or guest.

We feel sure that members of this committee are not fully informed as to the many ramifications of section 9 of H.R. 11865 and how they will adversely affect the motel and restaurant industries.

We were not given the opportunity to participate in public hearings on this section as none were held. The legislation was brought to the floor of the House under a closed rule which prevented the offering of amendments.

The motel industry, representing nearly 62,000 operations, with an invested capital of $12¾ billion and gross income of well over $4 billion was not notified that a proposal to base social security coverage on tip income as well as wages, would be considered as part of the Social Security Act of 1964. No other affected industries were notified.

We can see little valid need for the hasty action proposed in section 9 of this bill. The reporting of tip income is a highly involved procedure if any semblance of accuracy is to be secured.

Customarily the value of tips is a thing never revealed by an employee to his employer. The employer is loath to seek out, or to seem to seek out, this information. Employees would resent giving employers a written statement of tips. The very announcement of such a requirement would at once create friction between employers and their tipped employees.

There is no guarantee of an accurate reporting of tips. There is inducement not to report accurately. A young employee, not mindful of social security benefits would report low so as to reduce his payments and avoid the revelation of his income tax liability. A casual employee, a transitory employee, would tend to do this also. An old tipped employee approaching retirement would give greatest importance to social security benefits soon to be realized and tend to report high. In either case, the employer and the Government would be at the mercy of the employee.

What of the employee who does not report in writing? The bill provides that if an employee does not report within 10 days from the end of the month in which the tips were earned the employer shall have no responsibility with respect to that month's tips.

Bear in mind that all manner of tipped employees are covered by this bill. There are bartenders, bellmen, and barbers as well as porters, tax drivers, parking lot employees, chambermaids, and beauticians. There are others who are not often thought of as recipients of tips or gratuities.

There is no objection to the principle of applying tips to social security payments since the social security system has long been the law of the land. But there is objection to doing so in the manner proposed by this bill. Tips are unique. They are different. They represent a transaction between the employee and the customer.

The employer never has custody, possession, or control of tips. He does not know the value of tips. He is not going to find this out with accuracy. It is unfair to impose the burden of collection upon him.

If the employee is to count his tips for social security, let the law provide that he may do so as if he were self-employed as is now provided in the unique situations of ministers of the Gospel, tenant farmers, and court reporters.

So there is no need for haste. Extensive hearings should be held by the Committee on Ways and Means of the House and the Committee on Finance of the Senate. Many industries used tipped employees. All should have an opportunity to be heard.

This provision (sec. 9 of H.R. 11865) should be held over for hearings by another Congress next year when proper time can be devoted to it.

HAWAII RESTAURANT ASSOCIATION,
Honolulu, Hawaii, July 31, 1964.

Hon. HARRY F. BYRD,
U.S. Senate, Washington, D.C.

DEAR SENATOR BYRD: It is our understanding that H.R. 11865, which was given a closed rule by the House Rules Committee on July 21, contains a social security tax based on tips feature. We strongly urge you to do all in your power to remove this feature from the bill. Our objections are based on the fact that no hearings were held on this subject and the restaurant industry was given no notice of its inclusion in the bill prior to approval.

We believe the social security tax based on tips feature would affect employee morale to a considerable degree and ultimately have a negative bearing on employer-employee relationship since tipped income has been traditionally respected by the employer as belonging solely to the employee and therefore unaccountable to the employer. Aside from this aspect, there is the burdensome cost of recordkeeping. In all fairness to those most concerned with this feature, it would seem highly advisable to consider it later as a separate measure when some of the problems involved may be presented and when changes may be suggested.

We shall very much appreciate your efforts on our behalf in this matter.

Sincerely,

ROY E. KING, Jr., *President.*

DETROIT, MICH., *July 29, 1964.*

Re H.R. 11865, the social security bill.

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

DEAR SENATOR BYRD: As president of the Metropolitan Restaurant Association of Detroit, I have been urged to write you regarding the social security based on tips of restaurant employees of H.R. 11865.

The complexities involved in such action and the resultant problems would seriously disrupt an industry which presently is just recovering from the "expense-account slump."

We would welcome the opportunity of discussing this problem with you and sincerely feel that the social security on tip income feature of this bill should be considered later as a separate measure.

Very truly yours,

R. C. SCHWEIZER,
President, Metropolitan Restaurant Association of Detroit.

(Whereupon, at 11:10 a.m., the committee recessed to reconvene at 2:30 p.m., the same day.)

AFTERNOON SESSION

Senator DOUGLAS. The committee will come to order.

The first witness this afternoon is Dr. John G. Sugg, of the American Optometric Association.

Dr. Sugg, we are very glad to have you.

I see you are accompanied by an old friend of mine, Mr. William MacCracken.

Won't you testify, Dr. Sugg?

STATEMENT OF JOHN G. SUGG, O.D., ON BEHALF OF THE AMERICAN OPTOMETRIC ASSOCIATION; ACCOMPANIED BY WILLIAM P. MacCRACKEN, ATTORNEY

Dr. SUGG. Mr. Chairman, my name is John G. Sugg. I am an optometrist practicing my profession in Fayetteville, Ark. My appearance here is in behalf of the American Optometric Association.

With me is Mr. William P. MacCracken, Washington counsel of the American Optometric Association.

I am serving my third year as a member of the board of trustees of the American Optometric Association. For 4 years prior thereto I was director of its department of public information. I graduated from the Northern Illinois College of Optometry in 1949 and that same year was admitted to practice in the State of Arkansas. I have served on the board of the State association as its vice president and president. I was awarded an honorary degree of doctor of ocular science by the Illinois College of Optometry. I was president of our local junior chamber of commerce, a director of the U.S. Junior Chamber of Commerce and received that chamber's Distinguished Service Award in 1957. I am past president of the local Rotary Club and I served for 3 years in the U.S. Navy in the Pacific.

The American Optometric Association is the national organization representing the profession of optometry. It has a membership of between 12,000 and 13,000. Every State and the District of Columbia is represented in our house of delegates.

Optometry is the art and science of vision care, and as such, optometrists are primarily concerned with the maintenance of normal efficient vision, the prevention of its deterioration and impairment, the correction of impaired vision by the use of lenses, contact lenses, subnormal vision aids, and visual training as well as the detection of diseases with proper referral for treatment. Members of our profession are to be found not only in the large cities, but also in the smaller rural communities.

There are 10 accredited schools and colleges: Illinois College of Optometry, Indiana University Division of Optometry, Los Angeles College of Optometry, Massachusetts College of Optometry, Ohio State University School of Optometry, Pacific University College of Optometry, Pennsylvania State College of Optometry, Southern College of Optometry, University of California School of Optometry, and University of Houston College of Optometry.

These colleges require that an applicant for admission must have completed 2 years of preoptometric studies at the college level. A minimum of 3 years additional study devoted to optometry is required

and many of the schools require a fourth year for the student who desires to obtain a doctorate degree. There are six points that I would like to emphasize.

(1) Every State of the United States and the District of Columbia by statute, licenses and regulates the practice of optometry.

(2) A substantial majority of our citizens voluntarily seek the services of optometrists for their vision care.

(3) Unfortunately, in the administration of health care programs, financed in whole or in part by congressional appropriations, the beneficiaries thereof have been and are being denied either directly or indirectly the right to avail themselves of the services of optometrists and have the charges paid out of federally appropriated funds.

(4) Congress has heretofore found it necessary and advisable to enact legislation to make the services of optometrists available to the beneficiaries of certain health care programs including title X of the social security law and the law establishing the medical department in the Veterans' Administration.

(5) It is in the public interest that beneficiaries of all health programs which include vision care and are financed in whole or in part by appropriations authorized by the social security law be entitled to obtain the services of a duly licensed optometrist if they so desire; and

(6) That said services should be paid for at the same rate as would similar services rendered by any other duly licensed practitioner.

The 1950 amendments to title X of the social security law, required that services of optometrists should be made available to the beneficiaries of the aid-to-the-blind program who desired to utilize them. In 1953, as a result of this amendment, the Industrial Home for the Blind in Brooklyn, N.Y., inaugurated what was known as the optical aids service. Peter J. Salmon was its executive director. He himself was legally but not totally blind. Six weeks ago, in New York City, our association presented him an Apollo Award. It was my privilege to be present on that occasion when he addressed a luncheon audience of approximately 2,000 people. It was an occasion which I shall never forget. I regret that Mr. Salmon is not here in person to repeat what he said then. But I am going to take the liberty of reading to you excerpts from the transcript made on that occasion. At the beginning, he ran his fingers over his manuscript and said, very haltingly as he felt along:

> The method I am using right now in addressing these few remarks to you is the one used by totally blind persons throughout the world. It is braille. I read braille with my fingers for some 40 years, and then something wonderful happened to me—I became the first legally blind person to benefit from the use of optical aids—so much so that I was able to discontinue using my braille and to read everything with my sight, even to looking up a name and number in the telephone book.

At this moment Mr. Salmon reached in his pocket, took out a pair of glasses with telescopic lenses and took out a typed manuscript and said all this:

> The thrill I experienced was not only because of what the low-vision service has meant to me, but more because there are now some 50 clinics in the United States modeled after the first pioneered in by the Industrial Home for the Blind.
>
> As you know we look to the optometrist to carry on his painstaking, exact, and I must say very fruitful service on behalf of these persons who are classi-

fied as "blind" but who have some remaining sight. The original statistics which we announced of being able to help approximately 70 percent of those who are treated through this service has held, and thousands of blind persons have benefited through this service.

Optometry has played the key role in this development, and your thoughtfulness in presenting this award to me today gives me the opportunity to thank you publicly for having the vision and the technical knowledge, as well as the ingenuity to develop the best use of remaining sight for these legally blind persons. We have been willing, with your cooperation, to overcome the skepticism which existed back in 1953 when this program was first announced, and the years that have elapsed have proved the worth of this very meaningful service so that today it has become a part of the ongoing rehabilitation process in a number of agencies for the blind and in teaching universities as well as hospitals.

It has profoundly affected blind persons economically, socially and indeed spiritually; spiritually because it has given them for the first time an opportunity to be doubly sure of the extent to which their remaining sight can be used, and because of your dedicated skill and painstaking examination—real progress has been made in a field that hitherto was considered a "closed book."

It is with this in mind that I can express to you thanks from all of those who helped us in the early days of the low-vision service at the IHB—Dr. George Hellinger, Dr. William Feinbloom, Mr. Louis Bettica, and the other members of the IHB staff. We thank you in particular on behalf of the legally blind persons who have benefited through the low-vision services in which the optometrists have played the key role.

Mr. Chairman, while not all of the members of this committee participated as Members of Congress in the enactment of the 1950 amendments, I am confident that those members of the committee who did assist in making this service available must experience a keen sense of satisfaction in having done so. Of the 16 titles to the social security law, there are 5 others by reason of which Federal funds are available for vision care; namely, Title I: Old-Age Assistance; Title IV: Dependent Children; Title V: Maternal and Child Welfare; Title XIV: Aid to the Permanently and Totally Disabled; and title XVI, commonly referred to as Kerr-Mills.

In view of what has transpired, in the aid-to-the-blind program as the result of the 1950 amendments, I respectfully suggest that an amendment be incorporated in any bill which the committee reports. If it is the only amendment to H.R. 11865 it will be known as section 17 of the bill. The following language is suggested:

Any individual entitled under the Social Security Act to have payment made for vision care which may be rendered by an optometrist may obtain the services of any duly licensed optometrist and the services so rendered shall be paid for at the same rate as would be paid for similar services rendered by any other duly licensed practitioner.

This would not increase the cost to the Federal Government 1 cent. In fact, there would be substantial savings in travel costs and it would enable some of the beneficiaries to become self-supporting taxpayers.

Before closing, Mr. Chairman, I want to thank you and the other members of the committee for according me this opportunity to present this statement and to assure you of my willingness to answer any questions which you think relevant.

Senator DOUGLAS. Thank you very much, Dr. Sugg.

May I ask—what would be the practical scope of this amendment? Would it add eye care, vision care, to any additional titles of the bill?

Dr. SUGG. No, sir; it would not add anything. It would simply give the patient the right to go to whomever he wanted to have the care.

Senator DOUGLAS. Doesn't he have that right now?

Dr. SUGG. Not in practice; no, sir.

Senator DOUGLAS. Didn't the 1950 amendment give—wasn't the 1950 amendment designed to give it?

Dr. SUGG. Let Mr. MacCracken answer that for you, please.

Mr. MACCRACKEN. Senator, we thought that it would have that effect, but it has been limited strictly to title X, and these other titles——

Senator DOUGLAS. What is title X?

Mr. MACCRACKEN. Title X is aid to the blind.

Senator DOUGLAS. Aid to the blind?

Mr. MACCRACKEN. Yes, and it was under that title.

Senator DOUGLAS. Eye care cannot be rendered as a medical service to those on old-age assistance, to dependent children, to mothers, or to permanently and totally disabled?

Mr. MACCRACKEN. The answer to your question, Senator, is, it is not being done. I think it could be done if the welfare department was willing to do it.

Senator DOUGLAS. Why isn't the welfare department willing to do it?

Mr. MACCRACKEN. No, they are not.

Senator DOUGLAS. Why not? What is the reason given?

Mr. MACCRACKEN. Well, because in the other sections or titles, they refer to it as being medical care, and they say that the optometrists are not medics.

Senator DOUGLAS. What is the difference between optometry and ophthalmology?

Mr. MACCRACKEN. I will be glad to answer it, if it is all right, Senator.

Senator DOUGLAS. All right.

Mr. MACCRACKEN. The ophthalmologists are primarily trained and utilized for medication and surgery; treatment of glaucoma, which is one of the common diseases we are familiar with; removal of cataracts, detached retinas, and things of that kind which all come within the scope of the ophthalmalogist.

Senator BENNETT. Isn't it also true they must have a basic medical degree?

Mr. MACCRACKEN. Oh, yes.

Senator BENNETT. They must have an M.D. degree; and you do not?

Mr. MACCRACKEN. Yes; and then they specialize in the care of the eye.

It used to be that unless a man passed the board, which is given, passed the examination for ophthamology, why he wasn't known as an ophthamologist, he was only known as an eye, ear, nose, and throat specialist. But in more recent years, they are willing to permit any man who specializes in the eye, whether he has passed the board or not, to use the term ophthamologist, because there is no legislation under the State——

Senator DOUGLAS. He has to have a medical degree, first; doesn't he?

Mr. MACCRACKEN. Oh, yes; he has to have a medical degree and, as I say, when the term first became known it was limited to the man who had passed the board examination, but now, I understand that

there are quite a good many who are permitted to use it. Of course, it is voluntary, merely because they do specialize, even though they haven't passed the board.

But the optometrists all have to pass a State board examination.

Senator DOUGLAS. Are you eligible for membership in the American Medical Association?

Dr. SUGG. No; I am not.

Senator DOUGLAS. You are not eligible?

Dr. SUGG. No, sir; I do not have a medical degree.

Senator DOUGLAS. Are the ophthamologists eligible?

Dr. SUGG. Oh, yes.

Senator DOUGLAS. Do you think the fact you are not members of the AMA and the ophthamologists are members of the AMA may be any reason why you are not regarded as eligible under these five titles to the bill and confined to title X?

Dr. SUGG. In my opinion, that is the reason; yes, sir.

Senator DOUGLAS. Then the reason is the opposition of the American Medical Association?

Dr. SUGG. Yes, sir.

Senator DOUGLAS. Thank you.

Senator Bennett?

Senator BENNETT. I have no further questions.

I think you have brought out the crucial thing, that these people or these men have a degree, and to that extent they fit in the same general character, at least from the point of view of the AMA, as the osteopaths, chiropracters, and other people who practice health service but without a medical degree.

Senator DOUGLAS. Wait a minute. Don't quite include optometrists with chiropracters.

Dr. SUGG. Thanks.

Senator BENNETT. I was saying in the view of the American Medical Association.

Senator DOUGLAS. Of these 10 accredited schools and colleges, how many of those are profitmaking colleges and how many non-profitmaking colleges?

Mr. MACCRACKEN. They are all nonprofit, Senator.

Senator DOUGLAS. All nonprofit?

Mr. MACCRACKEN. All nonprofit.

Senator DOUGLAS. So it cannot be charged that the optometrists are educated at profitmaking diploma mills.

Mr. MACCRACKEN. No sir.

Dr. SUGG. Definitely not.

Mr. MACCRACKEN. That used to be, as it was with medicine and law and everything else. But now that has all been eliminated. There are no diploma mills in this country. I think they have one up in Canada that we are trying to keep—of course, they can't practice here, but—the men with those diplomas, but they can use our mails to defraud our citizens. We are trying to stop that.

Senator DOUGLAS. I notice you have a Southern College of Optometry. Where is that located?

Dr. SUGG. It is in Memphis.

Senator DOUGLAS. Is that affiliated with any other educational institution?

Dr. SUGG. That one is not affiliated. It is an independent, nonprofit school.

Senator DOUGLAS. The Los Angeles College of Optometry, is that affiliated with any other educational institution?

Dr. SUGG. It is not, either.

Mr. MACCRACKEN. I don't think Los Angeles is.

Dr. SUGG. I think not.

Senator DOUGLAS. Is the Pennsylvania State College affiliated with what is known as Penn State College?

Mr. MACCRACKEN. No.

Dr. SUGG. It is not.

Ohio State and Indiana——

Senator DOUGLAS. Are those affiliated?

Dr. SUGG. Those are affiliated with State universities.

Senator DOUGLAS. With State universities.

Mr. MACCRACKEN. California and Houston.

Dr. SUGG. Ohio State University has just put a 6-year doctorate degree in optometry.

Senator DOUGLAS. University of California, School of Optometry, is that affiliated with the University of California?

Dr. SUGG. Yes.

Senator DOUGLAS. University of Houston College of Optometry?

Dr. SUGG. Is affiliated; yes, sir.

Senator DOUGLAS. The Pacific University College of Optometry, at Forest Grove, Oreg.?

Dr. SUGG. Yes, sir. Forest Grove, Oreg.

Mr. MACCRACKEN. One of your colleagues is a trustee of Pacific; isn't he?

Senator DOUGLAS. Is that so?

Senator BENNETT. How about the Illinois College of Optometry?

Dr. SUGG. It is not affiliated.

Senator DOUGLAS. Thank you very much.

Senator BENNETT. May I ask one further question?

Senator DOUGLAS. Certainly.

Senator BENNETT. Isn't the decision as to whether or not you may be compensated, may be recognized for the treatment of people receiving public assistance under sections others than section X, a State decision?

Mr. MACCRACKEN. It is not entirely. It is partially so and partially under HEW.

Senator BENNETT. Are there any States in which you are given that privilege with respect to any other section?

Mr. MACCRACKEN. Oh, yes. For example, under Kerr-Mills, many of the States in enacting the enabling act, you know, under Kerr-Mills that requires enabling legislation on the part of the States, have specifically provided for the utilization of the services of optometrists.

Now, of course, they don't have to include vision care under Kerr-Mills if they don't want to. But take, for example, New York State. New York State did include vision care, but did not expressly provide for the utilization of the services of optometry. The result was that they had to put on a campaign to put through an amendment. It was put through either this year or last, I think it was last year, after a very strenuous battle, in which I understand there were 300 long-

distance telephone calls in 1 day made to Albany to make sure that the Governor would sign the bill after it passed both houses of the legislature.

Right now in Wisconsin there is a battle going on out there as to whether or not the services of optometrists shall be made available in their vision care program.

Senator BENNETT. Well, the situation then is, it is permissive with the States and you want the plan mandatory?

Mr. MACCRACKEN. Mandatory only if vision care is provided. We are not trying to make them include vision care. But if they are going to have vision care, then we think that the——

Senator BENNETT. Vision care is your phrase. Does this include all kinds of treatment of eye problems which you are competent to treat?

Dr. SUGG. All kinds of which we are competent to treat, yes. If you are talking pathology, that is less than 5 percent of the——

Senator BENNETT. What you are saying, by using the phrase "vision care" is that with respect to any service that you are licensed to render you want it mandatory on all the States to require that you be allowed to render that in all of these other welfare——

Dr. SUGG. We want it mandatory that the patient has a right to choose to whom he goes.

Mr. MACCRACKEN. Freedom of choice.

Senator BENNETT. But you don't want the State to be left in a position to say, "We will," or "We won't?" The States have the right now.

Dr. SUGG. The administration is where it is not being done.

Senator DOUGLAS. You want freedom of choice for the patient?

Dr. SUGG. Right, sir.

Senator DOUGLAS. As a great American stated yesterday, that the country has been based on.

Dr. SUGG. What Mr. Hoover said.

Senator BENNETT. But not freedom of choice for the State welfare department.

Mr. MACCRACKEN. Not for the welfare department.

Senator DOUGLAS. Mr. MacCracken excited my interest. He spoke of a battle going on in Wisconsin, and of telephone calls made to Albany. You cannot have a battle unless you have conflicting armies or contestants. Who are the conflicting armies, Mr. MacCracken?

Mr. MACCRACKEN. The American Medical Association, Senator.

Senator DOUGLAS. They are the opponents of this provision?

Mr. MACCRACKEN. They are the opponents of the provision. As a matter of fact, the AMA has on every occasion when there were any social security amendments before the Congress, asked Congress to repeal the amendment of 1950 to title X, notwithstanding what has been done in some 50 clinics like the one up there on——

Senator DOUGLAS. In other words, they wish to have a monopoly in fitting glasses, is that correct?

Mr. MACCRACKEN. Well, of eye care, the whole field, both surgery, medicine, and we are willing to give them that. They have got that, not we are giving it to them. They have got it. They should have it. There is no question about that.

But in the 1962 amendments, the AMA and this National Medical Foundation for Eye Care both appeared before the House Ways and

Means, and I think before this committee, and advocated the repeal of the amendment to title X, the 1950 amendment to title X.

Senator BENNETT. I have no further comment.

Senator DOUGLAS. I have no further questions.

Thank you very much.

Mr. MACCRACKEN. Thank you, gentlemen.

The CHAIRMAN. The next witness is Mr. Andrew Ziomek, of the National Licensed Beverage Association.

STATEMENT OF ANDREW ZIOMEK, IMMEDIATE PAST PRESIDENT, NATIONAL LICENSED BEVERAGE ASSOCIATION

Mr. ZIOMEK. Mr. Chairman and members of the committee, my name is Andrew Ziomek and I am the immediate past president of the National Licensed Beverage Association.

I am a restaurant and tavern operator in Clementon, N.J. I speak on behalf of the 40,000 members of my association, which is an organization composed of restaurant, tavern, bar-cafe, and cabaret owners located in 30 States and the District of Columbia.

We are small businessmen. Our members provide food, beverages, and sometimes entertainment for public and private gatherings. Most of our tavern and restaurant operators maintain employees who receive tips.

Let me bring to your attention today the problems we would encounter should section 9 of H.R. 1865 be enacted into law.

We are pleased to learn of the statement of one of the sponsors of the proposed legislation, which was as follows:

> I believe that these workers have enough integrity and enlightened self-interest to make an accurate report of their tips. They are now required to pay income taxes on the amount of their tips. Most of them wish to have the law extended so that they and their dependents will be eligible for higher benefits under the law—benefits which they are anxious to purchase, knowing that this kind of prepaid insurance will provide security in their retirement.

This statement was made by Senator Keating on July 15, 1963.

We were also pleased to learn that the proposed legislation was the product of study dating back to 1958 by joint committee of the interested Federal agencies. It came as a disappointment to see that the solution involved in the bill was nothing more, after this long labor than the tried-and-true method, the lazy way, of imposing the burden of new coverage effective on the employer.

We have been told, of course, that this is not a significant imposition in that no real responsibility will attach to the employer, except to the extent that the employees report income from tips to him.

We are also informed that any difficulties that we have will be cleared up by the regulations of the Internal Revenue Service.

We disagree that this is so. Past experience on travel and entertainment expense hearings have proved this. We submit to this committee that as a small businessman these assurances of lack of difficulty will not eliminate the fundamental objections which we have to this approach.

To add any additional obligation on the part of the employer in the complexity of the Internal Revenue Code, which we as laymen cannot hope to comprehend, requires that we obtain professional advice from

lawyers and accountants. We must have from them not only what is actually expected of us initially, but thereafter in the day-to-day attempt to comply with these requirements as long as we remain in business.

We submit that a small business, family business, as many of our members operate, cannot afford additional expenses of this type.

I might say that in a family business, we do manage to raise some of our own unskilled help, such as maybe a daughter might go back behind the bar and help you wash the glasses or something like that, but a lawyer and an accountant in the same family is not a likely coincidence.

A whole new area of book and record keeping and clerical burden of reporting is added to our problems which are not connected with the conduct of our businesses. There must be a limit to the extension of these problems.

We do not like to appear before the committee and speak in generalities of an increased burden. However, we do feel that the drafters of the law and regulations in this field all too frequently adopt the easy solution of adding to our troubles and avoiding theirs. They seem to operate under the assumption that we will procure whatever competent advice we need and that somehow we will be able to absorb the cost.

We suggest that this burden should be avoided by having the Government create a structure for the collection of this tax in which the burden of collection and enforcement are not delegated, or I should say, thrust upon the private employer without regard to his size or his ability to perform.

Another factor which is not realistic in this approach to this commendable extension of fuller social security coverage to some of our employees is that the employer will now be compelled for the first time to inquire into and, in effect, monitor the transactions between the waiter, for example, and the customer for the Internal Revenue Service.

Heretofore, this was essentially a matter of a waiter operating as an independent contractor. If he performs his work well, he may be rewarded with a handsome gratuity. If his personal attention to the customer is not up to the expected standard, he may receive nothing. If section 9 should become law, employers become a deeply interested party in the transactions between customers and employees.

We strongly urge upon the committee that this treatment of the waiter, waitress, or busboy in this area as an employee rather than as an independent contractor is unrealistic and will create many problems, as we will hereinafter set forth.

From the standpoint of effective operation of the business, this type of legislation (and I believe it is safe to assume regulations thereunder) will undoubtedly create personal complications and difficulties between employer and employee.

We hope that the committee will carefully consider the questions which occur to us on the practical basis which we cannot readily answer from the language of the proposed legislation:

1. What does the employer do if half of his employees willingly file statements while the remainder do not?

2. What does the employer do if he has reason to suspect that one or more of his employees are either understating or overstating the amount of their tip income?

3. Will it not be virtually necessary for the employer to insist upon compliance or discharge the employee, who may otherwise be a valuable asset to the business, simply to avoid complications in his reports?

4. What assurance does the employer have that he will not be embroiled in the inevitable controversies between IRS and his employees over the propriety or accuracy of their returns.

5. What protection is there against later claims by employees that the reports of the employer did not properly reflect the amounts reported or the moneys paid to the employer for the purpose of this law?

These are but a few of the questions which may or may not be answerable within the framework of the bill as it is before the committee, or by committee direction which will influence the preparation of regulations on the subject.

However, we cannot help but speculate on them and sincerely ask that the committee give careful attention to the potential problems in making its determination as to the advisability of the acceptance of section 9 as a solution to this problem.

We, therefore, suggest to the committee that an imperfect solution to the problem should not be adopted and perhaps permanently engrafted on the law. Other possibilities suggest themselves.

In line with the above quoted statement of a sponsor that most of the employees are anxious to purchase the coverage, knowing that this kind of prepaid insurance will provide security in their retirement, the law should make such purchase possible.

This could be accompanied by intensified effort by the Government agencies concerned to educate the employees with respect to the advantages available to them as self-employed persons for this type of income.

This could be done without involving the employer in all of the problems which we have indicated are inherent in the bill proposed. It would then be unnecessary to create a fictional relationship between the employer and the tips which a waiter or waitress may receive in the eyes of the law.

With the increased use of computers, the proper correlation of employees' reports for income tax purposes and full enforcement by IRS of the requirements that such taxes be paid, it seems to us that this problem could be resolved without this additional straw on the already overburdened camelback of the small businessman.

We appreciate the opportunity to appear before the committee and are grateful for its courtesy and attention. We have full confidence that the committee will carefully study the problems inherent in section 9 of the bill.

Thank you.

Gentlemen, may I in addition make one remark that I have been thinking over this morning, that to permit the young element who do not have to go to their employers until possibly the age of 60 to start making these returns to them, this is the greatest hoax that is being perpetrated upon the people who daily go, and are wage earners and

daily through their payrolls are paying social security while these people who are getting tips in their old age go in and get the last eight quarters paid and collect social security.

I don't think this is fair for the young people of this Nation, and with that I close.

I thank you.

Senator McCarthy. Were you present this morning when I suggested to the representatives of the restaurant association that one solution might be that you take for social security purposes the quarterly tax report filed with Internal Revenue by the employee who gets tips?

Mr. Ziomek. I was, Senator, and I was greatly appreciative of your remarks in that direction.

Senator McCarthy. Thank you very much.

Senator Bennett. Before the witness leaves, I am raising this because I was very much interested in the chairman's suggestion this morning, but it raised a question in my mind what do you do with the employee who works for 10 or 12 employers, to whom does he make his quarterly statement, and which employer is going to be responsible.

Mr. Ziomek. Well, I don't think that the solution is that he makes this report to the employer. I think it should be on the estimated tax returns as we do as businessmen on a quarterly report, as the Senator says, a quarterly report, not a monthly report.

Senator Douglas. The difficulty, though, is that the employer contribution would be due from a number of different employers; there is the greatest weakness in the plan.

Mr. Ziomek. And by the same token, I don't think that I as an employer if he should return at the end of the month and work for five different people and turn around and pay for the other four people.

Senator Douglas. This is correct.

Senator Bennett. That is the risk.

Senator Douglas. This is the problem.

Mr. Ziomek. That is the problem, Senator, and we as small people, and I am not speaking of the big operations in the business.

Senator Douglas. I understand.

Mr. Ziomek. We have over 300,000 licensees in these United States who are mom-and-pop licensees, if you understand what I mean, who have maybe one or two employees.

Senator Douglas. I understand.

Senator Bennett. What would you do if the man came and presented you with a statement that he had been paid $150 in tips and your records showed he had worked for you 1 night?

Mr. Ziomek. Well, Senator, may I tell you somebody shows me $150 in tips, you know what I would say, I would want his job.

I had that little talk before—these waiters are cute, you know, and some of these bartenders, and I know of instances in going around this country where bartenders pay for jobs, just to get the tips. They bid for jobs. They tell the owner how much they are going to pay, and that is so.

Senator Bennett. I am sure it may well be so.

Mr. ZIOMEK. Of course, those are not the kinds of people that I would say the NLBA represents. Those fellows don't need an association. They always tell they are too big for an association and they can buy the legislation, which we get for them for nothing.

Senator BENNETT. Yes.

Senator DOUGLAS. Thank you very much.

Mr. ZIOMEK. Thank you, sir.

Senator DOUGLAS. Our final witness this afternoon is Mr. C. T. Anderson representing the International Union of Hotel Restaurant Employees and Bartenders.

Mr. Anderson is an old friend of mine. We are glad to have you.

STATEMENT OF C. T. ANDERSON, WASHINGTON LEGISLATIVE ADVISER, INTERNATIONAL UNION OF HOTEL RESTAURANT EMPLOYEES AND BARTENDERS

Mr. ANDERSON. My name is Cyrus Anderson. I am the Washington legislative adviser to the Hotel Restaurant and Bartenders International Union. I do not have a prepared statement. I thought I could best utilize the short period of time allocated me in trying to give the committee some of the background of the reasons why this particular section is in this bill.

Some 3 years ago when I agreed to represent the hotel restaurant employees in Washington, they told me that the biggest problem that confronted their union was the tremendous gap between actual income on the part of their people and the social security base on which they are compelled to retire under present conditions.

They told me further that for 25 years they had been working with agencies of the Government in an effort to do something, work out some methodology to correct this problem.

At this point one thing occurred to me, and I should like to impress this on this committee, that organized society through the medium of the U.S. Government took very little time in figuring out a way to require these people to pay their income taxes on this very earning base we are talking about.

There is a procedure by which these people pay at least a major portion of the income tax liability on these tips that we now are discussing.

This procedure is not usual; this is a highly unusual procedure. There are standards used by the Internal Revenue Service, a more or less arbitrary assessment, dependent upon the type of room or the type of business or the type of establishment the man may be working at.

In fairness to the Service I must say this, I think they are understated. I don't think they are unfair to our people, and our union has not complained about this methodology used in arriving at the income tax liability.

My first step in trying to get at this problem was to seek meetings with people at the Social Security Board in Baltimore, at the Treasury Department in Washington, and at the Internal Revenue Service here.

After a long series of meetings with these people, I presented to them my concept of how we ought to proceed. I suggested that we take the employee's income tax liability at the end of the calendar year, and

that this income tax liability, however arrived at, whether assessed by the Internal Revenue Service or voluntarily supplied by the employee, that this be the basis for a postdated application of the Social Security Act for these people.

They agreed in principle with me on this, and they agreed that this was after all the final and the best judgment of all about how much money these people actually were earning, and how much was attributable to wages and how much was attributable to tips.

But then we ran into the machine monster. We now have traffic problems in Washington and more and more and more society has to adjust itself to the machine, and in this instance I was told categorically by the social security people that all of their reporting, and all of their data processing, and the whole operation which involved millions of people, is geared to quarterly reporting, and monthly payment of benefits, and that any system that went outside of this would create a terrific burden for the Government, and they couldn't agree with us.

Even so they, because they were anxious to try to solve the problem, they tentatively agreed to support such an approach in the Congress.

At which point we called here in Washington a meeting of some 450 to 500 representatives from all 50 States of the Union of this union, and we outlined for them the proposal that we were actively talking with the Government agencies about.

From the floor came suggestions that there should be income tax reporting simultaneously with the social security reporting. We are very tired of our people coming to us and complaining at the end of the year that the income tax man grabbed him by the heels and shook him and imposed an arbitrary amount, and couldn't some system be worked out where they could report their income taxes as they went along.

I went back to the Government agencies, and told them the feeling of our people and of our officers, and they prepared the structure of the bill that has resulted in the section that is now in contest before this committee.

Following the preparation of this bill, now in the preparation of this bill, I should like to point out, the industry's representatives for whom we have the highest regard, we enjoy a fine relationship with our employers, we regret very much that we are not together on this instance.

We understand their position. We hope they understand ours. But in any event the industry people were brought in by the Treasury on several occasions, and many changes were made in the draft in an effort to try to meet the objections of the industry.

Unfortunately this was not successful, but a real effort was made by everybody concerned to work out something that all of us could live with.

Following this, the bills were introduced in the Congress, at which point I went to the chairman of the Ways and Means Committee of the House, a very powerful man, a man with great responsibility, and he made it clear that he had trade extension problems which consumed a great deal of time in 1 year.

The following year there was a tax problem, which consumed an equally large amount of time. Then there was a medicare problem.

So we kept asking for hearings, we would like to have hearings, we wanted hearings, but these were not possible because it seems that both the Ways and Means Committee and the Finance Committee have been carrying the great bulk of some of the most important work of the Congress in the last 3 or 4 years and you gentlemen have felt this yourselves more than anybody.

But in any event we could not persuade the chairman of the House Committee to hold a hearing.

Finally, he said to me:

When we have another social security bill we will handle this matter.

And he said:

It is my feeling we have had so many hearings before our committee and the record is so full of testimony from all interested parties, that really another hearing would be redundant.

With the result that in this last bill that you now have before you, this particular section was adopted in the committee without dissent. The bill itself was reported out with only two dissenters, and it is interesting that one of the dissenters, a gentleman, a Congressman from California, on the Republican side, Mr. Utt, introduced a companion bill to our program and believes in this amendment that we are now discussing.

On balance he could not support the final result of the Ways and Means Committee, but my point is that the entire committee was in agreement on this matter, both sides of the aisle.

It went to the House with the closed rule which I suspect had very little to do with this problem and a great deal to do with other problems, but in any event there was a closed rule, and it is now before your committee.

We have no feeling at all that this bill is perfect. I have listened to the comments here before this committee today, and several things have come up that I would like to comment on.

First of all, the question of self-employment. It happens that I am a native of the State of Illinois, the acting chairman's State, and this is a State like most States wherein the consumption of alcoholic beverages and the dispensation of food is rigorously regulated at all levels of the local government, municipal regulations, county regulations, State regulations, and every activity in these establishments that we are now talking about, barbershops and restaurants basically, are regulated and the operators of these establishments are required by law to impose upon their employees conditions of sanitation, conditions, all manner of conditions, pursuant to the operation of that business.

So to suggest that a waiter is self-employed and is just a free entrepreneur in an establishment is outrageous.

In Illinois, for example, they have an act which holds the employer, the owner of an establishment, responsible for the death of a man who may be given too much liquor in his tavern.

If you go into a tavern in Illinois, and become intoxicated, to the extent that you are not responsible for your actions, and you walk across the street against a red light because you were too intoxicated to know the difference, and walk into a moving automobile and you are killed, if it can be proven in court that you were served too much liquor in this establishment your death can be attributed to the negligence of the owner of that establishment.

So that there is a far greater relationship between these people than simply self-employed people.

Secondly, I should like to say this. That at every juncture in the framing of this bill, efforts were made to relieve the employer of any responsibility over which he had no control.

The gentleman who preceded me raised the question what would an employer do if some of his employees filed and some them didn't.

Well, of course, the employer is not responsible for this. He is not even responsible for reporting that the man did not file. The income tax liability and the social security tax liability under this act is the basic responsibility of the employee, and if he does not comply with the law, steps can be taken by the Treasury Department to handle him like they handle anybody else who does not meet his tax problem.

What does the employer do if he has reason to suspect that one or more of his employees are either understating or overstating the amount of his tip income. It is theoretically true to speculate that a man may increase his tip reporting by a substantial amount but I should point out that under present income tax statutes, it is going to cost him a whole lot more for overstating personally to the income tax people than it is going to cost the employer to the social security people.

Will it be necessary for the employer to insist upon compliance or discharge the employee who may otherwise be a valuable asset to the business?

Well, if an employee doesn't do the job that is part of his responsibility, whether it be he refused to wash his hands and in the case of a waitress in the case of a high-class cocktail lounge refuses to wear a girdle.

There are many reasons why waiters and waitresses are discharged. There is nothing in this law that requires that a waiter or waitress be discharged if he does not report his income. There are penalties that he must look to to the Federal Government but not to his employer.

But the point that I would like to leave with the committee is that this is not a new problem. This is a problem that is almost 30 years old. Economists and lawyers have been struggling with this problem for a long, long time.

We now have a proposed system which the Treasury Department agreed to and helped write, the Internal Revenue Service agreed to and helped write, and the social security folks agreed to and helped write and that we agreed to and helped write.

The House committee, in its judgment, deleted that section requiring quarterly reporting for income tax purposes by waiters and waitresses.

So that you have before you only the social security problems.

The original proposal before the House committee contained income tax withholding and reporting. That has been deleted. We hope very much that some form of social security coverage on tips can remain in this bill.

However, on behalf of the international union, I should like to emphatically advise the committee that we are opposed in toto to any arbitrary figure of $30 or $40 represented as income by people in this industry, and we repeat, so long as there is a methodology of requiring the payment of income tax on full earnings in this industry, then we

believe that some method should be found to cover these same earnings under the social security system.

Senator DOUGLAS. Well, that is precisely what I suggested this morning. That you would have an identical system of reporting for social security purposes as tax purposes.

Would you agree to that?

Mr. ANDERSON. Yes, sir. We will agree to quarterly reporting on social security, yes, sir.

Senator DOUGLAS. And that the same form can be used?

Mr. ANDERSON. As a matter of fact, the same form is used for both purposes now, Senator.

Employers report, I think, on the same form.

Senator DOUGLAS. How would you deal with this perplexing problem that Senator Bennett brought up, where a man will report his income from tips over the quarter but he has been employed by multiple employers?

How would you assess the relative proportion of the contributions to be made by A, by B, by C, by D, by E, and so on?

Mr. ANDERSON. It would have to be on a monetary basis. A man reports his quarterly income and he has to report it in terms of dollars, and if he worked in one establishment 1 night, and earned $10, the whole reporting is based on figures representing income.

Senator DOUGLAS. But then you would ask the waiter or the bartender to report the amount received from each employer?

Mr. ANDERSON. Yes, yes.

Senator BENNETT. Instead of filing 1 quarterly report he might have to file 10 quarterly reports?

Mr. ANDERSON. No, I think he could file just one report.

Senator BENNETT. But he has got to report his income to each employer so that particular employer will withhold it.

Senator DOUGLAS. Not necessarily. The Internal Revenue could deal with the employer.

Senator BENNETT. But the alternative is to have one employer responsible for all the withholding that should have been made by other employers.

Mr. ANDERSON. No, there is a reservation in this bill which saves the employer, any employer, from any responsibility for any moneys not within his control.

Senator BENNETT. Then, in other words, a man can work for 10 employers, choose 1 of the 10 for whom he worked only 1 night, make the total report, but the man for whom he worked only 1 night is only responsible for paying his share of the 1 night's income and the other 9 employers go free.

Mr. ANDERSON. Well, if the man reports all of his employers to one employer he is violating the law, and the employer would simply—he would have a record and he would know that the man only worked for him one night.

Senator BENNETT. What about the nine other employers to whom the man does not report?

Mr. ANDERSON. If he reported only the one employer he would be covered for that amount of earnings.

Senator BENNETT. That is right.

Mr. ANDERSON. The burden is on the employee, if he wants coverage, he must report his earnings and the employer from whom he earned or in whose establishment he earned the earnings.

He must, the burden is on the employee, if he seeks social security coverage, he must file the accurate reports. If he doesn't file the reports he doesn't get the coverage.

Senator BENNETT. That is right.

So in the situation in which a man works for 10 employers he must file 10 reports with 10 employers and each of the 10 employers must file a report for him.

Senator DOUGLAS. No, if I may interject.

Mr. ANDERSON. No?

Senator BENNETT. As I see it.

Mr. ANDERSON. Senator, as a matter of fact, those 10 employers are filing reports right now because in almost every instance waiters are paid in 2 forms. They are paid with basic wages guaranteed by the employer on which he must report and on which he must pay social security tax and is now so doing, so that these 10 people already are reporting on this man.

All he does is add to it the amount of his tips.

Senator BENNETT. Let me point out that so far as the income tax is concerned each of those employers at the end of the year will send in an information return.

Mr. ANDERSON. Yes, sir.

Senator BENNETT. But it is the employee himself who has to make the statement and pay the tax.

Now, under this bill, the employer must make the statement and pay the tax.

Mr. ANDERSON. Not on income, sir.

Senator BENNETT. No, but on social security.

Mr. ANDERSON. On social security only.

Senator BENNETT. When you move out into the income field you create a completely different problem.

Mr. ANDERSON. Yes, sir.

Senator BENNETT. Let me go back again.

In the social security field the employee would have to report to 10 employers and 10 employers would each have to make a withholding or, yes, would have to pay a share of the social security tax, and make a withholding, but none of the 10 employees would be in a position to know what statement had been made to the other 9, and none of the 10 would be able to know except, unless there were a very gross and obvious involvement, whether or not he was paying more than his share of that man's total earnings for the month.

Mr. ANDERSON. Well, I repeat, if he worked for the man 1 night, and the man reports his tips he has to pay income tax on it, and the employer and the employee have to pay social security tax.

And I think because they are now reporting these, all of these people now have social security accounts, and social security is being paid into their accounts, the problem is covering into those same accounts and adding to these same reports that are now being filed the amounts attributable to tips on which the Government is now collecting income tax.

Senator DOUGLAS. I would like to suggest on the records system, without being an expert, that you do not have to have the same records system for tips that you have for wages.

You certainly could have a card for the individual employee with a designated punch as to whether or not he receives tips, and in the automatic data processing those who receive tips could be automatically classified in that particular group.

Then you have narrowed your field immediately. Certainly it would then be possible by means of employer numbers to sort out the particular employers from whom the waiter or tip employee has stated that he received tips, so that I think that you can get a system of punchcards which would more or less automatically do the sorting.

I am not an expert on the IBM machine.

Mr. ANDERSON. That, Senator, would perhaps unfairly impose on small people the requirement for the installation of data processing machines.

Senator DOUGLAS. No, I am speaking——

Mr. ANDERSON. Of the Government.

Senator DOUGLAS. I am saying that the data processing would be done either in the social security or the Internal Revenue office.

Mr. ANDERSON. This is exactly what they propose to do now.

Senator DOUGLAS. Yes.

Mr. ANDERSON. Another point brought into this discussion, Senator, is this, and I would like to mention it. The whole field of tips is changing and changing rapidly. The question of responsibility, the question of responsibility of the various people involved for reporting, has been discussed here this morning.

The employer now has the responsibility for reporting the basic wage of a waiter. He also has the responsibility for reporting so-called banquet tips. These are functions at a hotel wherein you go in and if your daughter has a wedding and you have something that costs $500 they impose a 15 percent overall charge to cover gratuities, and from this they distribute it to the banquet waiters, and these are now reported, both for income tax and for social security purposes.

There are two other forms of tipping which make up the balance of the problem.

The first is what we call tips of record, and the other is cash tips. Twenty years ago cash tips comprised almost the entire problem. But there has been more and more emphasis on so called credit cards or tips of record and, as a matter of fact, almost every large hotel or every large restaurant which does a big volume does a tremendous amount of business which involves tips of record, so that they now have in their hands accurate information on how much these waiters are receiving and they actually pay out to the waiter these amounts.

Senator GORE. Is social security tax withheld on that?

Mr. ANDERSON. No, sir, nor income tax, nothing is withheld on tips of record.

Senator DOUGLAS. The withholding, as I understand you then, applies only to the percentage gratuities that are attached to a function of some magnitude.

Mr. ANDERSON. Controlled by the hotel. That is if the banquet department sells a banquet, and caters a banquet, they bill the person, and in the bill there is an amount for gratuities, and the person contracting for the function is told not to tip the waiters.

That is part of the arrangement. But if you go on with an American Express Card and put down a $4 tip for the waiter, that is processed through the hotel and restaurant books and it is paid back to the waiter by the hotel.

But there is no withholding for social security or income tax.

Senator McCarthy. Would the Senator yield there?

Senator Gore. I have finished.

Senator McCarthy. I want to raise a question about the testimony we had this morning with reference to the practice followed by the New York Hotel Association.

As I recall the testimony was that by agreement in which the Internal Revenue department was involved, or the Social Security department, they proceed on the assumption that wages and tips total $70 a week.

I gather from what you said that the inclusion of tips of record for tax withholding purposes and for social security is not necessarily legal. What would the legal basis be for what apparently is an approved practice involving the New York Hotel Association.

Mr. Anderson. Well, the New York Hotel Association and one local of this international union have entered into a collective bargaining agreement about 3 years ago, to do this very thing, and a very substantial amount of money is now in escrow up there and efforts were made in the Internal Revenue Service to accommodate this particular situation to the existing law.

Senator McCarthy. It is not legally cleared yet?

Mr. Anderson. Yes, it has been approved by the Internal Revenue Service.

Senator McCarthy. Yes.

Mr. Anderson. But I think the basis of its approval is that section dealing with health and welfare plans generally, and there is some kind of a contract where they buy so much social security coverage.

This was not, this contract was not, negotiated by our international, and we do not believe that this is the answer.

We believe we have a responsibility not only to our members, we have a responsibility to all people in the United States who even though they may not be members of our union who have this same problem, who earn substantial livings as waiters and as people in the service industry generally.

They get ready to retire, their retirement base is on little or nothing, and this is the social security challenge with which we are all faced, our union and everybody.

Senator McCarthy. My question is more as to the legality of what they are doing, as to the legality of withholding what are not even tips of record but cash tips or estimates.

Mr. Anderson. There is no basis in law now for withholding on tips of record. They are not described as wages.

Senator McCarthy. But they are withholding on tips under this Hotel Association of New York agreement.

Mr. Anderson. No, this is a collective bargaining agreement, and they are not withholding on tips. What they did was that the employer agreed that he would assume that an employee was earning $70 a week, and he would pay social security on that basis.

Senator McCarthy. Social security on that basis.

This raises a question, too. You are not really supposed to pay more into the social security fund than your actual wages. You can't buy more social security than your wages warrant. If you have $2,000 of income, you can't buy $3,000 worth of social security.

Mr. ANDERSON. I can't give you any answer on it.

Senator MCCARTHY. I don't want to press you.

Mr. ANDERSON. The Internal Revenue Service made their judgment, and their reasoning you would have to get from them. We believe in income tax withholding on a quarter basis and if you would ask us what we would like for you to do we would like for you to put that in on the Senate side that the House took off.

Senator DOUGLAS. The Senator from Tennessee and I tried that 2 years ago and had no success. I doubt if this would be the entering wedge for that. But is it not possible to get unified administration of reporting in collection of tips both on the tax side and on the social security side?

That is the challenge which I threw out this morning to the restaurant employers.

Mr. ANDERSON. Yes, sir, I think it is.

Senator DOUGLAS. Is any representative of social security here this afternoon?

Mr. ANDERSON. I think it is a question of whether to report monthly or quarterly, Senator. It is just that——

Senator MCCARTHY. This is really a procedural question. Assume that the same waiter worked for 10 different employers over the period of 1 month. At the end of the month he would file his report with each one of these men, the amount of tips.

Each of these employers would have a record of the amount of wages which they had paid to him on which they would be obligated to pay social security, would they not?

Mr. ANDERSON. That is correct.

Senator MCCARTHY. If he filed his report under the terms of this bill, he would have to send with that report, would he not, his contribution to social security?

Mr. ANDERSON. Yes, sir.

Senator MCCARTHY. And the burden on the employer then would be to add his contribution for the amount of the tip and include that with the payment he was making to the social security fund on the basis of the wage record that he had?

Mr. ANDERSON. Yes.

Senator MCCARTHY. If he objected to the amount of the tip which was reported, what recourse would he have? If he challenged it, if he questioned it? Some fellow might say, "I will just lay all my tips on employer A and I will pretend I didn't get any from the other eight or nine."

Mr. ANDERSEN. I am not technically competent enough to know whether or not such a built-in protection device is in this bill. I suspect there is, but if there is——

Senator MCCARTHY. I suppose the obligation would be on the——

Mr. ANDERSON. If there isn't, I can say to you, sir, that we would agree wholeheartedly to a provision which would relieve any employer of any responsibility for such an unscrupulous fellow. I don't think this is going to happen very often, but if it did happen we would

have no objection to language being inserted which would protect this employer.

Senator McCarthy. Well, the obligation, of course, is on the employee to file an accurate report.

Mr. Anderson. Yes.

Senator McCarthy. To each of his employers.

Mr. Anderson. Yes.

Senator McCarthy. I suppose that employer A could say, "Well, your tips were so high we will probably have to reduce your wages."

Mr. Anderson. The wages are not very high anyway, Senator.

Senator McCarthy. This would be no threat in most cases?

Mr. Anderson. No.

Senator McCarthy. Let me ask you what percentage of increase in the base for social security reporting would you expect to take place if tips were included?

Mr. Anderson. I would think, Senator, that on the average it would triple it.

Senator McCarthy. Three times or twice again.

If you started with a hundred dollars—with $20 it would be $60.

Mr. Anderson. Yes, sir, I think it would triple.

Senator McCarthy. Three times the base.

Mr. Anderson. I think the relationships between tips and wages in the service industries is very, very wide.

Major hotels in Washington pay $30 a week guaranteed wage. Very few of them are any higher than that.

Senator McCarthy. And this is the basis on which the social security is paid?

Mr. Anderson. Yes, sir. The Gaslight Club pays nothing.

Senator McCarthy. No social security base there at all?

Mr. Anderson. They pay no salary at all.

Senator Douglas. The Gaslight Clubs.

Mr. Anderson. Playboy Clubs pay no salary. They don't need it. They make plenty. The tips are very high.

Senator Douglas. Senator Gore?

Senator Gore. I wish to congratulate you upon your appearance in behalf of many local workers who are not organized. I think I have noticed a tendency, at least I have been disturbed by what I think is a tendency, for the leaders of organized labor no longer to represent the great mass of working people, but rather to be particularized in representing what appear to be the interests of certain elements of organized labor whose income is now definitely middle class and sometimes upper middle class.

I am glad to see one labor leader still speaking out on behalf of the great mass of working people, particularly those with much less than middle-class income.

Mr. Anderson. Thank you, sir.

Senator Gore. How do you feel about medicare?

Mr. Anderson. Mr. Justice Jackson was a great Justice of the U.S. Supreme Court, and although I am not a lawyer I have always admired lawyers and when I was a high school student because all my life I had considerably more freedom than the average boy because my mother and father were deaf mutes and I signed my own report cards and I had control over my own time, and I must confess that a

large part of my time in my high school years was spent in the District Federal Court for Southern Illinois presided over by a fine old gentleman named Judge Fred Wham.

Instead of going to the movies I liked to go to court and I have always admired lawyers and occasionally I have learned something from lawyers.

When Mr. Justice Jackson told a gathering of lawyers one night that I happened to be infiltrated into that "There are usually 10 reasons why the Supreme Court ought to hold for your clients but pick your best reason and stick to that."

I am here to testify on social security on tips.

Senator DOUGLAS. You are not going to be led into any extraneous comments.

Senator GORE. I really seek information. I am offering——

Mr. ANDERSON. The labor movement generally is wholeheartedly in favor of medicare. This is a challenge, this is a problem, to quote President Kennedy, that comes into everybody's home and into everybody's life.

The answer is going to be found someday. It may be in the form of the amendment that I have heard something about, that is going to be presented either to this committee or on the floor, which provides a certain amount of options as I understand it, but the Hotel, Restaurant & Bartenders International Union joins with Mr. George Meany and the executive council of the AFL–CIO in endorsing the King-Anderson medicare bill.

Senator GORE. Thank you.

Senator DOUGLAS. Senator McCarthy?

Senator MCCARTHY. I have no questions.

Senator DOUGLAS. Does Senator Bennett wish to ask any additional questions?

Thank you very much, Mr. Anderson.

We will adjourn this afternoon until 10 o'clock tomorrow morning.

(Whereupon, at 3:50 p.m., the committee recessed, to reconvene at 10 a.m. Wednesday, August 12, 1964.)

SOCIAL SECURITY: MEDICAL CARE FOR THE AGED AMENDMENTS

WEDNESDAY, AUGUST 12, 1964

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

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

Present: Senators Byrd, Douglas, Gore, Hartke, McCarthy, Ribicoff, Williams, and Carlson.

Also present: Elizabeth B. Springer, chief clerk; and Fred Arner and Helen Livingston of the Education and Public Welfare Division, Legislative Reference Service, Library of Congress.

The CHAIRMAN. The committee will come to order.

We are very pleased today to have Senator Jacob Javits of the State of New York.

Will you proceed, sir.

STATEMENT OF HON. JACOB K. JAVITS, A U.S. SENATOR FROM THE STATE OF NEW YORK

Senator JAVITS. Mr. Chairman, I am grateful to the committee for holding a hearing. As the Chair knows, I have been active in this matter for a long time, and have always been most careful to present my views to the committee before seeking to have them considered by the Senate.

I might say, too, Mr. Chairman, that I think we are very fortunate to have as a member of the Finance Committee to consider this problem the former Secretary of Health, Education, and Welfare, Mr. Ribicoff, my longstanding friend and colleague, because I think the expertise gained in the job that he had will be very valuable to all of us, and this, Mr. Chairman, stands whether or not he agrees with me.

Mr. Chairman, I am testifying for the health care program with which Senator Anderson and I and others of our associates have been associated, and which got a very substantial vote in the Senate last time it was considered in 1962.

It may be recalled that the bill lost as an amendment to another social security bill by four votes.

Since that time, Mr. Chairman, a fine body of information upon this subject has been developed by a blue ribbon group of citizens headed by Arthur Flemming, who has already testified before this

committee, now president of the University of Oregon and himself a former Secretary of Health, Education, and Welfare, and including among its membership also another former Secretary, Marion Folsom, of my State, of Rochester, N.Y., as well as doctors, insurance company officials, and other distinguished Americans; and I believe that the report of this committee which, in my judgment, rendered an outstanding public service, should be commended to the Finance Committee in consideration of this whole subject.

I call attention to that again. I believe it is very adequately before the committee, and there is no point of putting it in the record, but it is the report of the National Committee on Health Care of the Aged which was issued in 1963 and of which copies are available and I shall be glad to make them available to every member of the committee.

Second, Mr. Chairman, I believe that a health care plan for the aging is more important than a 5-percent increase in social security benefits.

I wish to state that flatly to the committee.

I believe that the approximately $77 a year which the normal social security recipient family would get under the 5-percent increase is fine and I am all for it, but it does not begin to relate to their needs in terms of a medical care plan. I wish to associate myself with those on this committee who have expressed themselves strongly upon that subject.

Now, as a matter of practicality, I also agree that it may be just as well to give those who choose it an option to take the 5 percent or the medical care plan, but I think that is as far as I would personally go the option route, but no more, because I believe this is essential.

For myself and my own constituency, I would not hesitate to vote to supplant the 5-percent increase with the medical care plan.

I believe the rest of this committee bill is extremely important, and I hope very much to support it. It has some very fine provisions including the opening of the social security system to doctors, which I am entirely in favor of.

Also, Mr. Chairman, I hope the committee will bear with me if I refer to the fact that for many years I have been plugging, as the curbstone saying goes, for extending to age 22 the benefits of the child's insurance, the child survivor's insurance to those who attend school after they reach the age of 18.

I think this is a splendid provision in this bill.

Now, the medical care plan, Mr. Chairman, which I have laid before the Senate, together with my own associates—in view of the fact that Senator Anderson was not yet ready to join in a bipartisan effort on this very much the same plan, as he did in 1962—is incorporated as an amendment to the bill pending before the committee, amendment No. 1163, submitted on behalf of myself, Senators Case, Keating, Kuchel, Mrs. Smith, and Cooper, which has been referred to the Committee on Finance. There were some misprints and other minor corrections to be made in the amendment after its printing, Mr. Chairman, and as I shall submit it in the corrected form, I now submit to the committee as an exhibit the amendment to which I am testifying, and ask unanimous consent that it may be received and either printed or dealt with as the Chair wishes.

The CHAIRMAN. Without objection.

Senator JAVITS. I thank the Chair.

Now, in a word, the amendment which I have proposed is in two parts, and it is distinguished from the so-called administration approach by the fact that it is in two parts. The second part is the distinguishing feature of the amendment proposed by my associates and myself.

The first part provides for a hospitalization insurance program to all over 65 on a social security-financed basis, and gives a basic 45-day hospitalization and very much the same provisions which we have become accustomed to considering as part of the administration's plan.

The difference between my own plan and the administration plan is that ours has no deductible, such as the $90 deductible in the administration's plan.

Secondly, my proposal carries a flat 45 days of hospitalization, and it is viable on its own financing because we have increased the social security tax to an aggregate of 10.16 percent, which we are advised by the Actuary of the Social Security Administration, Mr. Myers, is necessary in order to carry this plan.

Now, I might say to the committee that if the committee should think favorably of including such a plan in the bill, that it is entirely possible to trim the 45 days to 40, 41, 42, or 43, or some reduction in nursing home benefits, and thereby bring the increase in the social security tax down to the magic 10 percent, which has been so much discussed, or even less. Upon the actuarial experience, the aged requirement for hospitalization can be reasonably and fairly met by a 40-day standard as well as by a 45-day standard.

But the reason I have stuck to the 45-day standard is that this is the pattern that Senator Anderson and I set, and this is the pattern which seems to be the accepted one as a normal one for hospitalization if we are to have a medical care plan at all.

Therefore, in order not to change the rules in the middle of the debate, I have kept to the 45-day proposition.

But I emphasize that the 45 days is not a magic figure and that it can be adjusted, and that by adjusting it you deal with the question of costs.

But if you take the plan exactly as we have designed it, that is Senator Anderson and I, 2 years ago, and which substantially carries over into now, it is a plan which will require an aggregate maximum tax of 10.16 percent.

It provides for 45 days of hospital care, and up to 180 days of skilled nursing home care or 240 days of home care following treatment in a hospital.

Now, it is not 100 percent like the administration approach, but it is so substantially like it that I did not wish to take the committee's time to go into the refined details which the committee can very easily ascertain from its own staff analysis.

It is the second part of the bill, Mr. Chairman, that I would especially like to call to the attention of the committee because it represents a unique factor which my associates and I have for such a long time tried to build into any medical care plan.

This part deals with the private sector, and it opens an opportunity to the private sector on a national 65-plus basis.

May I repeat that, because it is the whole key to this idea? It opens to the private sector on a national 65-plus basis, an opportunity to provide insurance for health over and above the basic Government coverage for the things which the Government does not cover, and that at a very reasonable premium.

The reason that the premium becomes reasonable is because it is applied universally, it is free of tax, and it involves an across-the-board actuarial risk which very materially cuts down its costs, including costs of promotion, costs of selling, and the other costs which are normally incident to any effort for health coverage, even nonprofit health coverage.

Now, the bill then would effectuate this by allowing the formation of federally chartered nonprofit corporation with subsidiary regional corporations in which private insurance and group service company can participate by membership in those associations as insurers of a uniform basic plan at a uniform low rate with regional variations, both in premium and in benefits, depending upon the needs of particular regions.

This would be available to anyone over 65 who wanted to buy it on a voluntary basis. The estimated cost is $2 a week per person covered and it, therefore, should be brought well within the financial reach of 80 percent of our older citizens who can afford to pay roughly a hundred dollars a year for the difference between basic Government hospital coverage and complete coverage.

It would be complete, Mr. Chairman, and the testimony of the Committee on Health Care of the Aged, which, as the committee, this committee, will see from examining—its membership, a very expert body, backs up that statement—covers expenses for physicians' and surgeons' care, diagnostic and surgical services, drugs, and appliances.

Now, Mr. Chairman, this is extremely important because all the testimony of the geriatrics experts and the doctors, and so forth, say one thing beyond anything else and that is, keep the older person ambulatory. I held an important seminar at Columbia University, College of Physicians and Surgeons, which has been made available to all my colleagues and perhaps again, Mr. Chairman, I ask unanimous consent that I may make that report available to the committee.

(The matter referred to is as 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 & Surgeons, and vice president 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 & Surgeons.
Dr. Aura E. Severinghaus, associate dean, College of Physicians & 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. Dietrick, 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 & 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 & 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 illness 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 setup 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. Dietrick, 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 business 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 shortened. 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 Met-

calf 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. Provisions 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 younger 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.

The most distinguished doctors in this field made one thing clear; keep the patient on his feet, and you save yourself enormous costs in his health care. It is for that reason that the committee should, if it does, dig into this subject and I hope it will, give the utmost considerations to the availability of a physician without any socialized medicine or implication of it, and that is avoided by the fact that Government does not have any relation with the physician.

The physician under my plan keeps his relationship as he does today with a carrier, some kind of an insurance carrier, volunteer, commercial or a cooperative, that is a trade union or a veterans' organization or whatever may be the plan in a particular area for a particular group of people.

The other point which is so critically important is this, Mr. Chairman: I think it is a legitimate fear that if you have a Government plan alone without a complementary opportunity for complete health care such as is contained in this bill or another kind—I am not married to this. I think this is the best, and these very distinguished people have authored it, and I go with them thoroughly,

but the reason for it, the fundamental reason in governments, Mr. Chairman, is this: If you have a Government plan, then you have bidding politically, and I think the conservatives have the better side of that argument. If you have a strictly Government plan it is bound to be bid up whether it is actuarially viable or not.

But if you have a private enterprise outlet or if you have a private sector outlet, then your Governor over the Government plan becomes the private sector, because a person then cannot appeal on humanitarian grounds of, "Well, he needs the care and he is not getting it."

The opportunity to get it is constantly available in this private sector complementary coverage, and to me that is the most decisive argument for a plan which is not solely a Government plan, and solely confined to certain planned minimum hospitalization opportunity.

Finally, Mr. Chairman, the Kerr-Mills bill. I think it is inherent in everything that I have said that Kerr-Mills is an essential part of the total picture, because if 80 percent of our older people can get comprehensive coverage on a public-private plan like the plan I have just outlined to the committee and with which I am sure the committee is well acquainted, then it follows that there still remains a percentage who need some other kind of help, and that would come under Kerr-Mills.

Now, at the same time that one says that, Mr. Chairman, one must say that Kerr-Mills, however, is not a cover-all of a general medical plan because it is too expensive, and is inclined to be too heavily emphasized in favor of the advanced States which are prepared to take advantage of it. Now that, it seems to me, is very clear from the figures.

My own State of New York, for example, from April 1961 to the end of fiscal 1963 received over one-third of all Federal funds spent for this program, and we have about 10 percent of the aged in our States.

Now, why? The answer is that we were ready to put up the funds which matched it, and that we were lively in terms of getting on the ball and doing the job. But the cost is very high.

The average monthly cost per patient is $300 according to the reports of the New York State Department of Social Welfare, and we are taking care of 32,000 aged in New York State at a cost of $110 million a year under Kerr-Mills.

Now, the reason, as I think the committee knows, and it is one of the big problems pointed out with Kerr-Mills, is that Kerr-Mills can be just as adequate, just as broad in the way of benefits as the State is willing to pay for it in terms of its share, and the Federal money comes in automatically to match the State, no matter what benefits the State may decide that it wishes to give.

Now, it might seen strange, Mr. Chairman, that coming from a State which is "profiting" as much as the State of New York, I am here to testify that I want another plan.

I don't think this is wise in terms of any broad general coverage. But I do that because we are talking about the aged, not about the particular financial operations of my State. My State will be financially viable whether it works this fully in this particular plan or not.

The important thing is to give the aging the health care that they need, and I believe that the Kerr-Mills way is not the way to cover the aged. I think it is the way although I think it does need some tightening up and consideration in terms of what I have just referred to, to deal with the indigent aged. I think that has now been proved but it also has been proved that it is not the plan that can deal with health care for all the aged.

It is upon that basis, Mr. Chairman, that I, to summarize, believe (1) that we owe a duty to the American people to give them a medical care bill for the aged.

I think this is a sleeper issue. I think it is one of the biggest domestic issues in the country and the minute it comes into the area of active discussion it will again flare up as the big vital issue that it is, not only for the aged but for their children. Let us never forget that.

This isn't just a program for the aged. On the argument that the social security tax is regressive and taxes the lower element in the population uneconomically, let me say that is the way the worker wants it and, Mr. Chairman, I ought to be able to speak to that with great conviction because I started out against social security because I believed it was regressive, and I think I made some pretty good arguments on that score, and practically every member of my party went with me.

But I became convinced, Mr. Chairman, that the worker wanted to pay this form of insurance; he wants it that way. For him it is dignity and self-respect and assurance for his later years which he values very highly, and as he wants it that way, I felt that we might just as well consolidate the forces that were for it instead of keeping them separated.

So, it is on that basis, Mr. Chairman, that I offer to the committee, one, the proposition that we should have a medical care plan; two, that it ought to be in this bill; three, that it is superior in importance to the 5-percent increase in social security benefits; four, that the aged ought to have the opportunity, for a comprehensive plan, not just a hospitalization plan; five, that the public-private plan is the best for that purpose; and, six, that Kerr-Mills will not do the job, but is a necessary element in the totality of what we do.

Thank you.

(The prepared statement referred to follows:)

STATEMENT OF SENATOR JACOB K. JAVITS, REPUBLICAN, OF NEW YORK

The problems confronting our older citizens call for the kind of comprehensive response incorporated in H.R. 11865. I am especially pleased to note that it extends payment of child's insurance benefits until the child reaches age 22 if he is attending school or college as a full-time student after he reached 18. This is a measure which I have proposed as legislation (S. 1770) and supported for many years in the Congress as a vitally necessary assistance for the education of our youth.

But we must be prepared to cope with new health problems as well as social problems created by the increase in our overall population of the number and percentage of men and women over 65 years of age; and in this respect H.R. 11865 makes no provision. Accordingly I propose as an amendment to this bill a dual public-private program of health care for the aging.

Health care for the aging is a sleeper issue in this country, but it is there and it is a vital issue. The need exists, government can help to solve it and feasible and practical government-private action is available. This pending social security bill is a proper vehicle for a medical care for the aging amend-

ment and such alternative amendment will be submitted. I predict the issue of medical care for the aging will become one of the most urgent in this election year.

Scientific advances in medicine and health care are helping us to live longer, and it has been estimated that by 1970, the number of Americans over 65 will total over 20 million. Of these, an even greater percentage than ever will be in the 80- to 90-year bracket. At the same time they will require much more hospital and medical care than younger persons. Yet, according to studies of the Department of Health, Education, and Welfare, on the basis of income they will be far less able to meet the costs of hospital and health care, which are continuing to rise.

According to Bureau of Census statistics the per capita income of 80 percent of all retired persons is $2,000 a year or less. This is not enough to enable them to meet the costs of adequate health care or to carry adequate insurance to cover these costs. The Senate Subcommittee on Health of the Elderly reported last month after extensive hearings that only 9 million of the 18 million who are 65 and over had any kind of health insurance and that only 1 in 4 of this 9 million held hospital insurance that could be defined as adequate under the definition established by the American Hospital Association. This definition calls for a policy whose benefits pay at least 75 percent of hospital costs.

The subcommittee further reported that the remaining 9 million without hospital insurance are the ones who need protection the most; namely, "predominantly the very old, those in poor health, the unemployed, and those with the lowest incomes."

In the last decade the consumers' price index has been estimated to have gone up by 12 percent, but medical costs rose by 36 percent and hospital costs by 65 percent. Group insurance premiums have also risen drastically in the 4 years between 1960 and 1964, in some States rising as high as 83 percent for the group over 65.

This is why I deeply believe we cannot ignore the problem of health care for the aging, a problem which my amendment can help substantially in solving.

Experience in New York State demonstrates conclusively that the Kerr-Mills MAA program is necessary but that it cannot effectively help the majority of older citizens who need health care. It is also a very expensive program. New York was one of the first States to implement this program, and from April 1961 to the end of fiscal 1963, New York received 35.2 percent of all Federal funds spent for this program. New York with only 10.2 percent of all Americans 65 years of age and over received more than one-third of the Federal funds.

The actual figures are even more startling on the high cost of MAA. In 1963 a monthly average of 32,000 aged in New York State were cared for at a cost of $110 million. This year an estimated $125 million will be spent on the program in the State. MAA is the costliest of the six public assistance programs in the State, and the average monthly cost per person is approximately $300, according to the New York State Department of Social Welfare.

With our older citizens being priced out of the health care market by high medical costs and very high private insurance costs, the inescapable conclusion is that only a mass approach on a nationwide scale, such as my amendment proposes, can achieve broad pooling of risks, complete availability, and costs low enough to be feasible.

The report issued by the National Committee on Health Care for the Aged, which was organized at my suggestion over a year ago, offers a new approach to a solution of the problem. My amendment incorporates the committee's recommendations, and establishes a dual Government-private health insurance program for all persons 65 years of age and over.

Using the social security approach, my amendment provides 45 days of hospital care and up to 180 days of skilled nursing home care, or 240 days of home care if it follows treatment in a hospital. In a limited number of instances, patients may be able to enter directly into a hospital-affiliated nursing home upon review and determination in advance by qualified hospital medical staff members. This provision could lead to some reduction in the costs of the hospital program. Ideally, all nursing homes under this program should be hospital affiliated, but due to their limited number, authorization has been

written into the legislation to give the Secretary of Health, Education, and Welfare discretionary authority in qualifying nursing homes for the program, if they do not have affiliation but meet other acceptable standards.

To administer the public hospital plan in the States, provision has been made for the services of voluntary organizations, and the Secretary is authorized to invite proposals from health organizations for consideration. Federal administrations will be undertaken only if State or voluntary agency proposals are not satisfactory. The entire thrust of this part of the program is to limit the Federal Government share to basic hospital and nursing home care.

The second part of the bill dealing with the private sector is intended also as a built-in governor to make any future expansion of the Federal program unnecessary. Under the dual public-private program provided for in this legislation, there would be a complementary national private health insurance program which would concentrate on covering expenses for physicians' and surgeons' care, diagnostic and surgical services, and drugs and appliances. With this coverage the older citizens would then have a well-rounded package of basic health protection.

The legislation calls for a nationwide federally chartered nonprofit corporation with subsidiary regional corporations in which private insurance and group service companies can participate in a concerted effort to overcome the obstacles that bar a satisfactory solution to the problem. The private insurers would develop a plan providing uniform basic coverage at a uniform low rate, but with regional variations. This standard insurance policy would be available to everyone over 65 who wanted to buy it on a voluntary basis. The estimated cost is about $2 a week per person covered, and should therefore, bring it within the financial reach of 80 percent of our aging citizens.

To make this nationwide complementary insurance possible, under conditions that would permit pooling of losses made necessary by accepting all applicants without selection, and removal of legal and other obstacles to very low cost insurance, the bill provides for exemption for participating companies from the provisions of the Sherman Anti-Trust Act, for exemption from all taxes on premiums for the approved plan, and for a symbol signifying official public endorsement of the basic complementary insurance plan.

This standard plan would in effect provide a discount to older citizens to encourage them to obtain supplementary protection under private insurance at rates which would be the lowest possible. Together with the hospital care insurance in the public sector, protection for the largest portion of the total health care bill of the older citizen will be accounted for.

This amendment is offered as an option to the 5-percent increase in insurance benefit payments in order to keep the total employee-employer tax to no more than 10.16 percent, or one-half of 1 percent more than H.R. 11865 calls for. There are those who feel that there is some magic in holding the total employee-employer tax rate to 10 percent. The costs in my amendment can be held to that figure if we modify the benefits by providing a 2-day deductible on the 45-day hospital benefit, and by reducing the nursing home benefits from 180 to 90 days with a reduction to 120 days in the home care benefit. I have been assured that with these modifications the tax rate can be brought within the 10-percent limit on the $5,400 base.

The potentialities of this public-private program for solving an increasingly difficult and costly problem go far beyond any existing practice developed to meet a social need. It comes closest to meeting the requirements of health care experts as well as of legislators in both parties and it does it at a cost which is relatively modest in view of the magnitude of the problem. My amendment avoids the dangers of socialized medicine by limiting the role of the Federal Government, preserves the traditional doctor-patient relationship, and provides for the participation of the private sector of our economy which has built up a tremendous and deserved interest in this field over the years.

The CHAIRMAN. Thank you very much, Senator Javits.

We are always glad to have you, sir, before the committee.

Any questions?

Senator DOUGLAS. I want to commend the Senator from New York for a very constructive proposal. I am going to defer my questioning to the Senator from Connecticut who is most expert in this field.

I do think it is both unusual and praiseworthy for a Senator from a State to say that he thinks his State is getting a larger proportionate share from a program, which is somewhat unheard of in the U.S. Senate, and I want to especially praise the Senator for that.

Would there be any supervision over the rates charged for this private insuarnce corporation which you propose for non-hospital non-nursing-home, non-home-care service?

Senator JAVITS. Completely. It is completely subject to the Secretary of Health, Education, and Welfare.

Senator DOUGLAS. Would you replace the present State control over Blue Cross charges with Federal control?

Senator JAVITS. I would not. This is confined to this particular policy. The policy which I referred to would be a policy for those over 65 on a nonselective basis which would be universally available, and what makes it universally available is the cooperation of the carriers, all the carriers who wish to participate.

Senator DOUGLAS. Who would exercise supervision over rates?

Senator JAVITS. The Secretary of Health, Education, and Welfare. But I wish to point out to my colleague that he would exercise supervision only in this particular field.

Senator DOUGLAS. I understand.

Senator JAVITS. For this particular policy. And that would include Blue Cross or anyone who participated in this plan.

Senator DOUGLAS. The Blue Cross rates are presently supervised in general by the States.

Senator JAVITS. Exactly so. But they are supervised across the board. All this would do would be to carve out this particular policy. It would not change their supervisory status as to all their operations.

Senator DOUGLAS. Are Blue Shield rates controlled by the State?

Senator JAVITS. Yes, they are.

Senator DOUGLAS. That is all, Mr. Chairman.

The CHAIRMAN. Any further questions?

Senator CARLSON. Mr. Chairman, I just wish to commend our distinguished colleague from New York for what I would say is one of the finest and best statements that we have had on the entire health care program before our committee, at this hearing at least, and it does raise some thoughts as to future programs. I was interested in your suggestion that this program might well be in operation complementary with the Kerr-Mills bill, which, in your opinion, does then have a field even if this program or a similar-type program was approved.

Senator JAVITS. Very definitely.

Senator CARLSON. I noticed, too, that you mentioned that you could come within the 10 percent, which seems to be a figure that is being used around here when it comes to costs, by reducing the number of days from 45 down to 40, 41—2, or 3.

Senator JAVITS. That is right.

Senator CARLSON. Then the other suggestion, if we did not follow that one, would be, of course, to raise the base pay that could be used for the tax rates.

Senator JAVITS. Exactly. It could be raised to—the average figure, I think now, I think they are pretty right about this, Senator Carlson, the average figure, and I am drawing on my recollection and I think it is correct, of earnings per factory worker which is the norm for judging the standard of living and other problems in our country, I think today is about this $5,400 figure so it is true that the $4,800 figure is archaic.

Now, the point is that you are deferring the operation, even of the maximum figure here, for a few years, and I think it would be worthy of the committee's inquiry to see whether on quite reasonable and honorable projections it is a fact that the $5,400 figure may, when you reach the maximum social security tax, will also be out of date and perhaps a figure of $5,600, $5,800, even $6,000 might then be the norm of factory workers' income.

In short, we have a tendency to have the maximum compensation to which the tax is applicable lag behind the figures. We had that in the $4,800. We may very well have that in the $5,400, and, I think, the Senator's suggestion on that ground would be very well worth exploring and looking at.

Senator CARLSON. I want to say that the distinguished Senator from New York has called our committee's attention to some problems I think we are going to have to meet, the problem so far as this one member of the committee is concerned is one of time.

Here we are with less than 10 days, I hope, of legislative session for this Congress, and this is a great field. As the Senator from New York has stressed this morning there are many facets of it that ought to be explored and I am sure those of us who are really interested in health care programs would need more time than just to report out a bill without some real serious deliberation in executive session as well as additional hearings.

And looking at it from a legislative standpoint I frankly do not see how we can, in my opinion, add a health care program to the present social security bill without more time.

But that is my personal feeling on this matter.

Senator JAVITS. Mr. Chairman, I would say to Senator Carlson, of course, we aren't sure that we are not going to get more time. We may very well be recalled here.

Senator CARLSON. That is right.

Senator JAVITS. And we may have a repetition of that great drama of 1960 when our beloved and departed colleague, Senator Kennedy, came back here to fight exactly this battle, and it may happen again.

I might say finally, Mr. Chairman, I hope the Chair will forgive me for saying this, that I would hope that if the committee can do something now, I certainly urge it very strongly and that is why I am here. I would hope that sooner or later this committee—and that is not impossible, the Chair, whether he agrees with me or not in this matter, is a man of tremendous position in the Nation and very, very highly regarded and has a sense of being a national instrument often even though he may not agree, I know that to be characteristic of Senator Byrd.

Under the auspices of the committee or under the auspices of the President of the United States, sooner or later the great insurance industry of the United States must be called together, and must be told this is their baby.

They have got to come up with an answer to the 65-and-over health care problem. It is going to bedevil them and they are going to get something they may not like but they are the people who ought to really solve it, and in all honesty my approach is an effort to crystallize what should be accepted as their responsibility.

The CHAIRMAN. Thank you very much.

Senator JAVITS. Thank you.

Senator CARLSON. Mr. Chairman, I notice the Senator from Connecticut left. I assume he did want to ask some questions. I am sorry I took the time but if he wants to come back——

Senator JAVITS. I can come back.

Senator CARLSON. Thank you.

(At the request of the chairman, the following is made a part of the record:)

U.S. SENATE,
COMMITTEE ON LABOR AND PUBLIC WELFARE,
August 4, 1964.

HON. HARRY FLOOD BYRD,
Chairman, Committee on Finance,
U.S. Senate, Washington, D.C.

DEAR MR. CHAIRMAN: I am writing to you in behalf of S. 1262 and S. 1208 introduced in the first session of this Congress and now pending before the Finance Committee.

As both bills provide for disability benefits under title II of the Social Security Act for any individual who is blind, I respectfully request that they be given consideration by the committee at the same time consideration is given to the House-passed social security amendments bill, H.R. 11865.

With best wishes.

Sincerely,

JACOB K. JAVITS, *U.S. Senator.*

The CHAIRMAN. The next witness is Mr. Walter McNerney of the Blue Cross Association.

Mr. McNerney, take a seat, sir, and proceed.

STATEMENT OF WALTER J. McNERNEY, PRESIDENT, BLUE CROSS ASSOCIATION; ACCOMPANIED BY BERT TOLLEFSON, WASHINGTON REPRESENTATIVE

Mr. MCNERNEY. Thank you, Mr. Chairman.

My name is Walter McNerney. I am president of the Blue Cross Association, the National Association of Blue Cross Service Plans. I appear here today as a representative of these plans which collectively provide hospital benefits to 59 million persons in the United States, including over 5.3 million aged citizens.

Next to me is Mr. Tollefson, who is the Washington representative of the Blue Cross Association.

With your permission, sir, I would like to submit this written testimony for the record and excerpt from it now some of the principal remarks that are contained in it for the sake of time.

The CHAIRMAN. That will be done, sir.

Mr. MCNERNEY. Thank you.

I would like to start by laying down a few perfatory comments regarding the issues at hand.

We, like all conscientious citizens, feel that everybody in the community, the aged included, should have ready access to health care as it is needed.

We feel the benefits that are provided the aged as well as other citizens should be structured on a sound, medical, public-health basis.

We feel any Government program that is designed to help should be flexible so that it can stimulate the voluntary sector and accommodate to changes in the medical sciences and medical organization.

We feel the proposition that elderly people require more health care than is presently available is true, and that the Federal Government should seek a framework within which all disadvantaged persons including the aged might receive help.

We believe this is going to be an expensive job that is going to require all available resources in the country.

We have learned through experience that administering health benefits is an increasingly complex job. By making it possible for more of our senior citizens to purchase coverage through the voluntary system of which we are made a part the Government would at once avoid duplication of scarce skills and machinery and importantly strengthen the ability of that machinery to serve all age groups.

We recognize that the provision of purchasing power for various segments of the population and the servicing of benefits are two quite different matters.

Whereas Government assistance is needed and is already being provided to help accomplish the first, there is no reason to extend Government action in the second area because of the adequacy of today's widespread voluntary institutions.

Now, I would like to comment on some major issues that are applicable to current and prospective proposals for financing health care of the aged, rather than dealing with any specific ones.

In my written statement, which I have submitted to you for the record, there is a description of the background of Blue Cross. I think most of you are familiar with it.

Let me say, as a high point, that this is a group of institutions that over the last 30 years in this country have paid more for hospital benefits than all other private carriers combined and now exceeds a rate of over $2 billion annually.

Blue Cross was designed and it exists to serve not just the economically fortunate, not just good risks but the total community, and as evidence in part of not only our intention but our performance, I should like to submit the fact that about 9.1 percent of our subscribers are over 65 which is coincidentally about the same percentage of the aged to the total population.

The Blue Cross plans historically have not conceled contracts. They have encouraged people to stay in Blue Cross, either as a member of the retired group, as a person converting from a group to an individual status. They have had open enrollments, they have had special senior citizens' campaigns, and through these devices, without cancellation, without any threat of it, we have now accommodated over 5.3 million of our senior citizens.

With this as background, I would like to address myself briefly to the question of what are the problems of the aged in financing health care.

In conjunction with the American Hospital Association we studied the problem, I think in fairly great depth in 1962, and I would be glad to provide copies of this study to the committee.

In that monograph we came to the conclusion that some of the aged are not able to provide for themselves all the medical care they needed. Although the gap is closing, there are still those who need further help.

The causative factors we believe are sometimes complex but the net result is that a segment of the aged population does not have enough purchasing power to protect itself against heavy medical costs.

The basic problem of the aged is not unavailability of programs providing protection against the cost of health care. On the contrary, Blue Cross and other segments of the voluntary system can and do provide many of the aged with adequate protection. The problem is that some of the aged with limited income cannot avail themselves of this protection.

Unfortunately, I feel, definitive information is lacking on may aspects of the status of the aged, and this has inevitably led to some speculation supporting various points of view.

For example, the true extent of multiple health coverage of the aged is not known. Standards for evaluating the economic needs of aged individuals, or families headed by aged individuals or aged persons living as a part of the family have not been widely accepted nor would one set of standards apply throughout the country.

Is, for example, $1,200 too much or is it too little? Many of our data are presented as averages where as the true problem may lie in distribution. There are, for example, proportionately greater disparities among the aged than among the remaining population.

Remember also in scrutinizing the aged as a population segment we are not dealing with a fixed, cohesive, constant element. This portion of our people is in constant fluctuation.

Daily it grows larger although at a decelerated rate; its economic characteristics change, even its geographical distribution among the States is unstable.

There seems to be a need appearing to cluster, on the basis of what studies we do have, around segments of the population that are disadvantaged as to other necessities of life such as adequate food, shelter, and clothing rather than any single age group of the total population.

Our conclusions must be drawn to some extent on broad economic comparisons of the aged relative to younger groups or varying personal experiences or on empirical observations.

Can the voluntary system solve all of the problems?

The voluntary system, we feel, cannot solve all of the problems. One possibility in the hospital field would be for the hospitals to accept aged patients at a discount. The fact is now that there are regular payrolls to meet in hospitals. One cannot rely extensively on volunteer help, and there is, therefore, no cushion against which to absorb discounts for any segment of the population. Furthermore, the public is becoming vocal about the costs that it must now pay.

Philanthropy is a possibility but this is limited for it always has been in terms of a percentage of total operating costs. With the rate of hospital cost growth, it is going to be fortunate if philanthropy can keep up with its capital contributions and its contributions to education and research, let alone attempt to take on the problem such as the aged.

It is possible to conceive of the voluntary carriers such as Blue Cross subsidizing the aged through broad risk sharing.

Blue Cross pioneered in this concept through the design of a community rate where most people in the community in very broad categories paid the same rate regardless of their experience.

Recently Blue Cross has had to modify its community rating techniques in a competitive environment. This has not resulted in a diminution or a vast cutback in the subsidy of the aged, but it does put a limit on the extent to which we can go. Even with Blue Cross extending from our better risks to our poorer risks some subsidy, there will remain a number of aged who cannot enroll in the first place or maintain very large payments.

We come down to the essential problem of how to derive money from one part of the population to assist another, and the only other substantial way of doing this is through taxation.

It is worth repeating that the fundamental problem is lack of sufficient purchasing power, and the inability of the voluntary system to produce a financial subsidy sufficient to meet all aged adequately is often irrelevantly generalized to imply a universal weakness in the system including its capacity to provide top-quality care and adequate benefits.

These benefits are there. The challenge of government is to bring them within the grasp of those who cannot afford them.

I would like now to touch upon a few public policy issues, based on our experience in the market. We think that the Congress in addressing itself to this problem should keep in mind that whatever step is taken beyond the basis of a sound medical public health program, it would be unfortunate to divorce quality of care from quantity. In this regard, as for all age groups a balance must be struck between ultimate need and conflicting demands from other segments of our economy.

Several methods, we believe, are available to conserve government resources without jeopardizing the vast amount of purchasing power that now is stimulated from the private sector. In fact, proper government design might very well stimulate further private purchasing power.

For instance, there is widespread support within the voluntary system for the adoption of a requirement which would result in government assistance being related on a sliding scale to the income or spendable assets of the aged.

Those below a certain level might receive full government support, those in the next higher bracket less, and so forth. This simple device has several advantages and is worthy of your serious consideration.

The fact is that while many of the aged are destitute and ill, most are neither, and the latter do not regard themselves as needing help. This is attested to by the millions of senior citizens who are self-sufficient and have prepaid protection against health hazards.

The hard core seems to involve the very old, particularly women who are chronically in poor health and who are no longer engaged in or have the prospect of employment to supplement their meager income.

By relating the degree of assistance to an uncomplicated determination of the adequacy of each aged person's income, not to include the assets of children or relatives, the thrust of the Government's pro-

gram, of its subsidies, could be at the point of greatest need. This would allow a broader and more comprehensive range of benefits to be covered with a given amount of money, while preserving maximum effectiveness of purchasing power in the private sector and reducing pressure on the doctor to use the most highly expensive inpatient hospital services.

A determination of eligibility based on income need be no greater invasion of privacy than personal income tax filing.

The difficulty of a program providing the same benefits for all in a category, such as for the aged, is that it can expand only, it cannot contract.

It has been calculated that an adequate benefit for the aged consisting of 120 inpatient hospital days, outpatient hospital services, skilled nursing home, and home care on a two-for-one hospital substitute basis, medicine and surgery in hospital, as well as partial protection for home and office care and prescribed drugs, would cost about $250 a person per year even at today's costs.

The total annual cost for 17 million aged would be approximately $4.5 billion. Such a program of benefits, however modest at its inception, would grow in this direction on a current-cost basis and would put a heavy burden on payrolls without regard to growing income and other needs of retirees.

On the contrary, a program of benefits based on some reference to economic status of the aged can expand or contract as the status of the aged changes. Its cost, although large, can, in reflection of the economic well-being of the country and the performance of the voluntary system, stop appreciably short of the above-cited current cost and, once established with enthusiastic Federal support, can act as a stimulus for many sources of money (Federal, State, employer-employee pension programs, direct purchases of voluntary insurance, and philanthropy) all of which will be needed to do a sound and progressive job. There should be no illusion about the cost or the need for cooperative effort being less.

Another way for the Government to consider conserving its resources would be to state the benefits of any programs with which it had connection in only general terms.

So, that it could reflect without changing the law, changes in the medical sciences, and at from time to time include expanding into areas such as rehabilitation without a major occurrence of legislation.

Also, we feel that eligibility might be related to retirement rather than to age alone.

Finally, I would say under main issues that the design and administration of health benefits involving such functions as ratemaking, underwriting, financial audits, development and evaluation of new benefits, claims processing, professional relations, and implementation of controls over utilization is a complex task requiring experienced personnel and seasoned skills. Duplication of the skills and machinery currently available should be avoided by the Government as a matter of policy. This infers that fullest use should be made of the resources of the voluntary system, not only for the sake of effectiveness and economy but also to avoid heightening the manpower problem in regard to skills already in short supply.

Currently, for example, Blue Cross is administering benefits for needy citizens in eight States and involved in planning in several others. Programs include OAA and MAA and to a lesser extent GPA, aid to dependent children, aid to disabled, and aid to needy blind.

Finally, I would like to dwell a bit more on the costs of health benefits because I think this is an important topic.

As has been stated, health benefits for the aged covering major segments of all elements of the health dollar excepting dental services would cost approximately $250 per person per year or approximately $21 a month, excluding administrative overhead.

Similarly, it would cost approximately $4.50 a month to qualify for 5 days of inpatient hospital care and approximately $9.50 and $10.50 to qualify for 30 days and 120 days, respectively, without any reference to diagnostic, nursing home, medical and surgical, office, and other allied services.

In talking of meeting the needs of the aged, the Government should face squarely these facts and keep in mind that the costs cannot be depressed significantly without jeopardy to quality of care.

Some of the literature describing the performance of the voluntary system leaves the beguiling impression that if someone else were to do the job it would cost appreciably less. There is room for further measure and modification of utilization, a great deal of energy is being devoted to this, but we should not pretend that somehow or another the costs will turn sharply downward.

Hospital and medical care is expensive here and abroad—so expensive that its cost must be weighed carefully against other population needs. Many State and local governments currently paying considerably less than hospital costs can testify eloquently to the problem involved.

Now, a recent social security bulletin citing data drawn from a nationwide sample, showed that 11 percent of aged couples and 7 percent of aged individuals had medical bills in excess of $1,000 in 1962.

On the other hand, 25 percent of the couples and 50 percent of the individuals surveyed had medical bills of less than $100; 1 in 4 were hospitalized among aged couples; and 1 in 7 among aged individuals.

When a hospital stay was involved one-half of the couples and two-fifths of the individuals had medical costs exceeding $1,000.

It is important to note that among those who were hospitalized there was a considerable amount of money spent on the episode of illness for nonhospital expenses, both for couples and for individuals.

For other than hospital expenses $632, and $295 for other than hospital expenses for the couples and individuals, respectively. These figures, incidentally, would be higher if the value of free services received by the aged for doctors and institutions were added.

These and other data show that medical costs fall unevenly among the aged, as they do for all age groups of the population. Some experience few, others incur considerable costs. Also, it can be seen that whereas the hospital is a major cost element, hospitalization is apt to occasion a significant number of other medical expenses, doctors, drugs, nursing home, and so forth, all of which also require payment and good medical practice indicates that these be available, also, on a sharedrisk basis.

Essential choices are to be made as follows: To what extent to increase purchasing power of the aged through cash or health benefits and whether to buy all aged a narrow range of benefits or some a broad range of benefits.

The amount devoted to health benefits is necessarily in conflict with the amounts paid in cash benefits. The economic fact of life is that anything like current Federal Government planning a full set of benefits cannot be written for the particularly disadvantaged and for all other aged as well.

In conclusion, I would like to say that Blue Cross shares the Government concern with the well-being of the aged and other citizens. Based on our studies we believe some are in a disadvantaged position, and require Government help in financing their personal health services.

We feel the core of the problem from a public policy point of view is that some of the aged lack purchasing power.

The essential job for Government is to put this purchasing power in their hands.

The essential decision is how. In this statement we have outlined some criteria and identified some public policy issues which we hope that the Congress might find useful in evaluating any bill.

In each instance we try to keep in mind the impact that any move would have on the growth and orderly continuation of the voluntary system, and care rendered the total population of which the aged are only a part.

The present system has worked well. I think that the aged should be a cause to strengthen it. They should not be isolated from the community as objects of charity either in administering benefits or the identification card they carry.

I hope these observations have been helpful and I certainly would be glad to answer any questions.

(The prepared statement of Mr. McNearney follows:)

FINANCING HEALTH CARE OF THE AGED

A statement by Walter J. McNearney, President, Blue Cross Association

My name is Walter J. McNearney. I am president of the Blue Cross Association, the national organization of Blue Cross hospital service plans. I appear here today as a representative of these plans, which collectively provide hospital benefits to 59 million persons in the United States, including over 5.3 millions 65 years of age or older.[1]

The following premises, based on extensive Blue Cross experience in financing health care, are prefatory to my comments on the issues at hand.

Like all conscientious citizens, we feel that everyone in the community should have ready access to health care as needed.

We believe that prepaid health benefits for the citizenry should be based on a sound medical-public health program, structured to encourage effective use of health facilities and services.

We believe that any Government program should be flexible. It should reflect, even stimulate, changing patterns of medical science and organization. It should recognize the widely varied levels of services and skills now available and should aim at promoting even higher standards.

[1] There were 5.3 million aged citizens enrolled in Blue Cross as of Jan. 1, 1963, according to a special poll of plans. A comprehensive poll has not been repeated since, but additional reports as of April 1964 confirm that at least an additional 300,000 enrollees have been added.

We support the proposition that there are elderly persons requiring more assistance in obtaining health care than is presently available, and that the Federal Government should seek a framework within which all disadvantaged persons, including the aged, might receive help.

The cost of adequate care for the aged is such that we believe a marshaling of all available resources is needed to do the job.

We have learned that the process of administering health benefits is increasingly complex. By making it possible for more of our senior citizens to purchase coverage through the voluntary system, the Government would at once avoid duplication of scarce skills and machinery, and would importantly strengthen the ability of that system to service all age groups effectively.

We recognize that the provision of purchasing power for various segments of the population and the servicing of benefits are two quite different matters. Whereas Government assistance is needed, and much is already being provided, to help accomplish the first, there is no reason to extend Government action in the second area because of the adequacy of today's widespread voluntary institutions.

Now I should like to comment on major issues applicable to current and prospective proposals for financing health care of the aged, rather than dealing with any specifically.

BACKGROUND

The interest of Blue Cross in the aged and other disadvantaged segments of the population is a matter of record.

Over the past 30 years Blue Cross has grown from a few isolated prepayment ventures into a national network of plans. In these three decades it has provided more hospital benefits than all other private carriers combined, at a rate which now exceeds $2 billion annually. Always, Blue Cross has striven to serve the total community—not just the economically fortunate, not just those who are "good risks." As evidence of this close identification with the total community, note that the percentage of Blue Cross membership which has achieved senior citizen status is practically the same as the percentage of all senior citizens to the total population of the United States, 9.1 percent.

Because any proposal to extend the public sector's participation in the financing of personal health services raises questions as to how well the voluntary system has performed, we should take a look briefly at the current situation. In focusing on the prepayment field, I shall leave to others the presentation of the impressive record written in the past and continued into the present by the health professions, the voluntary hospitals, and the many related facilities. The singular success the American people have achieved in making high quality medical care widely available is attributable to a unique American phenomenon: the interaction of private incentive, responsible community enterprise, and governmental support, all concentrated on the solution of specific problems.

The record of the voluntary system as a whole in the United States in bringing health coverage to the public is extraordinary in relation to other countries. Voluntary carriers reach every community in the United States. Between 1940 and 1963, the number covered by some form of hospital benefits has grown from approximately 12 million to approximately 140 million persons. The growth had been from 9 percent to about 75 percent of the total population. In 1962, dollar volume of prepaid and insured hospital benefits was more than 1,000 percent greater than it had been two decades earlier, an increase due to the offering of broader benefits and to rising hospital costs as well as increased enrollment.

How well has the voluntary system provided adequate coverage to the public? I cannot speak responsibly for all carriers, but I can offer a few observations about the 76 Blue Cross plans of the United States. These plans are locally incorporated community-based nonprofit organizations dedicated to making health services available to all through the operations of the individual plan or through the associated action of several Blue Cross plans. They were started with the blessing of State legislators who faced problems such as those being considered today and who introduced special enabling legislation supporting Blue Cross' desire to make hospital care available to all segments of the community.

Blue Cross plans responded to the stimulus of this support. Blue Cross members, once enrolled, are encouraged to continue their membership despite advanced age or deteriorating physical condition. They may convert to a direct-pay basis when leaving a group and may maintain that status throughout their lives.

Open enrollment seasons are held periodically, during which individual members of the community, including the aged, may join. In addition, Blue Cross staffs have worked closely with labor and management and local and Federal Government in the development of programs which include retirees in the basic employed group. This increasing acceptance of private responsibility for helping to meet the costs of health care for retired persons in this manner is, we believe, noteworthy. It should be added that approximately 42 percent of Blue Cross aged enrollees are group enrollees.

Blue Cross plans, with more than 20,000 full-time personnel, cover every community in the country. Plan staffs include professionals skilled in the complexities of hospital operation, reimbursement, claims administration, and the design of contracts suited to the benefit needs of the community. They work harmoniously with local leaders and with community agencies, and are active in many vital local projects, such as regional hospital planning groups, to forestall the erection of unneeded buildings and to stimulate the building of new ones where they are truly required, as well as to promote the coordination of community health services. Blue Cross plans urge the formation of hospital and medical society utilization review committees, as safeguards against unnecessary hospitalization and longer hospital stays than are actually essential, audits of hospital costs, support of programs under which health facilities are held to high-quality standards through a system of accreditation, and meaningful experimentation with such growing community services as coordinated home care and other aspects of progressive patient care. All of these efforts have had the support of, or are the result of, direct contributions from organized labor and management as well as subscribers in local and Federal Government. Their leadership has been a strong factor, along with the stimulation of State regulatory bodies, in Blue Cross growth and progress.

This sensitivity to local conditions is important in the administration of a health benefit program, since the blend of facilities, manpower, and medical practice varies considerably among sections of the country, and even within States. Lively responsiveness to neighborhood economics and local social conditions as well as to broad national concerns is a significant aspect of Blue Cross' interest in the health problem and care of the aged.

WHAT ARE THE PROBLEMS OF THE AGED IN FINANCING HEALTH CARE?

The Blue Cross plans, drawing upon their own experience and seeking counsel from other sources as well, studied in depth the health financing problems of the aged. The results of the study, done in conjunction with the American Hospital Association, were published in a monograph entitled "Financing Health Care of the Aged" in 1962. For the reasons set out in that monograph we came to the conclusion that some of the aged are not able to provide for themselves all of the medical care they need. The causative factors are many and sometimes complex, but the net result is that a segment of the aged population does not have enough purchasing power to protect itself against heavy medical costs.

I want to make the point now that the problem of the aged is not the unavailability of programs providing protection against the cost of health care. On the contrary, Blue Cross and other segments of the voluntary system can and do provide many of the aged with adequate protection. The problem is that some of the aged, with limited income, cannot avail themselves of this protection.

It is pertinent to note that in 1961, 28 percent of the $5.35 billion spent for medical care of the aged came from public sources while 72 percent came from private sources. These figures do not encompass the private charitable contribution to care which is made through many community hospitals and by the healing professions. Proposals to strengthen the Kerr-Mills Act and newly proposed legislation should be evaluated with full cognizance of the fact that the aged are only a relatively small, albeit important, percentage of our total population, and that a majority of them have found substantial health security through private initiative and the voluntary system.

Unfortunately, definitive information is lacking on many aspects of the status of the aged. This has led inevitably to speculation to support of various points of view. For example, the true extent of multiple health coverage among the aged is not known. Standards for evaluating the economic needs of aged individuals, families headed by aged persons, or aged persons living as part of a family have not been widely accepted, nor would one set of standards apply throughout the country. Many of our data are presented as averages, whereas the true problem may lie in distribution. There are, for example, proportionately

greater disparities of income among the aged than among the remaining population.

Remember, too, that in scrutinizing the aged as a population segment, we are not dealing with a fixed, cohesive, constant element. This portion of our people is in constant flux. Daily it grows larger, although at a decelerated rate; its economic characteristics change; even its geographic distribution is unstable.

We see references indicating that spending units with aged heads tend to have less medical debt than younger aged units. Hospital administrators generally do not complain of a disproportionate problem with the aged with regard to bad debts. There is little hard evidence, one way or the other, as to a significant unmet need for hospital care in any age group within the population, let alone the aged. These needs appear to cluster around segments of the population that are disadvantaged as to other necessities of life, such as adequate food, shelter, and clothing, rather than around any single age group of the total population. Our conclusions must be drawn to some extent on broad economic comparisons of the aged relative to younger age groups (for example, the percentage with prepayment or insurance, the relative percentage who own their homes, etc.), on varying personal experiences, and on empirical observation—all within a rapidly changing cross section of aged problems.

Many of us who have attempted to focus on the financing capabilities of the aged are persuaded that their unique status calls for public action in the sphere of personal health care. We should not pretend, however, that our information is precise enough to produce consensus on all key points. Any suggestion, on the other hand, that basic decisions should await more specific studies is apt to be tabbed as a delaying tactic in an attempt to preserve the status quo at all costs, or as a way of deliberately looking for problems. As one who believes that public policy should have as strong a factual base as time and emergencies permit, I hope that continued attempts will be made, this year and in the years that follow, to define the issues more sharply, as a support for a solid consensus as to public policy on the financing of health care of the aged.

CAN THE VOLUNTARY SYSTEM SOLVE ALL OF THE PROBLEMS?

Assuming that a number of aged persons lack adequate health care protection in the form of prepayment, insurance, or from current Government programs, the question arises as to whether, given a reasonable period of time, the voluntary system could meet the challenge with its present resources. The Blue Cross plans addressed themselves to this issue in 1962. Their conclusion was then and still is that external aid is needed.

One current source of aid to the needy aged, and to other indigent persons as well, is the hospital itself. Many hospitals accept the responsibility of providing care for needy aged citizens, without prior reference to the likelihood of payment to cover the cost of care. The modern hospital, however, has regular payrolls to meet, and cannot count on volunteer and underpaid help to take up all of the slack for all disadvantaged groups. Inadequate income from disadvantaged groups often must be recaptured through higher charges to all age groups. The public is already becoming vocal about the costs of personal health care, which raises fundamental questions as to the practicality and equity of continuing to rely too heavily on this kind of subsidy.

Fund drives and other forms of philanthropy have been relied on in the past and are still important. Experience in recent years, with hospital costs rising at a higher and faster rate than personal income, suggests that this source will be needed to an even greater extent to help meet the capital costs of plant modernization and replacement as well as the costs of research and development.

It is possible for voluntary carriers to subsidize the aged through broad risk sharing. Blue Cross pioneered this concept by setting the same rate for everyone in the community. Thus, the better risks helped defray the cost of protecting the poorer risks. Unfortunately, many competitors of Blue Cross have offered lower than community rates to selective risk groups, and the removal of the leavening influence of these groups has put limits on the extent to which community plans can meet a community problem. Some persons seemingly are anxious to depreciate the current effectiveness of Blue Cross in minimizing costs to the aged. They overlook two essential facts: (1) Experience rating as well as community rating can and does make provisions for a community factor which is composited and used to help the nongroup aged as well as other needy citizens, and (2) approximately 42 percent of aged enrollees (as has been mentioned)

are group enrollees who benefit greatly from the more favorable experience of younger group members (the percentage in this category is growing). The essential point to be made is that whereas the subsidy of the aged by other enrollees is significant, it cannot be extended without extraordinary resources to those who are well below the ability to enroll initially or to maintain below-cost payments.

Every choice mentioned earlier essentially boils down to deriving money from one part of the population to assist another—in this case, the aged. The other substantial way of doing this has been and is through taxation.

It is worth repeating here that the fundamental problem we are considering is a lack of sufficient purchasing power in the hands of the aged. The inability of the voluntary system to produce a financial subsidy sufficient to assist all aged adequately is often irrelevantly generalized to imply a universal weakness in the system, including its capacity to produce top quality care and adequate benefits. The voluntary hospitals and voluntary health prepayment plans have clearly demonstrated their performance capabilities in hospital services, high-quality patient care, and sound prepayment. Given the means to support the disadvantaged population, the voluntary system can and is willing to face the challenges in providing the best of care to the aged.

IMPORTANT PUBLIC POLICY ISSUES

In the design of any program giving Government support to the voluntary agencies several important policy decisions must be made. A few are identified here, reflecting Blue Cross experience. It is hoped that they will be useful reference points for the Congress in judging various proposals.

The basis for these decisions should be a sound medical-public health program, one that places scarce resources in their most effective array for the well-being of the aged. Reference is made to "scarce resources" because of the fact that, although services available to the aged should be expanded, the degrees of expansion cannot be unlimited. As for all age groups, a balance must be struck between ultimate need and conflicting demands from other segments of our economy.

Several methods of conserving Government resources are possible without jeopardizing total purchasing power. These, in fact, might well stimulate it.

For instance, there is widespread support within the voluntary system for the adoption of a requirement which would result in Government assistance being related on a sliding scale to the income or spendable assets of the aged. Those below a certain level might receive full Government support, those in the next higher bracket less, etc. Such a simple device has several advantages and is worthy of serious consideration.

While many of the aged are destitute and ill, most are neither, and the latter do not regard themselves as needing help. This is attested to by the million of senior citizens who are self-sufficient and who have prepared protection against the most feared health hazards. The hard core of the problem seems to involve the very old, particularly women who are chronically in poor health and who are no longer engaged in, or with the prospect of, employment to supplement their meager incomes. By relating the degree of assistance to an uncomplicated determination of the adequacy of each aged person's income (not to include assets or income of relatives or children), the thrust of the program's health service subsidies could be at the points of greatest need, thus allowing a broader and more comprehensive range of services to be covered (medical and drugs, for example, as well as institutional) with a given amount of money while preserving maximum effectiveness of private purchasing power and reducing pressure on the doctor to use highly expensive inpatient hospital services. A determination of eligibility based on income need be no greater invasion of privacy than personal income tax filing.

The difficulty of a program providing the same benefits for all in a category, such as for the aged, is that it can expand only, it cannot contract. It has been calculated that an adequate benefit for the aged consisting of 120 inpatient hospital days, outpatient hospital services, skilled nursing home and home care on a 2-for-1 hospital substitute basis, medicine and surgery in hospital, as well as partial protection for home and office care and prescribed drugs, would cost about $250 a person per year even at today's costs. The total annual cost for 17.9 million aged would be approximately $4.5 billion. Such a program of benefits, however modest at its inception, would grow in this direction on a

current cost basis and would put a heavy burden on payrolls without regard to growing income and other needs of retirees.

On the contrary, a program of benefits based on some reference to economic status of the aged can expand or contract as the status of the aged changes. Its cost, although large, can, in reflection of the economic well-being of the country and the performance of the voluntary system, stop appreciably short of the above-cited current cost and, once established with enthusiastic Federal support, can act as a stimulus for many sources of money (Federal, State, employer-employee pension programs, direct purchases of voluntary insurance and philanthropy) all of which will be needed to do a sound and progressive job. There should be no illusion about the cost or the need for cooperative effort being less.

Another way of conserving resources would be to describe benefits in the law only in general terms, with the promise that benefits would be consistent with the funds available from time to time and would, to the fullest possible extent, include such items as physican services, inpatient care in a general hospital, care in rehabilitation facilities, care in skilled nursing facilities, outpatent hospital diagnostic and treatment services, home health services, drugs, and biologicals. Some encouraging provision should also be made for experimentation and demonstration.

Such an approach would permit replacement of one type of benefit with another, as the desirability of such changes was indicated by advances in the theory and practice of medicine over the years, without need for changing the law. It would also accommodate changes desired by the public and changes in benefit patterns recommended by professional consensus.

Eligibility could be related to actual retirement rather than to an arbitrary age, especially since there is a distinclination on the part of some healthy and capable individuals to accept retirement at 65. This would help conserve Government purchasing power.

Also, deductibles, copay features, and indemnities on the benefits could be employed in liberal amounts in an effort to discourage utilization and reduce Government expenditures, but these return an arbitrary portion of the financial burden to the patient. The dilemma is that if the provisions are large enough to reduce utilization they may lead to underuse, which in itself is undesirable from the standpoint of the patient as well as the provider of financial help. Among the aged in particular, underuse of needed high-cost health services at a given point in time can have serious long-range consequences. Further, the collection of small copay amounts is an expensive job for the providers of care.

Beyond the points dealing with conservation of Government resources, further points deserve comment.

The supply of certain facilities, such as skilled nursing homes and home care programs, and certain professional specialties, is short and uneven across the country. Increased purchasing power can have a favorable influence on both the total supply of facilities and services, its distribution, and the quality levels maintained. Improperly paced, it could result in substandard care on the one hand, or severe shortages on the other. The Congress should be consciously aware of the impact that any program will have on a reasonable and orderly growth of health resources. All proposals should be subjected to professional appraisal to avoid doing damage to the health apparatus that services the country as a whole. The temptation to lower standards in the name of wider availability of whatever services happen to exist should be especially avoided.

The design and administration of health benefits involving such functions as ratemaking, underwriting, financial audits, development and evaluation of new benefits, claims processing, professional relations, and implementation of controls over utilization is a complex task requiring experienced personnel and seasoned skills. Duplication of the skills and machinery currently available should be avoided by the Government as a matter of policy. This infers that fullest use should be made of the resources of the voluntary system, not only for the sake of effectiveness and economy but also to avoid heightening the manpower problem in regard to skills already in short supply.

The Kerr-Mills Act, for example, recognized advantages in having an intermediary agency between the source of funds and the providers of care. In a direct Government-to-hospital relationship, there is inherent a temptation for Government to exert remote control over professional practices, regardless of local conditions. On the other hand, there is a known hypersensitivity to control, governmental or otherwise, on the part of the independent individuals who constitute the medical field.

Currently Blue Cross is administering benefits for needy citizens in eight States and involved in planning in several others. Programs include OAA and MAA and to a lesser extent GPA, aid to dependent children, aid to disabled, and aid to needy blind.

THE COST OF HEALTH BENEFITS

As has been stated, health benefits for the aged covering major segments of all elements of the health dollar excepting dental services would cost approximately $250 per person per year or approximately $21 a month, excluding administrative overhead. Similarly, it would cost approximately $4.50 a month to qualify for 5 days of inpatient hospital care and approximately $9.50 and $10.50 to qualify for 30 days and 120 days respectively, without any reference to diagnostic, nursing home, medical and surgical, office, and other allied services. If talking of meeting the needs of the aged, the Government should face squarely these facts and keep in mind that the costs cannot be depressed significantly without jeopardy to quality of care. Some of the literature describing the performance of the voluntary system leaves the beguiling impression that if someone else were to do the job it would cost appreciably less. There is room for further measure and modification of utilization. A great deal of energy is being devoted to this, but we should not pretend that somehow or another the costs will turn sharply downward. Hospital and medical care is expensive here and abroad—so expensive that its cost must be weighed carefully against other population needs. Many State and local governments currently paying considerably less than hospital costs can testify eloquently to the problem involved.

A recent social security bulletin, citing data drawn from a nationwide sample, showed that 11 percent of aged couples and 7 percent of aged individuals had medical bills in excess of $1,000 in 1962. On the other hand, 25 percent of the couples and 50 percent of the individuals surveyed had medical bills of less than $100. One in four were hospitalized among aged couples and one in seven among aged individuals. When a hospital stay was involved one-half of the couples and two-fifths of the individuals had medical costs exceeding $1,000. The mean total costs were $1,220 for couples (of which $588 were hospital and $632 other than hospital expenses) and $1,038 for indivduals (of which $743 were hospital and $295 other than hospital expenses). These figures would be higher if the value of free services received by the aged from doctors and institutions were added.

These and other data show that medical costs fall unevenly among the aged, as they do for all age groups of the population. Some exeprience few, others incur considerable costs. Also, it can be seen that whereas the hospital is a major cost element, hospitalization is apt to occasion a significant number of other medical expenses (doctor, drug, etc.) requiring payment.

Essential choices to be made are to what extent to increase purchasing power of the aged through cash benefits or through health benefits and whether to buy all aged a narrow range of benefits or some aged a broad range of benefits. The amount devoted to health benefits is necessarily in conflict with amounts paid in cash benefits. The economic fact of life is that under anything like current Federal Government planning a full set of benefits cannot be written for the particularly disadvantaged and for all other aged as well.

CONCLUSION

Blue Cross shares the Government's concern with the well-being of the aged and other citizens. Based on our studies of the financing of health care of the aged, we believe that some are in a disadvantaged position and require Government help in the financing of personal health services.

The core of the problem from a public policy point of view is that some of the aged lack purchasing power. The essential job for Government is to put this purchasing power in their hands. The essential decision is how.

In this statement we have outlined some criteria and identified some public policy issues which the Congress might find useful in evaluating any bill. In each instance we have sought to keep in mind the impact each element might have on the continued and orderly growth of the much larger system of service and care for the total population, of which financing health care of the aged is only a part. This system has worked well. The aged should be cause to strengthen it, not distort it. They should not be isolated from it as objects of charity either in terms of who administers their benefits or the identification card they carry.

I hope that you will find our observations and experience helpful. We should be glad to supply further information at your request.

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

Any questions?

Senator DOUGLAS. Well, Mr. McNerney, I found your statement very interesting, and very suggestive.

It reminds me, however, of a comment which was once made by an American novelist that he led the public up to the bedroom door and then slammed it in their face, and it was a novel at the turn of the century by Frank R. Stockton called "The Lady and the Tiger" which raised this question directly.

Now, you said you would be glad to supply fourther information at our request. I would like to ask you where you stand on King-Anderson?

Mr. MCNERNEY. Well, when asked this question before the House Ways and Means Committee I answered then and I would like to answer now that to the extent that King-Anderson admits that there are aged now who lack purchasing power to avail themselves of adequate benefits and sets forth a program to meet that need we support its objectives.

Senator DOUGLAS. That is what it does.

Mr. MCNERNEY. We feel that the method that is involved can be improved on.

Senator DOUGLAS. In what ways?

Mr. MCNERNEY. We feel the main weaknesses of the bill are these. That the benefits contained in it cannot be produced for the increased tax that has been suggested.

Senator DOUGLAS. Are you drawing upon the report of the health insurance association?

Mr. MCNERNEY. No, I am drawing upon the feeling of our own actuaries based upon experience with over 5.3 million aged.

Senator DOUGLAS. Do you not use as your basis the average hospital costs per patient per day?

Mr. MCNERNEY. Our difference on rates that would have to be charged for the benefits under that bill arises out of a different estimate of the degree to which per diem costs will rise in the future.

Senator DOUGLAS. It is not on differences in costs in the present?

Mr. MCNERNEY. No, these are well documented, but our extrapolation of these costs differs. Our estimate of utilization of some of the facilities such as nursing homes and other facilities allied with the hospital also differs.

The result is in good conscience we feel that this is a problem.

Senator DOUGLAS. Did you take into consideration the fact that average earnings will also rise, and that as average earnings rise total contributions rise? And, therefore, that this is an offsetting factor for the possible tendency for costs to increase?

Mr. MCNERNEY. We had available to us these data.

Senator DOUGLAS. In the past this has balanced as far as the ordinary social security system is concerned. This use in average earnings has balanced the increase in benefits. So the reserve fund has not been appreciably depleted.

Now, if you extrapolate one figure you have to extrapolate the other. If you extrapolate the increase in hospital costs you must also extrapolate the increase in earnings which results in increased contributions.

Mr. McNERNEY. I understand, and with this in mind we still feel the way we do.

Senator DOUGLAS. Have you submitted actuarial estimates as to that?

Mr. McNERNEY. We have met with representatives of the social security department and made clear to them how we feel and on the basis——

Senator DOUGLAS. Has this testimony been made public at all? Is it in the House hearings?

Mr. McNERNEY. We did not go into detail in the hearings, although I made roughly the same remarks I am making now.

Senator DOUGLAS. Would you submit for the record in the next day or so the figures upon which you based your estimates?

Mr. McNERNEY. We would be glad to do it.

Senator DOUGLAS. In the next day.

Mr. McNERNEY. Whether I can do it in the next day I don't know.

Senator DOUGLAS. This is a very important question and I don't think we can change our attitude on this, at least some of us cannot change our attitude, unless there is information, unless there are very definite statistics on this point. The weakness in this argument of increasing costs has always been that you take the projected increase in benefits but do not take into account the projected increase in earnings which at the same rate of contributions, and at the same time coverage will swell contributions.

Mr. McNERNEY. I will make every effort to submit this as soon as I can.

(The information referred to follows:)

In evaluating the cost of King-Anderson, we have made no attempt to project on a long-range basis such as was done by actuarial study 57 of the Social Security Administration. Any attempt to accurately predict income and expense through the year 2000 is not feasible. We are, therefore, confining ours to taking a look at what this may cost over the next few years.

First, there are three alternate programs proposed by the King-Anderson bill. A 90-day semiprivate care benefit period, and a deductible of $10 per day for 9 days, with a minimum deductible of $20; or there can be a 45-day maximum with no deductible; or a 180-day maximum with a deductible of 2½ times the average daily hospital cost. The bill assumes that these three programs would be approximately equal in cost, which is not true.

The 45-day maximum program would be by far the most expensive, while the other two options would be fairly close together at the start, but with the flat deductible related to per diem cost becoming more and more the less costly.

There are three primary areas of difference we have with the rating done in actuarial study 57. These are (1) in the basic assumption of days used per person per year, (2) the trend factor used to develop cost per day, and (3) in the elements of cost that would constitute reimbursement to hospitals.

Since practically all of the cost estimates that are provided in study 57, and which have been done by others, are conjecture, there is no firm answer as to what the program will cost. We believe, through work done using Blue Cross data and other information available, that the estimated costs are between 25 and 40 percent understated for the first year, and that there may be a continually rising degree of understatement during the next few years.

In 1962 a group of Blue Cross actuaries developed 3.2 days per person for an insured program, and we now believe that this could easily be increased to approximately 3.45 days based upon more recent data. Actuarial study 57 uses 2.68 days per person as a base for the early years, and this is from 20 to 30 percent below what it should be.

As to the cost of skilled nursing home benefits and home nursing care, we can do no more than anyone else and that is to guess what the cost of this would be. Because of limited facilities at the start, nursing home care may be relatively inexpensive but as time goes on its cost could be a substantial portion of the total program. Further, it is plain conjecture to state that the availability of this benefit will have any appreciable effect on the utilization of hospital care.

We find difficulty in reconciling the approach of using a social-basis of financing to pay for an item such as hospital care, the cost of which is not related to the financing mechanism. Study 57 on pages 29 and 30 admits to this problem and to the unknowns involved in hospital care. The assumption cannot be made that benefit costs relative to payroll will not be affected by rising trends. Hospital costs are rising more rapidly than taxable earnings, and this will require a constantly increasing tax rate for financing the program and/or benefit reductions to keep the program solvent.

Senator DOUGLAS. May I ask one or two other questions?

Mr. MCNERNEY. If I may, I would like to, with your permission——

Senator DOUGLAS. Surely.

Mr. MCNERNEY. Mr. Chairman, also, I would like to not suggest that this is my only sense of qualification with the King-Anderson bill. I think this is largely a technical point which we should be able to resolve through a meeting of people with actuarial experience.

I should go on for just 1 second and add that we have other reservations, too, I could state them very briefly if you would like.

Senator DOUGLAS. Yes.

Mr. MCNERNEY. Namely, there is in this country at the moment a paucity of good nursing home beds, a very sparse and thin distribution of home care programs and to create purchasing power overnight for 180 days of one and 240 days of the other is going to, I am afraid, suggest to the population that there is some response available that is in fact impossible.

These facilities are not currently available, and could not in any degree of quality respond to that need.

Senator DOUGLAS. May I deal with that?

Mr. MCNERNEY. Yes.

Senator DOUGLAS. I think it is a general law of life that supply follows demand. Create the demand for these services and you get an expansion of supply; create the demand in the form of purchasing power for nursing home care and for home health care, you would then get your supply of nursing homes which can be rather quickly constructed. Under the housing bill we have made provision for low-cost credit for nursing homes, and under the various training programs we are training large numbers of practical nurses.

Practical nurses seem to be one of the expanding professions. In the coal mining areas of my State of Illinois, which have suffered very severe blows, we are training a large number of young women to be nurses aids. We all know from experience in the war that you can train a corpsman in the course of 2 or 3 months, and working under the direction of a registered nurse or a doctor, this relatively semi-skilled person could do very good work.

Mr. MCNERNEY. I think that you and I would agree that the main problem here is manpower rather than buildings. I think that certain groups in our population would respond with alacrity to constructing the buildings to provide this care. Some of the auspices we wouldn't each like.

The real problem comes in the supply of doctors and skilled nurses and ancillary help such as occupational therapists, physical therapists, recreational therapists, physiatrics. I concur with you that supply follows demand. But the supply of these skills has been particularly—as you know, the Government has a policy on this—resistant over the past several years.

My concern is that you can't train a doctor in one or two or three——

Senator DOUGLAS. I am not speaking of doctors. I am speaking of practical nurses.

Mr. MCNERNEY. Well, the problem with a lot of skilled nursing care today is that it involves only that. This is what leaves people in bed, prevents what Senator Javits so well stated, them getting them on their feet with a sense of full programing in physiatric help.

I think what we want if we are to establish a public policy is to introduce a sense of quality and thrust into this area rather than creating a series of domiciliary institutions.

Senator DOUGLAS. May I say this, I have spent a good deal of time in naval hospitals after the war. I spent about 14 months, and received very fine attention and seldom saw a doctor—except when I was operated on. Indeed I seldom saw a trained nurse or registered nurse. Work was in the main carried on by corpsmen or by practical nurses, back here at home.

I became convinced that there has been overprofessionalization, so to speak.

Mr. MCNERNEY. Yes; this is always a potential problem. I think the only thing I would say to that is that where teams of qualified people have gone into nursing homes and evaluated the patients under our current system, several of the efforts have demonstrated that approximately a third of these people could be rehabilitated to the extent of going home.

Approximately a third of them could be made ambulatory who were bedridden and the others were more or less intractable.

With that potential of returning citizens to a taxpaying status or with their family or making people ambulatory who are vegetating, we should have a sense of standard, a sense of pace in spending large amounts of money, and all I am calling for here is a realistic appraisal so that we don't get a large group of people demanding this care and not being able to find it.

Senator DOUGLAS. I would simply say that during the war we hastily created very good medical services. I see no reason why this could not be done in peacetime for the 18 million aged, if we really set about to do it.

Mr. MCNERNEY. If I could make one more remark regarding King-Anderson, I think probably the main problem that many of us have is that that focuses on the institution, excludes the doctor in the home and in the office. It is light on ambulatory services.

This is the inevitable result of giving everybody something. If the same resources were taken to give a balanced medical public health program to an identifiable few, you would at the same time put the doctor in a position of using a wider variety of facilities in regard to the patient, and keep a large amount of private purchasing power that now exists in these areas.

Senator DOUGLAS. Are you advocating a return of the Forand bill which provided not only for hospital and nursing care but for doctor services?

Mr. MCNERNEY. No, I am suggesting that it would be possible for the Government to spend its money in reference to scaled income, which would do away with the many bad features of the means test which I don't support.

Senator DOUGLAS. You mean graduated charges?

Mr. MCNERNEY. Right.

The Government would help an individual more or less depending upon what category of income he fell. If someone were below the figure $1,500 the Government support to him might be 100 percent and correspondingly downward.

There would be declared possibly on a yearly basis, on a short form, and would be a way of giving relative to a patient's medical needs assistance while keeping a lot of private purchasing power.

Senator DOUGLAS. This is very interesting.

What you are proposing is a governmental subvention to meet the costs of treating the poor but no control over the charges made to the well-to-do.

Mr. MCNERNEY. Well, I don't—the charges to the well-to-do are going to persist under any system I have heard discussed today.

Senator DOUGLAS. These could be in the form of extra services, whether private rooms and so forth, which would not be provided under King-Anderson.

Mr. MCNERNEY. Well, under King-Anderson——

Senator DOUGLAS. And, of course, under King-Anderson medical and surgical services are not provided.

Mr. MCNERNEY. Surgery is not provided under King-Anderson. There are deductibles regarding the hospital itself.

I feel that under any system you are left with charges outside the support the Government gives. Those would be my general remarks on this.

Senator DOUGLAS. I don't want to prolong the questions and shut off my colleagues but I would like to ask you, What is the average monthly premium for persons over the age of 65 under Blue Cross?

Mr. MCNERNEY. The average monthly premium I can't tell you but I will supply you with that information.

Senator DOUGLAS. What is your guess?

This is a very vital factor.

Mr. MCNERNEY. Well, here is my difficulty; namely, that some people over 65 who have Blue Cross are part of a retired group, a large industry. They pay the same rates as all members of that working force pay, retired or not.

Some members of Blue Cross are group conversions. They formerly worked and they are now on individual pay.

Some came in through open enrollments, some came in through senior citizens. The rates vary depending upon what category they are in, even for the same benefits.

Senator DOUGLAS. Let's take New York, which is probably the most expensive State.

Under the recent increase in rates of Blue Cross which, as I understand it, has been approved by the New York State authorities, what

is the average Blue Cross rate per person over the age of 65 on a monthly basis?

I believe there has been an increase of 31 percent in New York.

Mr. McNERNEY. There have been increases. I can't recite the State figures. I would feel more comfortable if I could submit these figures to you so they could be accurate.

Senator DOUGLAS. Can your assistant supply this?

Mr. TOLLEFSON. No, Senator. We will provide it for the record.

Senator DOUGLAS. What would be the average rate in a State west of the Mississippi where the costs are probably lowest—States such as Kansas, for example, or Nebraska.

Mr. McNERNEY. That varies so much with the program that they are getting, the status that they are in, that I would have no average.

Senator DOUGLAS. Mr. McNerney, I thought you would have these at the tip of your fingers, so to speak.

May I ask what is the average protection in number of days of hospital costs which are met by Blue Cross?

Mr. McNERNEY. I would say this, that the bulk of our programs would be, I would say, 70 days or more.

Senator DOUGLAS. 70 days.

Is there any limit on the amount to be paid per day?

Mr. McNERNEY. Several of our plans are on a service basis, meaning that they pay the whole bill in this instance. Some of our plans have an indemnity on the room, that is just for the room charge they will pay up to a limit, they will pay all of the extra.

In some of our contracts there are deductible co-pay provisions.

I would say that roughly half of our plans are free of the deductible co-pay indemnity provision.

Senator DOUGLAS. Is there a maximum on the amount per——

Mr. McNERNEY. Only expressed as a number of days.

Senator DOUGLAS. No maximum per day?

Mr. McNERNEY. No.

Senator DOUGLAS. In this you differ from the private insurance plans.

Mr. McNERNEY. Yes.

And as a result we pay some very large bills.

Senator DOUGLAS. You have no maximum such as $10 per day?

Mr. McNERNEY. On some of our contracts there is a maximum on the room only but the other services which are likely to be considerable are fully paid in all of our plans.

We will be glad to submit these average figures.

(The information requested follows:)

Blue Cross family rates by State and category

G—Group plan.
NG—Nongroup plan.
SC—Senior citizen plan.

Plan	Monthly family rates, 1964
Alabama:	
G	$9.30
NG	9.50
SC	9.50
Arizona:	
G	13.04
NG	15.26
SC No. 1	15.00
SC No. 2	25.05
Arkansas:	
G	5.75
NG	7.40
SC No. 1	10.30
SC No. 2	17.90
California:	
Los Angeles:	
G	12.67
NG	13.65
SC No. 1	31.60
SC No. 2	8.75
Oakland:	
G	10.75
NG	12.09
SC No. 1	23.00
SC No. 2	31.60
Colorado:	
G	13.20
NG	15.00
SC No. 1	9.50
SC No. 2	8.05
Connecticut:	
G	8.70
NG	9.22
Delaware:	
G	7.96
NG	10.31
SC No. 1	11.04
SC No. 2	18.55
District of Columbia:	
G	9.80
NG	10.20
SC	24.00
Florida:	
G	9.90
NG	5.50
SC No. 1	24.00
SC No. 2	17.00
Georgia:	
Atlanta:	
G	9.82
NG	10.94
SC	18.90
Columbus:	
G	5.25–8.05
NG	6.90–17.05
SC	14.70
Savannah:	
G	9.50
NG	11.20
SC	10.20
Idaho:	
G	10.80
NG	12.50
SC No. 1	22.90
SC No. 2	15.20
Illinois:	
G	16.92
NG	17.84
SC	9.65
Indiana:	
G	13.00
NG	11.56
SC	15.75
Iowa:	
Des Moines:	
G	9.65
NG	10.40
SC No. 1	5.70
SC No. 2	15.85
Sioux City:	
G	5.75
NG	10.10
SC No. 1	5.05
SC No. 2	15.85
Kansas:	
G	9.90
NG	14.00
SC	17.50
Kentucky:	
G	6.00
NG	6.68
SC	15.50
Louisiana:	
Baton Rouge:	
G	7.15
NG	12.17
SC No. 1	11.58
SC No. 2	12.17
New Orleans:	
G	8.25
NG	10.00
SC	20.00
Maine:	
G	7.85–12.85
NG	8.15–13.95
Maryland:	
G	10.10
NG	10.70
SC No. 1	10.90
SC No. 2	7.90
Massachusetts:	
G	9.92–11.36
NG	9.20
Michigan:	
G	16.91
NG	19.45
SC	6.45
Minnesota:	
FG	21.15
NG	19.80

Blue Cross family rates by State and category—Continued

Plan	Monthly family rates, 1964
Minnesota—Continued	
SC No. 1	8.00
SC No. 2	12.50
Mississippi:	
G	9.21–9.86
NG	10.90
SC No. 1	10.00
SC No. 2	12.20
Missouri:	
Kansas City:	
G	12.05
NG	11.05
SC	18.55
St. Louis:	
G	8.50
NG	8.35
SC	19.70
Montana:	
G	13.51
NG	15.64
SC No. 1	29.60
SC No. 2	19.40
Nebraska:	
G	7.45
NG	6.05
SC No. 1	4.70
SC No. 2	7.90
SC No. 3	6.40
New Hampshire:	
G	8.75
NG	11.65
New Jersey:	
G	10.29
NG	11.22
SC No. 1	19.00
SC No. 2	14.48
New Mexico:	
G	14.95
NG	15.05
SC No. 1	22.50
SC No. 2	21.80
New York:	
Albany:	
G	15.40
NG	19.60
SC No. 1	9.66
SC No. 2	8.00
Buffalo:	
G	10.15
NG	12.10
SC No. 1	20.85
SC No. 2	18.40
Jamestown:	
G	7.98
NG	11.64
New York:	
G	8.72
NG	10.35
SC	10.80
Rochester:	
G	10.48
NG	13.50
SC	11.00
New York—Continued	
Syracuse:	
G	10.90
NG	11.80
SC	6.60
Utica:	
G	8.20
NG	9.60
SC	10.66
Watertown:	
G	11.60
NG	12.50
SC No. 1	9.60
SC No. 2	8.60
North Carolina:	
Chapel Hill:	
G	6.60
NG	9.55
SC No. 1	6.50
SC No. 2	15.80
SC No. 3	10.90
Durham:	
G	8.58
NG	6.50
SC No. 1	6.50
SC No. 2	15.80
SC No. 3	10.90
North Dakota:	
G	13.20
NG	16.15
SC No. 1	21.20
SC No. 2	15.60
Ohio:	
Canton:	
G	12.20
NG	11.90
SC	11.50
Cincinnati:	
G	11.10
NG	10.90
Cleveland:	
G	11.90–14.90
NG	16.10–20.10
SC	7.95– 9.95
Columbus:	
G	8.10– 8.20
NG	7.25
SC	5.00
Lima:	
G	6.50
NG	7.50
SC No. 1	5.50
SC No. 2	14.00
Toledo:	
G	11.40
NG	10.30
SC	7.00
Youngstown:	
G	13.55
NG	20.75
SC	20.00

Blue Cross family rates by State and category—Continued

Plan	Monthly family rates, 1964
Oklahoma:	
G	7.80
NG	5.20
SC	6.80
Oregon:	
G	7.75
NG	13.90
SC No. 1	22.90
SC No. 2	15.70
Pennsylvania:	
Allentown:	
G	9.45
NG	9.95
SC No. 1	11.14
SC No. 2	17.54
Harrisburg:	
G	9.80
NG	11.10
SC No. 1	7.00
SC No. 2	21.50
Philadelphia:	
G	13.35
NG	12.50
SC No. 1	13.34
SC No. 2	20.84
Pittsburgh:	
G	12.15
NG	12.95
SC No. 1	24.80
SC No. 2	16.70
Wilkes-Barre:	
G	9.50
NG	12.60
SC No. 1	19.20
SC No. 2	10.70
Rhode Island:	
G	8.30
NG	7.15
South Carolina:	
G	7.85
NG	10.00
SC No. 1	22.10
SC No. 2	17.10
Tennessee:	
Chattanooga:	
G	7.20
NG	10.00
SC	25.00
Memphis:	
G	10.10
NG	13.05
SC	25.00
Texas:	
G	7.70
NG	9.43
SC No. 1	8.75
SC No. 2	----------
Utah:	
G	11.95
NG	10.22
SC No. 1	19.80
SC No. 2	14.30
Virginia:	
Lynchburg:	
G	7.10
NG	6.85
SC	6.50
Richmond:	
G	9.40
NG	7.50
SC	8.44
Roanoke:	
G	8.30
NG	9.05
SC	10.50
Washington:	
G	8.75
NG	9.50
SC No. 1	8.50
SC No. 2	27.50
West Virginia:	
Bluefield:	
G	9.20
NG	10.00
SC	23.60
Charleston:	
G	9.10
NG	8.40
Parkersburg:	
G	8.30
NG	10.35
SC No. 1	21.20
SC No. 2	19.70
Wheeling:	
G	10.80
NG	12.85
SC	23.30
Wisconsin:	
G	14.55
NG	15.00
SC No. 1	24.00
SC No. 2	30.00
Wyoming:	
G	4.85
NG	10.90
SC No. 1	7.50
SC No. 2	16.50

Senator DOUGLAS. That is all, Mr. Chairman.

The CHAIRMAN. Thank you very much.

Mr. MCNERNEY. Thank you, sir.

The CHAIRMAN. The next witness is Dr. J. Buroughs Stokes, of the Christian Science Committee on Publications.

Mr. Stokes, take a seat, sir.

STATEMENT OF DR. J. BUROUGHS STOKES, MANAGER, WASHINGTON, D.C., OFFICE, CHRISTIAN SCIENCE COMMITTEE ON PUBLICATION

Mr. STOKES. My name is J. Buroughs Stokes. I am manager of the Washington, D.C., office, Christian Science Committee on Publication of the First Church of Christ, Scientist, in Boston, Mass. My appearance before you has been authorized by the Christian Science board of directors, the administrative head of the Christian Science denomination.

We greatly appreciate the fact that the Senate Finance Committee, in its hearing on the social security bill, decided also to consider the important subject of health care for senior citizens. This is of vital interest to all thinking people and the many problems involved must be solved. These, however, are complex and it is conceivable that no single solution exists. In fact, the various propositions which have been offered, upon study, show that they are far from perfect; and, if accepted, might even have a deleterious effect.

On the surface, the suggestion that the solution is to be found by providing a compulsory program under social security appears promising. But here again experts have testified that this too is found wanting on several counts.

For example, testimony before the House Committee on Ways and Means by a responsible organization stressed that the workers might eventually be unwilling and unable to bear the cost of this proposal in addition to the tax increase required for the present social security benefits. Others have pointed out that the measure proposes a limited program of compulsory national health insurance for the aged only which would be expanded until it provides complete health services and coverage for people of all ages under a system of national health. If this were to result, we hesitate to think of the concomitant problems such a system would introduce.

We believe that the compulsory social security approach of fixed service benefits infers that, in the field of health care, an individual, on reaching age 65, ceases to be a thinking, productive, and useful member of society. This approach suggests that such an individual is unable to plan for his future, make the proper selection of health services, or spend his money wisely. That this is not the case is borne out by the number of brilliant, productive members of society all around us who, despite being 65 years of age or older, are contributing so admirably to its advancement—the many members of Congress, lawyers, physical scientists, educators, businessmen, farmers, laborers, and average workingmen. Why, without their mature thought, experience, and ability, how can we, as a nation, go forward to help and bless mankind? We should not enact legislation which would tend to make or imply that those 65 years or older are "has-beens." This, we know, would be more harmful to the dignity, freedom, and health of man than any single thing.

The great majority of citizens, by their own individual ability and initiative, are already planning, meeting, and solving the problem of adequate health care. They are doing this by means of private savings, cooperative family action, or individual and group health insurance plans, social service organizations, company and trade union

health programs, retirement funds, and the like. We realize that, despite all of this, there is still an area in which the Government, both State and Federal, can be helpful in providing aid for the aged whose income and resources are insufficient to meet the cost of proper health care.

It seems to us that the Kerr-Mills law (Public Law 86–778), properly implemented, provides an equitable means of aid for the needy aged. Whereas Kerr-Mills may not be the perfect solution to the problem, nevertheless, the Federal-State approach to it, with the State deciding for itself the scope and extent of services, does have more advantages than disadvantages. The system allows for local initiative, future progress, and change, and the money to pay for the services is provided from all sources of income rather than that of merely the contributions of the self-employed, employer, and employee. This seems to be just and equitable.

Proposals, such as the Hospital Insurance Act of 1963 (H.R. 3920), frequently referred to as the King-Anderson bill, are designed to provide for the health care of all individuals 65 years and older who are eligible primarily for old-age, survivors, and disability insurance and railroad retirement benefits, and constitute a wide departure from the normal practice under these plans which provides benefits solely on a cash basis. Here, for the first time, if enacted, benefits would be afforded which all contributors could not use and accept. Particularly would this be true in the case of Christian Scientists who, because of their religious teaching and faith, do not employ medical treatment and care. Let me explain briefly. Christian Science relies solely on spiritual means for healing, as did Christ Jesus. It respects sincerely the unselfish efforts of doctors, surgeons, psychiatrists, and others. It respects the right of each individual to choose that mode of health care which seems to him most efficacious and most nearly in accord with God's will, but when confronted with sickness or disability, a Christian Scientist turns to a Christian Science practitioner for help through prayer instead of to a doctor; when in need of hospital care it is only natural for a Christian Scientist to go to a Christian Science sanatorium rather than a medical hospital.

Healing by prayer as understood in Christian Science has now been tested before the public for some 98 years. During this time a great body of evidence as to its efficacy in healing every sort of disease has been established. This care and treatment is known to be a safe, effective therapeutic system—so much so that Christian Science is practiced freely and without legal restriction in every State in the Union.

Furthermore, today hundreds of insurance companies in the United States recognize and pay for Christian Science treatment and care in their group health insurance agreements and their various casualty and accident lines. Also, the Aetna Life Insurance Co., in its uniform plan for retired Federal employees, and in its Government-wide indemnity benefit plan for active Federal employees which covers some 6 million employees and their dependents, provides for Christian Science treatment and care. Again, when the Social Security Act was amended in 1960 by Public Law 86–778 (Kerr-Mills) to provide for medical aid for the aged, it was worded so that Christian Science benefits could be included in any State program.

In the area of health care for the aged, private insurance plans have been, as you are aware, providing new types of programs such as State 65 and other geographical group plans like Continental Casualty's Golden 65. These plans have a great deal of flexibility in providing the types of health care elderly individuals want and need. Also to be commended are the plans of the National Association of Retired Civil Employees and the American Association of Retired Persons, et cetera. Under all these private programs Christian Scientists are able to obtain coverage of the type they desire and can utilize.

Throughout the years it has been stated that one of the great advantages of OASDI is that it correlates cash benefits with an individual's contribution so that the contributor is given a sense of participation, of self-respect and self-reliance. However, proposals such as H.R. 3920 provide ony for a set, inflexible system of services which the Federal Government deems best. This seems to us to be depriving the individual of his right of free choice and of his dignity. This would make it extremely difficult for an individual, such as a Christian Scientist, who has religious and conscientious objections against providing himself with medically oriented hospital insurance.

To summarize, we are opposed to the compulsory aspects of any proposal which would require every citizen covered by old-age, survivors, and disability insurance and the railroad retirement system during his entire working experience to make regular contributions, without exception, toward medical hospital insurance. If your committee should decide to so amend the present social security bill (H.R. 11865), we ask that it consider the possibility of making coverage voluntary, providing for administration through private insurance carriers, and allowing for a scope of benefits broad enough to benefit all of our senior citizens. This would not only be beneficial to the adherents and members of our denomination, but also to other citizens of our country who, for various reasons, we believe, would not desire or need compulsory coverage. It would also do much to enhance and reemphasize for all the great value and contribution of senior citizens to the development and advancement of our country.

Thank you for the opportunity and privilege of presenting our views on this important subject.

The CHAIRMAN. Thank you, Doctor.

The next witness is Dr. Russell B. Carson, of the National Association of Blue Shield Plans.

Take a seat, Doctor, and proceed.

STATEMENT OF RUSSELL B. CARSON, M.D., CHAIRMAN OF THE BOARD OF DIRECTORS, NATIONAL ASSOCIATION OF BLUE SHIELD PLANS

Dr. CARSON. Mr. Chairman, good morning. I am Dr. Russell B. Carson, of Fort Lauderdale, Fla., and I am engaged in the private practice of medicine in that city.

I am appearing before the committee as chairman of the board of directors of the National Association of Blue Shield Plans. Accompanying me, to my left is Mr. John Castellucci, the executive vice president of the association, and Mr. James Bryan, director of our Washington office.

The National Association of Blue Shield Plans is the coordinating organization of the 74 Blue Shield plans in the United States. There are now over 50 million people in this country enjoying prepaid medical and surgical security under these plans.

The Blue Shield name and symbol is a nationally recognized service mark. It is a highly respected symbol. It identifies the medical service plans which offer benefits specifically related to the medical needs of their local communities.

Blue Shield and Blue Cross share a common objective—to make available a comprehensive medical and hospital prepayment service to the entire population.

Blue Shield is engaged in covering physicians' services, while Blue Cross is devoted to the payment of hospital services. Although the local Blue Cross and Blue Shield plans work in close cooperation in most parts of the country, they are distinctly separate organizations, both locally and nationally.

Leaders of Blue Shield and of the medical community have always recognized that aging people present some special health problems, just as do many other segments of the population, such as the chronically ill, the handicapped, and the indigent. Our plans have always sought to bring the resources of the entire community to bear upon the problems of each of its component groups.

The growth of Blue Shield is an impressive reflection of the growing national concern to make adequate prepayment mechanisms for medical care available to all who need such help—regardless of age.

Blue Shield membership now includes more than 4 million citizens past 65 years of age, and all Blue Shield subscribers may continue their coverage when they pass the age of 65.

This means that a constantly growing proportion of America's working population have the opportunity of carrying their medical care prepayment into retirement.

In 1951 5 percent of all Blue Shield members, or nearly 1 million persons, were 65 years of age or older.

By 1959, or 8 years later, this number had grown to more than two and a half million persons representing 6.4 percent of all Blue Shield members, and our present Blue Shield membership of more than 4 million persons over 65 represents 8.2 percent of our entire membership.

It is particularly significant that while total Blue Shield membership during the 18 months ending December 31, 1963, increased about 5½ percent, the number of persons over age 65 covered by Blue Shield increased 21 percent. Thus, the growth rate of coverage of older persons has become nearly four times the growth rate of all age groups combined.

In 1959 only 10 plans offered individual nongroup membership without age limit. Today, 73 of the 74 Blue Shield plans representing over 99 percent of the total membership in this country, have available individual nongroup coverage for persons over 65.

Most Blue Shield plans have always offered benefits on a fully paid "service benefit" basis to subscribers in the medium and lower income brackets.

I wish to emphasize as significant this service benefit feature of Blue Shield. This means that local participating physicians have agreed with their local plans to accept plan payment as full payment for all

covered services, provided the income of the subscriber falls within certain income levels.

The service-benefit feature applies to Blue Shield senior citizens even more completely than to members in other age groups. Of the 73 Blue Shield plans that now offer a special senior citizen contract, 65 of them provide benefits on a fully prepaid service basis to low-income subscribers.

Apart from the remarkable progress we have made in providing health insurance coverage on an individual basis to those 65 and over, a more significant development has been the increasing practice of both local and national labor and management groups to negotiate a provision in their health and welfare programs for the continued coverage of retired employees under the same arrangements and conditions as apply to their active employees.

The best example is the pattern adopted by the Federal Government for its own retiring employees. Blue Shield and Blue Cross cover over 1,150,000 Federal employees, and in addition the members of their families, for a total of approximately 3⅓ million people.

Each year more than 25,000 retiring Federal employees take their Blue Shield protection into retirement. As retirees, these Federal employees, like many retiring from private industry, are assisted by their former employer in continuing their health coverage.

In the brief span of 23 years, marked by war, recession, and inflation, Blue Shield membership has grown from 370,000 to over 50 million and the total number of people covered by voluntary health insurance has grown from 12 million to more than 145 million, which represents 77 percent of the entire U.S. population.

The proportion of the over-65 population covered by voluntary health insurance will soon match the percentage of the total population so covered and the quantity and quality of coverage for those on both sides of the 65-year line will continue to improve at a rapid pace.

We are dealing with a problem which from day to day is progressively finding an adequate solution through voluntary methods. The number of our aged people who require governmental assistance grows proportionately smaller from day to day. The problem of financing health care for the aged is a diminishing one.

We have—we who have pioneered the voluntary health care movement, are the first to acknowledge that there will always be some people in all age groups who cannot purchase the medical care they need through their own resources. This relatively small group of people must be, to some degree, a responsibility of the community.

However, it seems wholly illogical to provide for the many who do not need help in order that the few who need assistance may receive it, as is proposed in the King-Anderson bill and in the other amendments calling for social security financing of hospital care.

We do not believe that Congress wishes to enact a program which would supplant or jeopardize a voluntary system which is accomplishing so much.

People of any age who need help in availing themselves of medical care should and must have help. If today Blue Shield and Blue Cross were suddenly eliminated from the American scene, millions of people would suddenly find themselves medically indigent in the face of any important medical emergency.

Why should Congress be asked to attack a problem of specific, identifiable need for citizens over 65 by a program that would cover everyone of this age—irrespective of need—and yet fall tragically short of matching or equaling the benefit programs which it would displace?

The provisions of the King-Anderson proposal are costly even in terms of the limited benefits the bill proposes to offer, and, if we interpret the current alternative proposals correctly, the benefits will be even less adequate than in the original proposal.

The ultimate costs of even the more limited program that has been proposed in the optional plan are totally unpredictable. And when such benefits are offered as an elective option, one can be certain that the hospital benefit option will be selected by those most likely to need hospital care—thus assuring an "adverse selection" and a far greater cost than would normally be anticipated for such benefits.

It is somewhat surprising to find some of the avowed supporters of the social security system proposing that a major social security benefit be offered on a voluntary basis.

If a hospital benefit proposal is enacted, it will inevitably be only the first step toward a comprehensive program of Federal health insurance.

Before long, Congress will be asked to extend this limited program by adding surgical and medical benefits for the aged. The history of the Social Security Act clearly shows that every congressional session has expanded the program. The inevitable expansion of any benefit system supported by social security means rising taxes on wages and salaries, and increasing Federal control of personal services.

And the force of the argument to expand federally operated medical care programs will be enhanced to the extent that the vitality of the voluntary system has been sapped by ill-conceived governmental intervention in the provision of health care.

The Federal Government injures the public interest if it sets up a program which inhibits the further development and growth of the voluntary plans. It could ultimately nullify their contribution to the health and welfare of the entire population.

In our opinion, Congress has provided an instrument, in the Kerr-Mills program, which if improved and fully implemented, is the best answer yet evolved for the specific problems of our aged and needy citizens.

We can demonstrate the practicality of utilizing Blue Shield plans as underwriters of the services provided needy elder citizens through the Kerr-Mills program. Blue Shield would welcome a much broader opportunity to make our contribution to this program.

The Kerr-Mills Act is essentially right. It can provide medical care where and when it is needed. It can provide the kind of care that a patient needs and when it is needed. It can provide the kind of care that a patient needs and to the full extent that he needs it. Its cost is supported by the entire community, instead of being loaded upon the wage earner, as the social security financed program would be.

The Kerr-Mills program should be improved. Congress should require the Department of Health, Education, and Welfare, after obtaining appropriate medical advice, to establish the basic principles of a medically acceptable benefit program for the elderly. Each State

should then be required to meet these minimum standards in order to qualify for Federal assistance.

The Kerr-Mills program should be further amended to encourage the use of the voluntary prepayment plans for underwriting the benefits. This would permit needy elderly people to avail themselves of the services of their own physicians and hospitals without a "means test" at the time when these services are needed.

By adapting Kerr-Mills to the voluntary prepayment structure, Congress would strengthen the Kerr-Mills program, and it would also contribute to the security and strength of America's entire voluntary health insurance movement.

By utilizing the prepayment plans, Congress would also achieve a stability and a predictability of cost for the Kerr-Mills program that is obtainable in no other way.

We believe that Congress can best serve the interests of all the people of the United States by making the fullest possible use of the existing prepayment system to underwrite the medical needs for all those segments of the population for whose aid or support our Government has a legitimate role.

Blue Shield would welcome an opportunity to advise and aid Congress in any plans to accomplish this objective.

We recommend that Congress consider amending the social security laws to:

1. Provide for establishment of minimum principles and standards for any State which wishes to qualify its MAA program for Federal support.

2. Recognize and encourage the further development of voluntary prepayment facilities which are already available and functioning.

3. Declare it unmistakably to be the intent of Congress that the Department of Health, Education, and Welfare should make maximal use of established prepayment plans to underwrite the MAA program in the various States in order, first, to stabilize the costs of this program; second, to minimize its welfare aspects; and third, to eliminate the means test at the time when medical care is required.

4. Provide for a clear separation of the MAA program from the OAA program, and for professional medical control and guidance of the MAA program.

Mr. Chairman, I would offer the following summary observations: Blue Shield plans have long been aware of the special needs of older citizens for medical care and for the economic means of obtaining such care.

More than 4 million citizens in the over-65 age group are now enrolled in Blue Shield plans, and Blue Shield members under 65 have the privilege of continuing their coverage after reaching the 65-year mark.

Blue Shield members over 65 now represent more than 8 percent of our entire enrollment, and new enrollment of over-65 subscribers has been growing four times as fast as our total enrollment. Most of these elderly Blue Shield members are entitled to covered medical services on a paid-in-full basis.

Our experience convinces us that the problem of providing medical care for the elderly is in process of solution, largely through voluntary methods, supplemented by such programs as the Kerr-Mills Act,

and that its solution would be hastened by using the voluntary prepayment plans to underwrite these programs for the needy aged.

We urge that Congress build upon the solid foundations of legislative enactment represented by the Kerr-Mills program, and of voluntary initiative represented by Blue Shield and its companion hospital plan, Blue Cross.

We urge that Congress take advantage of the knowledge and experience of the voluntary prepayment plans to strengthen the medical-aid-to-the-aged program. By doing so, we submit that Congress would discharge its public responsibility to the aged and it would also help to assure the ultimate success of America's voluntary prepayment plans in meeting the medical needs of the entire community.

We wish to thank you, Mr. Chairman and the members of the Senate Finance Committee, for your courtesy in permitting us to bring this statement and these recommendations to you.

The CHAIRMAN. Thank you, Dr. Carson.

The next witness is Dr. I. Lawrence Kerr, of the American Dental Association.

Dr. Kerr, will you take a seat, sir.

STATEMENT OF DR. I. LAWRENCE KERR, AMERICAN DENTAL ASSOCIATION

Dr. KERR. Just a point of personal privilege, Mr. Chairman. As a private citizen, it isn't very often we are afforded an opportunity to express our appreciation for your very many devoted years to the service of our Nation, and I would like to presume to do this now.

My name is Dr. I. Lawrence Kerr, of Endicott, N.Y. In addition to conducting a private practice, I am a member of the Council on Legislation of the American Dental Association. Accompanying me here today is Mr. Hal M. Christensen, director of the association's Washington office.

We appreciate the privilege of testifying before this committee, Mr. Chairman. We have asked to do so solely to discuss the various health-care-of-the-aged amendments to H.R. 11865. We have no position on H.R. 11865 as passed by the House.

We are well aware of the extraordinary demands on your time and, in accordance with the chairman's request, our presentation will be limited to 10 minutes.

Few domestic issues of recent years have been so politically controversial as the question of health care for the aged. Regrettably, much of the controversy has served to cloud, rather than clarify, the situation.

It is the dental profession's belief that this has been the result of a mistaken tendency to discuss health care and the aged as an isolated problem, rather than viewing it within the context of a total health program for the Nation.

The standard of health in the United States is as high as any in the world. This has occurred as a consequence of a system based firmly on private practice. The fact that this system has experienced such great success should give pause to those who would change and perhaps weaken it.

The fact that our system is based on private practice does not mean that government has no proper place in it. On the contrary, all levels of government have a positive and creative role to play.

The Federal Government has traditionally assisted in such health activities as hospital construction, expansion of community health services and facilities, general health and specific disease research, and general public health programs.

To these, the 88th Congress added one more: Assistance in providing educational facilities to train the health manpower needed by a growing and increasingly health-conscious population.

This new task is being accomplished through implementation of the Health Professions Educational Assistance Act, which received overwhelming bipartisan support in both Houses of Congress and which was unequivocally favored by the American Dental Association.

Within this framework, furthermore, there are additional actions which Federal and State Governments should take. One example in dentistry is strengthening State-level dental public health programs by enactment of a grant-in-aid program designed for this purpose. Similar grant-in-aid programs are already in effect for such other categories as cancer, heart disease, and maternal and child development.

We mention all this, Mr. Chairman, in order to make it perfectly clear that when the dental profession opposes placing health care for the aged under Federal social security—and it does oppose that—it is not out of any unreasoning bias against governmental action.

We are concerned that if Federal resources are concentrated on a new and massive treatment program, this would inevitably deter Congress from continuing to support adequately these other essential activities.

With that, Mr. Chairman, I would like to make some brief comments specifically about health care of the aged.

In analyzing the various solutions to this problem that have been offered, the American Dental Association has held to three basic principles:

1. Any person in need of health care is entitled to receive it, irrespective of his ability to pay.

2. Whatever programs are enacted to provide health care to those unable to afford it should be so designed as to include a method of determining who is in need and who is not.

Such a determination need not and should not be made in a way that demeans or humiliates anyone, but those who have the resources to be self-reliant should be expected to be self-reliant.

3. The principle of subsidiarity should be observed in enactment of any program. This principle merely means that there resides in the family, the community, the State and the Nation—in that order—the primary obligation for provision of care.

Only in this way can the most accurate judgment be made as to the needs that exist. An extension of this principle is that the community and the State must have an active and meaningful role in any program so established.

The proposed amendments to H.R. 11865, which would in varying ways place health care of the aged under Federal social security, clearly violate these principles in two important ways:

1. They would extend care arbitrarily to an entire segment of the population without regard to individual need. Strictly from a standpoint of logic, if it is proper for the Government to provide health services for one segment without regard to need, then it would be proper to provide such services for any or all other segments. Certainly, there are persons in all age groups within our society who for one reason or another do not receive adequate health care.

For example, we know that there are children who do not receive adequate dental care because their parents cannot afford it. Such children are entitled to assistance, but it does not follow that a massive Federal health benefits program should be established which would also include the many millions whose families are self-sufficient.

2. They would, without real justification, place the prime responsibility on the Federal level, completely bypassing the community and the State. We believe it is the community and the State that can best judge the needs that exist in their localities and most efficiently tailor a program to fully meet those needs.

There are, of course, other objections to the social security approach. For example, such proposals have as a premise the conviction that the aged health care problem is a permanent one that will enlarge in years to come. In all probability the direct opposite is true.

When a man who is 65 this year began his working career, this was a very different country. There was no social security system; there were few pension, retirement plans, or private annuity programs; health insurance was unknown.

Today, obviously, all this has changed and the young and middle aged of today will enter their retirement years with considerable protection in terms of cash income and health insurance coverage. What is more, every indication is that this trend will intensify rather than diminish.

Proponents of the social security approach underestimate voluntary health coverage, which has increased remarkably in recent years. More than half the people now over 65 have some form of coverage. And, it may be noted, we are for the first time witnessing a soundly established and growing system of prepaid dental insurance both on a nonprofit and commercial basis.

It is true that the private sector alone will, in the opinion of the American Dental Association, be unable to meet the full problem. Governmental assistance is necessary. Such assistance is presently available by means of the Kerr-Mills law, which the association strongly supports.

Admittedly, the Kerr-Mills program is not free from defects. Certainly, it needs fuller and more imaginative implementation by the States and perhaps perfecting amendments are needed. Even in its present form, however, it has demonstrated its ability to solve a substantial portion of this problem without embarking the Nation on an irreversible course that would distort the proper role of the Federal Government.

Since this Nation began, the private practice of medicine and dentistry has been the accepted method of providing health care to the citizenry. That it constantly needs to adapt itself to changing conditions is true. And it is doing just that at the present time.

Such programs as Kerr-Mills assist and supplement this effort of the private sector to meet new problems. A compulsory program un-

der social security, on the other hand, would completely transform our traditional health care system despite its long record of success and would do so at the very time when it is proving its ability to meet new challenges.

It is the hope of the American Dental Association, Mr. Chairman, that this committee will reject the various amendments to H.R. 11865 which would place health care of the aged under social security.

On behalf of the association, may I thank you for your courtesy in hearing us.

(The full prepared statement follows:)

STATEMENT OF THE AMERICAN DENTAL ASSOCIATION ON PROPOSED AMENDMENTS TO H.R. 11865, RELATING TO HEALTH CARE FOR THE AGED

The American Dental Association is deeply concerned with the problems inherent in the profession's efforts to make dental care available to every American, including those 65 and older. A major objective of the association is to assure that dental care is available to all our people without regard to income, geographic location, or any other factor.

The association has supported many Government and private programs designed to improve the quality and availability of dental health services. We have long recognized that the Federal Government has a legitimate and necessary role in improving health care standards for our people, and over the years we have supported many legislative proposals involving the participation of the Federal Government.

Many of the recommendations contained in the health message sent this Congress by the late President Kennedy are well conceived and the American Dental Association has actively supported them. We were particularly pleased by the legislation enacted in 1963 to increase the number of professionally trained health personnel. We believe that legislation such as the community health bill enacted in the last Congress and the mental health bills enacted this year are additional factors leading to the solution of our overall health problem.

Further, we recognize that the health care problems of the aged require attention. We do not believe, however, that the problem is of such dimensions as to justify any of the amendments to H.R. 11865 which are before you. These measures would establish a vast and irreversible federally administered program providing health services for a large segment of the general population irrespective of need.

We believe that the health care problems of the aged can and should be solved by less drastic methods which would neither distort nor detract from the traditional role of the Government in the provision of health services for our people. Two general points can be made in support of this contention.

First, that our sole concern is with the health care amendments to the legislation under consideration by the committee. It is only in this area that we feel competent to offer evidence and opinions that might be helpful in the committee's deliberations. Everything else is subsidiary to our major purpose, which is to maintain and improve the health standards of our fellow citizens.

The second point is that objective and exhaustive analysis of the approach common to the various amendments convinces us that such an approach is imprudent and not in the best interests of the American people.

While respecting the honest concern and the competence of those who support these measures, the American Dental Association is more convinced than ever that enactment of such legislation would seriously distort the proper role of the Federal Government in regard to health matters, would inhibit the further improvement of our Nation's health standards—already the highest in the world—and would not solve the problem they are supposed to meet.

In essence, these amendments would provide limited hospital and nursing home benefits to OASDI beneficiaries and other people 65 years of age and over. Such benefits would be provided by the Government without regard to the economic needs of the recipients.

Even though some aged persons require hospitalization in order to receive treatment for acute dental conditions, we are aware that dentistry is involved only to an incidental degree in the pending proposals. Despite disclaimers to the contrary, however, we believe it is is only realistic to expect that were these amendments enacted, it would mark the first step on an inevitable broadening

both with respect to benefits and coverage. The pattern for such extension can be seen in the history of the present OASDI law.

Strictly from the standpoint of logic, if it is proper for the Government to provide health services for one segment of the general population without regard to need, then it would be proper to provide such services for any or all other segments. Certainly, there are persons in all age groups within our society who for one reason or another do not receive adequate health care.

For example, the dental profession has long concentrated much of its attention on the dental health of children. This is because it is with children that the dentist can most effectively establish sound oral health and thus prevent much serious disease from occurring during adulthood and old age. From direct experience, we know that there are children who do not receive adequate dental care because their families cannot afford it.

Certainly, such children are entitled to assistance. But does it follow that a massive Federal health benefits program should be established which would also include the many millions whose families are self-sufficient?

We do not believe such an approach to be professionally or economically sound.

Relative to the importance of children's dental health, it is worth noting that since Britain began its national health program, there has been a concentration on restorative care for adults and a consequent neglect of preventive care for children.

The foregoing points up just one of the questionable assumptions underlying the amendments under discussion, that an entire age group should be set apart and receive special benefits because some—but far less than all—of its members are in need.

There are other premises behind them that in our opinion are equally questionable. One of these is the failure to recognize that the problem in its present dimensions is transitional. A man who is 65 this year probably began his working career in 1916 to 1920. This was a very different country then. There was no social security system; there was little in the way of pensions, retirement plans, or private annuity programs; health insurance was virtually unknown. Furthermore, today's elderly citizens lived out part of their middle years in the midst of a worldwide depression which undoubtedly limited their ability to provide for their retirement.

Today, obviously, all this has changed. We now have social security, widespread pension and retirement plans, and rapidly growing voluntary health insurance that can be carried into the retirement years.

In fact, a great many of the middle aged today, not to speak of future generations, will enter their retirement years with considerable protection in terms of income and health insurance.

It is not necessary for us to recount the remarkable progress that has been made in recent years in extending voluntary health insurance coverage to the aged and others. More than half the elderly now have some form of such coverage. In passing, it might also be noted that we are witnessing for the first time a soundly established and rapidly growing system of prepaid dental insurance both on a nonprofit and commercial basis.

These amendments, then, propose a permanent solution for a problem that very probably is temporary. They ask the Nation to transform the health care system that has served it so well at the very moment when it is demonstrating its ability to cope with this problem.

We believe, also, that the proponents of these amendments fail to recognize the impact the Kerr-Mills program has had and will continue to have.

In our view, Kerr-Mills has had a gratifying amount of acceptance in the short space of 3 years.

Having had some experience with the difficulty of obtaining passage of legislation at the State level and, indeed, the National level, we do not feel that adoption of authorizing legislation by 38 jurisdictions is a record of failure. Thirty-four of these jurisdictions have programs in operation. It is especially significant to note that among these jurisdictions are those having the majority of aged people in this country.

Admittedly, the Kerr-Mills program is not free from defects. It needs perfecting amendments by the Congress and fuller and more imaginative implementation by the States. But we believe it has demonstrated its abiilty to solve a major portion of this problem without embarking our country on an irreversible course that would distort the proper side of the Federal Government in the health field.

Within this framework of legitimate Federal participation, there is much that can and should be done.

The 88th Congress wisely recognized this in late 1963 when it passed the Health Professions Educational Assistance Act to help provide the facilities and manpower needed by an expanding and increasingly health conscious American public.

In this connection, we have grave doubts that present facilities and manpower can deliver the benefits envisioned in the proposed amendments to H.R. 11865 without neglecting needs equally pressing as those of the aged. In particular, we have noted references to the apparent lack of adequate nursing home facilities making it necessary to utilize expensive hospital beds for persons requiring less intensive care.

Congress on repeated occasions has recognized and acted to stimulate and complement State, community, and private efforts to improve our health care system. In hospital construction, in expansion of community health services and facilities, in health research, in specific disease and general public health programs, and in many other areas, Federal participation has provided inestimable benefits in improving health standards. There are other programs, too, which should receive attention from the Congress.

At the present time, the American Dental Association is seeking Federal legislation to strengthen State dental public health programs by providing, in the existing program of grants-in-aid to State public health departments, a categorical appropriation for dental disease. A bill (S. 1208) has been favorably reported by the Senate Committee on Labor and Public Welfare. Representative Oren Harris has introduced a parallel bill (H.R. 4582). The Special Committee on Aging of the Senate has commented on this legislation as follows:

"Enactment of either of these measures would aid substantially in the development of State and local programs to facilitate the provision of dental services to the institutionalized and homebound aged. Important elements of such programs could be the acquisition of portable dental equipment and the training of dentists in the technique of providing dental care to persons who, because of physical debility or other reasons, are unable to receive treatment under conventional methods." ("Developments in Aging—1959 to 1963," a report of the Special Committee on Aging, U.S. Senate, 88th Cong., 1st sess., p. 40.)

We recognize that the legislation just described is not within the purview of this committee, but it does serve to illustrate one of the positive approaches that the Federal Government can take in improving the health of the aged without endangering the existing system of providing health care.

More than passing mention should be made of the Federal Government's tremendous contribution in the field of health research. This program is devoted almost entirely to prevention of disease and thus benefits every segment of our society. The Government also sponsors a wide range of public health programs that are necessary and appropriate.

Its on-going commitments in these programs are large, and legitimate demands for expansion and improvement of them are not likely to diminish.

The association is fearful that concentration of Government resources on a new and massive treatment program will prevent it from continuing to support adequately these essential activities, in addition to diverting manpower.

The committee has heard testimony from various witnesses relating to the cost involved in implementing any one of these amendments. This aspect of the bill is not within our area of expertise, but we would comment that in our experience with other Government treatment programs, the pattern has been as follows: First, the Government overcommitted itself; it promised more than it could deliver. Second, costs were underestimated. Third, services or fees for services or both were cut, usually by laymen concerned with the budget rather than with the adequacy of care. Fourth, many practitioners withdrew from the program, freedom of choice evaporated, quality of care degenerated and patient-beneficiaries became dissatisfied and disillusioned. This sequence of events occurred in connection with the so-called Veterans' Administration hometown dental program which was instituted after World War II and which finally, after much bitter experience, was revised by a law enacted in the early 1950's.

We believe that once the Government embarks upon a program of this kind—providing health care to a segment of the general public without regard to need—it is reasonable to expect that eventually, the entire population will be included. The dental profession is concerned that such a consequence is inherent in these

amendments and that it would be to the ultimate detriment of both the recipients and the providers of health services.

The dental profession is greatly disturbed over the real probability that programs of the type embodied in these amendments may be extended until the Government becomes the sole purchaser of all health services. The doctors of dentistry in this country are with good reason concerned that under the domination of one giant consumer, there will be a loss of the independence and integrity that characterize and are essential to the acceptable practice of any profession.

In the case of practitioners of the healing arts, such a condition cannot help but result in an encroachment upon the professional judgments that must be made in the best interests of patient care; it cannot help but destroy the independence of professional judgment that has produced unequaled excellence in dental and medical treatment and care in this country.

The dental profession is confident that there are means of putting adequate health care within the reach of all those in need, including the needy aged, without resort to a system that we are sure will lead to a crippling of private professional practice and, in turn, to a lowering of general standards of health care.

Finally, the American Dental Association would like to make clear that it has the utmost respect for the sponsors of the various amendments to H.R. 11865 in their desire to meet the health care problems of the aged. We share their objective but respectfully submit that their solution is neither prudent nor necessary.

We recommend that the committee reject all amendments to H.R. 11865 which would place health care of the aged under social security.

The CHAIRMAN. Thank you, Dr. Kerr.

(The committee will adjourn until 10 o'clock tomorrow morning.

(By direction of the chairman, the following are made a part of the record:)

INDIANAPOLIS, IND., *August 3, 1964.*

Senator HARRY BYRD,
Senate Office Building,
Washington, D.C.:

The following telegram is being sent to Senators Hartke and Bayh:

Indiana State Dental Association joins with the American Dental Association to oppose legislation which would provide for health care of the aged under social security. We request you to vote "no" on any such proposal.

E. E. WADDELL,
President, Indiana State Dental Association.

STATEMENT BY ARTHUR S. FLEMMING, VICE PRESIDENT, NATIONAL COUNCIL OF THE CHURCHES OF CHRIST IN THE U.S.A., ON HOSPITAL AND NURSING CARE FOR THE AGED (SOCIAL SECURITY AMENDMENTS OF 1964)

My name is Arthur S. Flemming, of Eugene, Oreg. I am vice president of the National Council of the Churches of Christ in the U.S.A., president of the University of Oregon.

The National Council of Churches does support, in principle, the proposed extension of the social security program to uncovered groups in our national life.

However, without the addition of a hospital and nursing insurance feature, the proposed social security amendments of 1964 will be of very little help to our older citizens.

The proposed 5-percent cash increase in social security checks to those who are covered will be promptly removed from the pockets of many older people by unexpected hospital bills; the maximum monthly individual benefit increase of $6.40 which a 5-percent increase would provide is not enough to buy adequate private health insurance protection and it would not begin to cover today's hospital bills.

The only way to put more money into the pockets of older people is to protect the retirement income, savings, and equities they already have against the extra heavy burden of medical, hospital, and nursing care costs in old age. This will require social security-financed hospital and nursing insurance along with strengthened private insurance protection.

The general board of the National Council of Churches first adopted a general position entitled "The Churches' Concern for Health Services" on February 25, 1960. The following year, on February 22, 1961, a more specific position relative to the medical needs of the aged was adopted entitled, "The Economics of Medical Care for the Aged." Copies of these two position statements are attached for inclusion in the record of this hearing.

In the latter general board statement we read:

"To the extent that Christian duty can be discharged by the assumption of individuals, family, and group responsibility and without resort to governmental action, this is to be preferred.

"On the other hand, where needs of people can be met only by united, socially planned action, the Christian will choose such action rather than the neglect of basic human need."

Several studies have pointed out the need for insurance protection for the aged. Nine out of ten people 65 and over will go to the hospital at least once in the future. The typical aged couple will average over four hospital admissions after age 65. One out of every six aged persons will enter a hospital in any given year. Added to this, we know that when an older person goes to the hospital he will, on the average, stay twice as long as a younger person because he is more likely to have serious and long-lasting illnesses. People over 65 are in hospitals, on the average, over 2½ times as much as younger people, and their hospital bills are twice as large.

The great need for hospital care imposes an intense strain on the financial resources of older people. Half of the aged who are single have annual incomes of less than $1,000, and half the aged couples receive less than $2,500 a year. Roughly, half of the people over 65, moreover, have less than $500 in assets that can readily be turned into cash; over one-third of them have less than $100.

The latest estimate of the Health Insurance Association indicate that 54 to 55 percent of our 17.4 million citizens over age 65 are covered by some form of private health insurance. However, many of the policies they do have provide for small benefits under limited conditions and at high cost.

With regard to the hospital and nursing care needs of our older citizens, the conclusion appears unavoidable that private, nonprofit, and commercial insurance programs cannot meet the full need alone. Therefore, the National Council of Churches continues to support in principle legislation which will extend the benefits of old-age, survivors, and disability insurance to include adequate health care for the aged. The National Council of Churches also supports the maximum utilization of private, nonprofit, and commercial hospital and nursing insurance for the aged. To help our older people meet their heavy medical expenses, a combination of both private and social insurance coverage is needed.

When the United States first established the old-age and survivors insurance program under the Social Security Act of 1935, fear was expressed that the social insurance program would weaken the private and commercial insurance industry. Exactly the opposite happened. It is reported that from 1940 to 1961, life insurance in force grew from $115 to $685 billion. No one today seriously suggests that private and commercial insurance alone could provide the basic protection which old-age, survivors, and disability insurance provides even for the poorest family.

The 1961 national council resolution calls attention to two human values that are inseparable from the economics of medical care and we cite them here.

"(1) Quality of care: While high-quality medical care has been achieved under a number of different methods of payment, it is unrealistic to think that quality is ever completely separable from the economics of medical care. The national council urges that in the development of prepayment and insurance plans—under both private and public auspices—careful attention be given to arrangements which give maximum encouragement to the highest quality of care and the enhancement of the best relationship between physician and patient.

"(2) Individual dignity and freedom: Government participation in any welfare program does not necessarily involve loss of individual freedom or affront to personal dignity. In some circumstances, indeed, individual freedom is enhanced by the utilization of government to achieve a social goal, though it is obvious that such enhancement does not come about automatically. As the instrument of government is employed by a free people, they must be ever vigilant to guard their freedoms. In planning and developing any Government insurance program to help older people meet the cost of their medical care,

there is a Christian obligation to include provisions for its administration that will adequately safeguard freedom, dignity and self-respect."

FORCING THE AGED INTO INDIGENCY

Private and social insurance annuities now provide most older people with a measure of financial independence and economic security. We cannot allow the dignity which goes with self-reliance to be eroded by the increasing costs of illness in old age. Yet this is exactly what is happening. Many older people are being forced into financial helplessness by hospital, nursing, and medical bills which have eaten up most of their savings, the equity in their homes, and their credit. From a recent report of the Department of Health, Education, and Welfare we note the following fact: "In the first half of 1961, just about every third person approved for old-age assistance needed it directly or indirectly as a result of health difficulties. Among recipients getting the assistance to supplement OASI benefits—generally those with the greatest economic resources of their own—the proportion obtaining assistance on account of medical needs was as high as 2 in 5." [1]

Cash assistance from appropriated tax funds for the indigent older person who has no social security coverage is better than nothing; but direct relief is a poor substitute for private and social insurance protection available as an earned right, before one is reduced to penury.

SELF-RELIANCE AND SELF-RESPECT

The National Council of Churches supports both private insurance and prepaid social insurance in principle because they can safeguard the financial independence, self-reliance, and dignity of our older citizens. The moral and ethical basis for this preference is clear and quite compelling.

In prepaid hospital and nursing insurance, through the social security system, each individual contributes to an insurance fund during his working years which gives him paid-up social insurance protection at age 65. In case of illness, these funds are then his by right while he is still financially independent, not after he has been reduced to indigency.

The National Council of Churches commends to the Committee on Finance of the U.S. Senate the appropriate implementation, through the social security system, of this principle of contributory insurance protection for our older citizens.

RESOLUTION ON THE ECONOMICS OF MEDICAL CARE FOR THE AGED

A resolution unanimously adopted by the General Board of the National Council of the Churches of Christ in the United States of America, February 22, 1961

The good news of God's redeeming love and saving power, declared in the teaching of Jesus Christ was proclaimed in His concern for suffering and His ministry of healing. From the beginning, Jesus went directly to the sick and suffering. To all who came or were brought to him, he expressed his loving concern for the health of body, mind, and spirit. This divine concern has received repeated emphasis in Christian life and teaching. The Apostle Paul wrote that the strong should bear the burdens of the weak.

Through the generations Christians have turned to the victims of disease with increasing concern and at the same time have sought resources which might bring healing power to the sick. Consciously or unconsciously sharing God's purpose that mankind should have health, a ministry of healing has become an inherent aspect of a civilized and humane society.

As new health needs have appeared, new resources have been discovered for meeting them. In our day, as the number of aged persons has increased, there are among them many men and women who require financial assistance if they are to have physical and mental health and that spiritual health which may be dependent thereon. On their behalf today, ways should be sought and found to

[1] "Background Facts on the Financing of the Health Care of the Aged," Special Committee on Aging, U.S. Senate, May 24, 1962, p. 8. (Excerpts from the report of the Division of Program Research, Social Security Administration, Department of Health, Education, and Welfare.)

further the will of God once so clearly made manifest by Jesus Christ that men and women should be enabled to enjoy health.[1]

For the Christian, means are as important as are ends; but no more so. In our endeavor to achieve Christian ends we must choose those methods best calculated to develop and maintain Christian character and relationships.

No method is better suited to do this than sharing the unpredictable incidence of the cost of medical care through the various mechanisms of mutual aid that have been developed. The most widely accepted of these is the mechanism of insurance—both private and public.

To the extent that Christian duty can be discharged by the assumption of individuals, family, and group responsibility and without resort to governmental action, this is to be preferred.

On the other hand, where needs of people can be met only by united, socially planned action, the Christian will choose such action rather than the neglect of basic human need.

Therefore, we should seek to bring the blessings of modern medical care within reach of all by nongovernmental action to the extent that such methods can accomplish this. But we should not fail to support governmental action in circumstances where other methods are clearly inadequate or impossible.

On the average, American families spend nearly $300 a year for health purposes. Most of this money is spent to secure hospital and physician services, medicines, and prosthetic and other appliances after illness has already become serious. Comparatively little of it is spent for the maintenance of optimum health. This contributes substantially to demands on hospital facilities and to a lower level of general health and well-being than could be had by a wiser and more orderly expenditure of the same amount of money for preventive care. The rapidly rising cost of modern medical care puts it beyond the ability of most retired persons and low-income families to purchase such care on an emergency fee-for-service basis.

A very wide variety of nongovernmental efforts have been and are being made to meet this problem of medical economics. They range from indemnity health insurance provided by commercial insurance companies to prepayment, group practice health plans providing comprehensive, including preventive, care for nearly all the health needs of their subscribers through teams of physicians which include specialists and general practitioners.

The voluntary sharing among groups of people of the risks and hazards of illness, and the voluntary pooling of some of their funds to meet the cost of care for any in their group who may need it is indeed a Christian approach to this problem, whether this method is utilized by churches, labor unions, industrial managements, fraternal organizations, cooperatives, community groups, or by subscribers for health insurance. The National Council of Churches commends it and urges its widest possible application.

It is noteworthy, however, that the cost of health care and consequently of health insurance is rising so rapidly as to make it difficult for the average family to afford adequate coverage for its comprehensive health needs. While some 73 percent of the American people have some form of health insurance, nonetheless, only 25 percent of the total private medical expenditures are paid from such insurance.

About 4 million Americans who are today obtaining comprehensive medical care from group practice or other direct service health care prepayment plans pay for it by monthly subscription premiums amounting to less per year than the average $300 per family annual expenditure. It appears that one method of making the best of modern medical care available to more and more people lies in a rapid growth and expansion of voluntary health plans of this character.

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[1] The general board of the national council has already made clear its concern for the provisions of adequate standards of health care for all and for the cooperation of both private and public agencies in their maintenance as follows:

(1) "Christians should work for a situation wherein all have access at least to a minimum standard of living. Such minimum should be sufficient to permit care of the health of all and for suitable protection of the weaker members of society, such as * * * the aged." (Pronouncement on "Basic Christian Principles and Assumptions for Economic Life," adopted Sept. 15, 1954.)

(2) "The churches' concept of man * * * imposes a more fundamental obligation for the furtherance of health. Therefore, the availability and financing of medical care of high quality is of deep concern to the churches. * * * If voluntary prepayment plans cannot accomplish the desired ends, government should protect the health of the people by making possible the prepayment of health service." (Pronouncement on "The Churches' Concern for Health Services," Feb. 25, 1960.)

There are, however, certain groups in the population for whom even their ordinary medical needs cannot be met by voluntary prepayment plans, namely, low-income families and most people 65 years of age or older. Eighty percent of persons with family income of $5,000 or more have some form of health insurance, but only 33 percent of those with family income under $3,000. Only 35 percent of persons 65 or more eyars of age have any health insurance.

Voluntary health plans are unable to offer coverage for even a fraction of health care needs at charges either of these groups can possibly afford. Eighty percent of people 65 years of age or older have annual incomes of less than $2,000; about 60 percent, incomes less than $1,000. At least 7.6 million older people have liquid assets of less than $500. Yet 77 percent of people 65 years of age and older have chronic ailments, and the percentage increases to 83 percent for those 75 and older. The group 65 and older now require, for less than optimum health care, more than twice as much hospitalization per person as is needed by the rest of the population, and they spend on the average twice as much for health care as does the population as a whole.

Full advantage should be taken of recent amendment to title I of the Social Security Act which offers Federal funds to improve State medical care programs for aged persons on public assistance rolls and also provides matching funds for States desiring to aid medically needy older people not now on relief rolls but able to pass a means test as a condition of eligibility. This program offers the States opportunity to provide help for older persons at the bottom of the economic scale. However, it does not offer aged persons of moderate means and many of low income any solution to their problem.

About three out of every four policyholders in voluntary group prepayment plans are completely excluded from coverage upon retirement, and studies indicate that less than 5 percent can convert to individual policies without reduction in benefits. The voluntary prepayment plans, necessarily based upon experience rating, discriminate against high-risk groups and are not geared to the problems of chronic illness characteristic of old age. Policies commercially written for older people are not only beyond the means of most, but they are not based upon a philosophy of preventive medicine and optimum health, nor do they include provisions for diagnosis, followup, and restorative medicine.

As previously noted, the general board has stated, "If voluntary prepayment plans cannot accomplish the desired ends, Government should protect the health of people by making possible the prepayment of health services." This is precisely what the social security system would be able to provide efficiently through the mechanisms of old-age, survivors, and disability insurance. Therefore, the National Council of Churches supports in principle legislation which will extend the benefits of old-age, survivors, and disability insurance to include adequate health care for retired aged persons.[2]

There are human values that are inseparable from the economics of medical care. Two call for special consideration:

(1) Quality of care. While high quality medical care has been achieved under a number of different methods of payment, it is unrealistic to think that quality is ever completely separable from the economics of medical care. The national council urges that the development of prepayment and insurance plans—under both private and public auspices—careful attention be given to arrangements which give maximum encouragement to the highest quality of care and the enhancement of the best relationship between physician and patient.

(2) Individual dignity and freedom. Government participation in any welfare program does not necessarily involve loss of individual freedom or affront to personal dignity. In some circumstances, indeed, individual freedom is enhanced by the utilization of government to achieve a social goal, though it is obvious that such enhancement does not come about automatically. As the instrument of government is employed by a free people, they must be ever vigilant to guard their freedoms. In planning and developing any government insurance program to help older people meet the cost of their medical care, there is a Christian obligation to include provisions for its administration that will adequately safeguard freedom, dignity, and self-respect.

The counsel, cooperation, and active participation of the medical profession and other health workers in both planning and execution of a government health

[2] In its pronouncement on "The Churches Concern for Public Assistance," adopted June 4, 1958, the general board stated: "The National Council of Churches affirms that the use of social insurance as exemplified by old-age, survivors, and disability insurance is to be preferred to economic dependence upon the public assistance programs."

program are essential. The values to be realized from an improved level of health for America's older citizens are so great that we are confident that cooperation will be forthcoming from all who in our day are custodians of the almost miraculous capacity to maintain the health and cure the diseases of their fellow human beings.

In the light of the above concerns the general board authorizes representatives of the national council to testify at public hearings along the lines herein indicated.

The Churches' Concern for Health Services

A pronouncement unanimously adopted by the General Board of the National Council of the Churches of Christ in the United States of America, February 25, 1960

Churches have a major role in the development of health services. Health and holy are words with a common origin akin to whole, sound, hale, and well. Their close relationship in Christian history stems from the life and work of Jesus Christ who "went about all Galilee teaching in their synagogues, preaching the gospel of the kingdom, and healing every disease and infirmity among the people."

Through the centuries, even to this day, Christians have been constrained to show forth the love of God not only by preaching but also by healing. Society has frequently been alerted by the churches to meet health needs. Churches have nurtured a large proportion of the persons engaged in the health professions. Extensive health services have been developed and maintained by churches in this Nation and abroad. Through all their activities in the field of health, churches have aided men more fully to render service to God and their fellows and have expressed the Christian faith in love.

Health is not merely the absence of disease and infirmity, but is a state of physical, mental, social, and spiritual well-being. The churches have a continuing concern for all aspects of health, for the well-being of the whole man and the whole community of men. Therefore, churches are urged to work in the community, the Nation, and the world toward (1) promotion of positive optimum health, (2) prevention of disease and disability, (3) treatment and alleviation of disease, and (4) rehabilitation of all persons with disabilities.

Furtherance of Health

Churches should help their members become aware of health needs. They can promote health by supporting programs which raise standards of living, foster wholesome family relationships, and assist people in developing their capacities. The activities of the churches in pastoral care, Christian education and action, missionary work at home and abroad, social welfare, and world service are among many which encourage healthful living in this Nation and abroad. Health education, usually centered in public health services, voluntary health organizations, and the schools is also a responsibility of church-related health and welfare agencies and should receive attention and support from the churches.

The health of individuals is of deep concern, but Christian responsibility also extends to the public health. Prevention of disease and accidents through such measures as control of the environment, immunization, optimal nutrition, and the practice of principles of healthful living is of paramount importance. Maximum prevention requires support of sound and effective public health programs under both voluntary and governmental auspices.

When disease or disability has occurred, early detection, accurate diagnosis, prompt comprehensive medical care of good quality, and concurrent rehabilitative procedures should be available to all people, without regard to race, religion, ethnic background, or economic circumstances.

Adequate support of public services by church members is necessary to insure basic services of sufficient quality and quantity to meet the needs of the whole community. Economic and manpower aspects of modern health services are of such complexity and magnitude that it is incumbent upon all health agencies, both public and voluntary, to recognize that joint efforts and broad community planning are essential.

SPECIAL CONCERNS

Mental health

The increase in the incidence of mental illness in this generation is alarming. Mental and emotional aspects of all health services and problems demand special consideration by voluntary and governmental agencies. Preventive measures, early detection, more effective treatment, and rehabilitation should be subjects for expanded programs of research directed by professionally trained personnel.

Religion has contributed significantly to the maintenance and recovery of mental health, especially as the assurance of the love of God and fellow men has been imparted by churches to individuals needing recognition and acceptance in an unsettled world. The relation of religion to mental health should be a subject of continuing study.

The churches' contribution should also include participation in cooperative community planning, furtherance of sound community and church-related programs conducive to mental health, and support of more adequate and extensive treatment facilities, including psychiatric care.

Financing of health services

It is now widely recognized that the health of people is an important national resource, and, therefore, Government has increased its responsibility for the maintenance of optimum health. The churches' concept of man, centering upon his creation and redemption by God for a divine purpose, imposes a more fundamental obligation for the furtherance of health. Therefore, the availability and financing of medical care of high quality is of deep concern to the churches.

With the rising cost of medical care, serious or extended illness has imposed economic burdens which are beyond the capacity of many individuals and families to meet from current income. There is need for churches and church members to study the economic aspects of health services. Experimental patterns of health service, such as group health programs under the auspices of labor, management, or other responsible voluntary associations of people, deserve encouragement. Flexibility on the part of all health professions and the public; willingness to try new methods; cooperative planning, analysis, and evaluation are required to meet the needs of people.

Continued growth of prepayment methods shows promise of insuring high quality of medical service. The churches should encourage the inclusion of mental, dental, nursing, and other health services in programs of prepaid care, and the extension of the amount and kind of care available to retired and other aged persons and to persons living in rural areas. If voluntary prepayment plans cannot accomplish the desired ends, Government should protect the health of the people by making possible the prepayment of health services.

Health facilities, hospitals, and nursing homes

The traditional and vital role of church-related hospitals and other health services must be maintained and strengthened. It is especially incumbent upon the churches to seek out and help communities which cannot provide adequate health services, and to give sufficient financial support to church-related programs, including hospitals and nursing homes, to enable them to pioneer in meeting health needs. Church members should also support hospitals and services which are not church related.

Churches should insist upon the establishment and observance of high standards of care in all health facilities, especially in those which are church related. In all phases of their operations church-related facilities should reflect the Christian view of the dignity and eternal worth of every person, and the spiritual ministry should be developed as effectively as physical and mental health services. Trained chaplaincy services should be a part of the professional team in hospitals and other institutions of healing.

Health careers

Careers in the health field provide outstanding opportunities for dedicated Christian service. Christian motivation can increase substantially the effectiveness of health workers. Recruitment of qualified health workers should command the attention of the churches. Church-related schools and colleges have particular responsibility for both recruitment and training. The need is not alone for doctors and nurses, but also for many types of paramedical personnel, including dieticians, physical and occupational therapists, and attendants and aids in general and mental hospitals.

Some church-related hospitals are major training institutions for health workers, especially for physicians, nurses, technicians, and social workers, as well as theological students and chaplains. Their teaching facilities and methods should periodically be evaluated by persons with professional competence and responsibility. Training programs are needed, but they should not be financed as part of the cost of medical care. Other sources of financing must be made available, both within and outside the churches.

Volunteer services

Volunteers, both professional and lay, contribute significantly to health services. Physicians particularly have provided medical services for the economically underprivileged.

Acute shortages of health workers, including nurses, have made lay volunteers essential for the current operation of many health facilities and the provision of significant personal services to patients. In general and mental hospitals, nursing homes, and other facilities for the chronically ill and the aged, volunteers have made unique contributions. Volunteer home visitors and home helpers are also assuming increasing importance with the national growth in the number of older persons and the development of home-care services for the chronically ill.

The need for volunteer service is great and offers Christians unparalleled opportunities to witness for Christ with deeds of love and mercy. Local churches should assume a significant portion of the responsibility for recruitment, transportation, training, and sustained organization of volunteer services.

International health services

International health and wholesome international relationships have been advanced by generations of Christian health workers. The need continues with appropriate adjustments in organization and methods as changes occur throughout the world. The work of the mission boards is now supplemented by relief and rehabilitation services rendered through denominational and ecumenical agencies on the national and world levels. Health work, pioneered by Christian missions, has in recent decades been extended by other world agencies, including technical units of the United Nations and of national governments. Both church-related and other international health programs are worthy of strong support from the churches and their members.

Christians should be encouraged and trained to participate directly in voluntary and public programs. Important potentialities for Christian service by churches and church-related agencies may be found in the provision of technical training and Christian experience in connection with the education in this country of students from other nations.

Because world economic and scientific developments profoundly affect the health of millions of people, Christians should be increasingly concerned for programs of mutual aid, both governmental and voluntary. Increasing concern of the churches should also be expressed in relation to such problems as rapid population increases and developments in nuclear science which affect human health.

Health problems at home and abroad offer abundant opportunity for churches and church members to show forth the continuation of the acts of God as supremely revealed in the love and compassion of Jesus Christ.

SILVER SPRING, MD., *July 8, 1964.*

SENATE FINANCE COMMITTEE,
Washington, D.C.

DEAR SIRS: As per suggestion of the Honorable Harry F. Byrd, I would like to have my views on social security put before the above committee.

I feel that a married man should be allowed to earn more than $1,200 a year, for the following reasons:

We have been married 43 years and my wife has not worked in all that time.

Now, at the age of 65 she has to work to supplement our income so that we could live at least halfway decently.

I feel that a bachelor or widower, receiving the full amount of social security plus $1,200 a year he is allowed to earn, may get along, but for a married man, that is impossible.

My wife, due to the fact that she has not worked in 43 years, is inexperienced, besides not being in the best of health, cannot find a part-time job, and from personal experience for myself, I found it very tough to find one for myself.

I worked for Peoples Drug Co. but was let out because I could not work the hours they wanted me to.

In fact, because I made $110 for the month of October 1963, I lost a month's check of $176.

It is my feeling that a married man, whose wife, due to inexperience, or ill health, is unable to work, should be allowed to earn $2,600 a year or $50 per week, because there are 52 weeks in a year, not 48, which limits a retired man to less than $25 per week.

Hoping you will give this idea full consideration, I remain,

Yours truly,

MARCUS DONNENFELD.

PETERSBURG, VA., *July 29, 1964.*

Senator HARRY F. BYRD,
U.S. Senate,
Washington, D.C.

DEAR SENATOR BYRD: My last correspondence with you was May 19, 1964, regarding social security limitations on the earnings of widows with children. Since then, the Honorable Watkins Abbitt has introduced a bill (H.R. 11568) which is still in the committee.

Yesterday the House passed bill H.R. 11865 which raised social security benefits 5 percent and has various other amendments, but nothing has been mentioned about the right to work without losing social security. Mr. Abbitt's bill (H.R. 11568) is a good one and basic in the fundamental freedom for the individual—something which has seemed to fade as our "big business" Government grows. The 5 percent increase is not enough to "take up the slack" in raising a family, and one should have the freedom of being able to earn as much as one can, without being encumbered by a ridiculous $1,200 ceiling or denied their social security. Would it not be better to take off the earning limitations than to give any increase—which will cost more to everyone and not mean a "drop in the proverbial bucket" to the individual and his budget?

However, Senator, being realistic, H.R. 11865 has passed the House and is now in the Senate—and may possibly be before the Finance Committee; therefore, would it be possible to have "mother's rights to work" amendment (H.R. 11568) incorporated into H.R. 11865, or the idea thereof?

I will be most grateful for any help you can give on this, and will stand by for advice you may have as to my future action.

Most sincerely,

IRIS E. SPACH.

WACO, TEX., *July 28, 1964.*

Mrs. ELIZABETH SPRINGER,
Chief Clerk,
Senate Finance Committee,
Washington, D.C.

DEAR MRS. SPRINGER: In lieu of appearing before the Senate Finance Committee, if and when hearings are scheduled to consider adding Medicare to H.R. 11865, the Social Security Amendment of 1964, I would appreciate this letter being presented to the Senate Finance Committee.

By all indications and considering present proposed rate and base limitations which are apparently necessary to continue the social security program, the addition of Medicare would only tend to burden the already taxed social security program. The social security tax is very burdensome because it is based on gross income and is proposed to apply to the first $5,400 income. It is suggested that State and local governments be permitted to provide Medicare based on local circumstances and conditions, if the need exists. This observation exists among numerous members of our local populous.

Your consideration will be appreciated.

Sincerely yours,

KENNETH K. KENNY.

Hon. HARRY F. BYRD,
Chairman, Committee on Finance,
U.S. Senate:

In lieu of a personal appearance, the Association for Physical and Mental Rehabilitation desires to submit the following statement for the careful consideration of your committee. It applies specifically to social security bill H.R. 11865. It is understood that such written statements of substance will be included in the printed record of the hearings.

The subject headings of this letter are: (1) Purpose, (2) Introduction, (3) Definition of Corrective Therapy, (4) Professional Status and Competence of Corrective Therapists, (5) Need for Their Services, (6) Proposal for Their Inclusion in the Bill, (7) Correspondence and Contacts, and (8) Summary.

(1) PURPOSE

The objective of the Association for Physical and Mental Rehabilitation in this legislation is to achieve equality with the other paramedical therapies.

(2) INTRODUCTION

The membership of the Association for Physical and Mental Rehabilitation is composed of corrective therapists whose livelihood is the profession of exercise therapy. They are dependent upon a nondiscriminatory acceptance of their service by Federal legislation, and for the growth of their profession.

(3) DEFINITION OF CORRECTIVE THERAPY

Corrective therapy is a medically recognized therapy and rehabilitation modality, established after World War II, and operating at present under medical supervision in the Veterans' Administration, State, and private agencies throughout every State in the Union except Alaska and Hawaii.

The function of corrective therapists is given by the U.S. Civil Service Commission in its announcement No. 290-B, dated November 20, 1962, as follows: "Corrective therapists plan, administer, and supervise medically prescribed physical exercises directed toward maintaining or improving the general state of health of the patient by preventing muscular deterioration, conserving and increasing strength, and restoring function. They guide the patients in ambulation and develop proficiency in routines of personal hygiene for bedfast patients." It should be added that corrective therapists work in the general medical and surgical, neurological, psychiatric, tuberculosis, blind, and mentally retarded areas of treatment and rehabilitation. They are particularly skilled in assisting the patient to achieve the activities of daily living such as getting in and out of bed, self-feeding, walking, personal hygiene, and other self-help procedures.

(4) PROFESSIONAL STATUS AND COMPETENCE OF CORRECTIVE THERAPISTS

Corrective therapists are recognized by the U.S. Civil Service Commission and their duties are detailed in the U.S. Civil Service Commission classifications under date of August 1961. The nucleus from which the present organization of corrective therapy emerged after World War II was referred to by Dr. Howard Rusk as "the cream of the crop." Dr. Joel Boone, when Chief Medical Director of the Veterans' Administration, considered corrective therapy "a major contribution to medicine."

(5) NEED FOR THE SERVICES OF CORRECTIVE THERAPISTS

In less than a decade more than $150 million have been invested in the construction of the 270 rehabilitation centers and workshops established under the Hill-Burton Hospital Construction Act. With this accelerated construction, it is generally recognized that the greatest impediment to the adequate rehabilitation of the handicapped in this country is the extreme lack of qualified and competent personnel, including corrective therapists. Federal legislation of a nondiscriminatory or restrictive nature must be provided to bring the full potential of the country to meet this need.

(6) PROPOSAL FOT THE INCLUSION OF CORRECTIVE THERAPY IN THIS BILL

The present wording of the bill includes the terms "physical, occupational, and speech therapy." It is proposed that the term "corrective therapy" be in-

cluded to insure authorization of their services by the physician under the specific terms of the bill.

(7) CORRESPONDENCE AND CONTACTS

Senator Yarborough, through correspondence with Mr. Ball, Commissioner of Social Security, has aided our association in presenting our views as to the wording of this bill. These communications can be summarized as follows:

(*a*) It is the contention of the Association for Physical and Mental Rehabilitation that the present wording of this bill excludes corrective therapy, since it mentions only physical therapy, occupational therapy, and speech therapy, and omits corrective therapy.

(*b*) In reply, Commissioner Ball stated that the words "physical and occupational therapy" are generic terms and, as such, include corrective therapy.

(*c*) Commenting on this assertion, the Association for Physical and Mental Rehabilitation called attention to the fact that the terms "occupational therapy" and "physical therapy" are job description titles and as such denote the specific professions of physical and occupational therapy, that a person in a hospital situation or in the community when hearing the term "physical therapy," for example, would not think of corrective therapy or of a corrective therapist.

(8) SUMMARY

In a broad sense, we feel that this legislation poses a problem challenging our democratic beliefs and principles. The problem can be illustrated by the small business attempting to find an opportunity for development of its distinctive service. The need at this time is to mention not only the older established therapies but to include and utilize these new forces and elements that are attempting to find their rightful place in the professional world.

The Association for Physical and Mental Rehabilitation requires assistance in promoting opportunities to meet the growing national need, as well as to be able to compete with the large organizations which in various ways are able to restrict the growth and development of the small organization. It is extremely vital to our existence that we receive recognition in the statutes of State and Federal legislation. Commissioner Ball contends that we are already included in the bill since the definition for physical therapy found in medical dictionaries indicates that it is an inclusive term which encompasses corrective therapy. Therefore, there is no valid reason to refuse to mention corrective therapy by name in the bill H.R. 11865.

Respectfully submitted.

JOHN B. MURPHY, *President.*

NATIONAL TAXPAYERS CONFERENCE,
Jefferson City, Mo., August 6, 1964.

Hon. HARRY F. BYRD,
Chairman, Committee on Finance,
U.S. Senate, Washington, D.C.

DEAR SENATOR BYRD: Last January, in my dual role as executive director of the Missouri Public Expenditure Survey and chairman of the National Taxpayers Conference, comprised of citizen-taxpayer research organizations located in a great many of our States, I appeared before the House Ways and Means Committee to discuss the fiscal aspects of proposals to provide hospital and nursing care services for the aged under the social security system. A copy of my statement, which was concurred in by 25 of these State taxpayer organizations, is enclosed.

The Ways and Means Committee subsequently reported and the House has passed H.R. 11865, the Social Security Amendments of 1964, currently the subject of hearings before the Finance Committee. Although the House-approved measure does not include the so-called medicare provision, it would provide for increased social security benefit payments and also for further significant increases in the social security tax burden.

Under the House-approved version of H.R. 11865, even without provision for medical care for the aged, the social security tax rate would be increased next January 1 by approximately 5 percent—from 3⅝ percent to 3.8 percent—both employee and employer, and the wage base against which the tax would apply would be increased from $4,800 to $5,400. If the House bill is enacted, the combined rate on employee and employer would rise to 9⅜ percent by 1971, on an en-

larged wage base; the employee-employer tax contribution would be increased by almost 50 percent, from $348 in 1965 under existing law to $518 by 1971.

It thus seems appropriate that we bring to the attention of the membership of the Committee on Finance as well as the entire Senate our concern over the fact that the social security tax is becoming an increasingly burdensome tax for a growing number of persons.

It is my understanding that proposals to add some form of medical care for the aged are to be advanced both within the Finance Committee and in the Senate when H.R. 11865 is up for consideration. It must be obvious to all that the compulsory "medicare" plan as proposed in the King-Anderson bill would require an additional increase in the social security tax, over and above that provided in the House bill.

It is my further understanding that one of the proposals which may be advanced would simply provide social security beneficiaries with an "option" of accepting the House-approved increase in the regular benefit, or choosing to take this increase in some form of hospital care benefit. It seems equally obvious that this is but a thinly veiled attempt to work the beginnings of the compulsory "medicare" plan into the social security structure—the "foot-in-the-door" technique. The eventual effect upon the social security tax burden—and upon the financial soundness of the system—would be no different.

For this reason, it seems to me it would be most unwise to burden the social security system with the additional costs of even limited—optional or otherwise—hospital care benefits.

In order that our views may be made known it would be much appreciated if you would have this letter, and the copy of my statement before the House committee, included in the printed hearings of the Finance Committee.

Cordially yours,

EDWARD STAPLES, *Chairman.*

STATEMENT OF NATIONAL TAXPAYERS CONFERENCE SUBMITTED BY EDWARD STAPLES, EXECUTIVE DIRECTOR, MISSOURI PUBLIC EXPENDITURE SURVEY, TO HOUSE COMMITTEE ON WAYS AND MEANS, JANUARY 23, 1964

Mr. Chairman, my name is Edward Staples. I am executive director of the Missouri Public Expenditure Survey, located in Jefferson City, Mo. I also am currently serving as chairman of the National Taxpayers Conference, which is comprised of citizen-taxpayer research organizations located in more than 35 of our States.

A number of these organizations have requested that the record of these hearings indicate that they join in the statement I am presenting before this committee, and I should like to request that the record show their concurrence. These organizations are given at the end of this statement.

Mr. Chairman, I shall not attempt in this statement to analyze or discuss in detail any of the pending proposals which are designed to establish a program of hospital and nursing services for the aged under the social security system. Rather, it is my intention very briefly to discuss the fiscal aspects of these proposals as they will affect the social security system as a whole, and to raise some questions in this area which we feel should be given consideration as the committee considers these far-reaching proposals.

When our social security system was first established, the tax rate on employees and employers was 1 percent each, applicable to a taxable wage base of $3,000. Since that time, including the increase which became effective on January 1, 1963, the tax rate has been increased seven times, until at present the rate is 3⅝ percent on both employee and employer. Under existing law two additional rate increases are scheduled: in 1966 and 1968. These will bring the social security tax rate on employees and employers to 4⅝ percent each—or to a combined rate of 9¼ percent.

In addition, it should be noted that the taxable wage base against which this tax is applied has also increased three times, and at present stands at $4,800.

In short, the tax paid by employee and employer combined has increased almost sixfold, from a maximum of $60 at the inception of the program to a maximum of $348 under present tax rates and taxable wage base.

The tax paid by the self-employed, of course, has been maintained at one-and-a-half times that of other workers—and presently is at a rate of almost 5½ percent.

Under the bill before this committee, H.R. 3920, the tax rate would be increased by one-quarter of 1 percent each on employees and employers, over and above the currently scheduled increases, and the taxable wage base against which the tax would apply would also be increased, to $5,200. Thus, if this proposal were to be enacted, on top of presently scheduled tax rate increases, the combined rate on employee and employer in 1968 would be 9¾ percent on an enlarged tax base.

The social security tax is, in short, becoming an increasingly burdensome tax for a growing number of persons. For the low-income wage earner, such increases in the social security tax might wipe out—or more than wipe out—any benefit which he would derive from the pending tax reduction bill.

We are not the only ones, Mr. Chairman, who are raising questions about the increasing burden of this tax. Former Secretary of Health, Education, and Welfare Abraham Ribicoff, now U.S. Senator from Connecticut, was quoted in an interview with U.S. News & World Report, published February 5, 1962, as saying:

"I think we have reached a state of almost maximum taxation under social security. In my mind, I place that at 10 percent of payroll. Under the tax schedule of the present act you will get up to 9¼ percent for employer and employee in 1968. You add this one-half of 1 percent for medical care for the aging under social security, and you've about hit the top of 10 percent. I don't think people will go for more than 10 percent."

In addition, a staff expert of another committee of the House suggested that the social security tax rates are a "drag" on the economy, and should be cut back. This suggestion was made in the magazine of the Institute of Economic Affairs of New York University by Mr. J. R. Stark, counsel to the House Banking and Currency Committee. While I do not agree with all his points, particularly that rising benefits should be paid out of general revenue, I do believe his statement is of significance in indicating the burden imposed by rising social security tax requirements.

Another factor which in my view should be taken into consideration is the history which has been developed over the years for expanding the coverage and increasing the benefits under this program. On at least eight occasions since this program went into effect, Congress has enacted amendments expanding coverage to new groups, and benefit increases have also been approved on a number of occasions.

That this has had some effects upon the program's financial status seems apparent. The record indicates that expenditures have exceeded receipts in the old-age and survivors insurance trust fund in 5 of the last 7 years.

Further, one of the most recent additions to the social security structure, the disability benefit program appears to be in some trouble. Expenditures from the disability insurance trust fund exceeded receipts into the fund in calendar 1962, and according to official reports, as I read them, were expected to do so again in 1963, this year, and in each of the next 3 years. The fund's trustees have made a proposal designed to put it on firmer financial footing. In this same connection, we have noted the proposal of Chairman Mills (H.R. 6688) which is designed to improve the actuarial status of the trust funds by raising the amount of taxable income for social security from the present $4,800 to $5,400. This measure, as I understand it, would also allot a proportion of the increased social security revenues to the disability fund.

Thus, we see the occasion arising for increased social security tax payments even without adopting H.R. 3920.

I believe it is fair to indicate that the pending proposal to establish a compulsory health insurance program under social security would provide for limited health benefits. If adopted, the H.R. 3920 program would be subjected to great pressures for further expansion. Experience under our social security system shows repeated broadening of its provisions, accompanied by rate increases, as I have already indicated. Demands could be expected to include larger and larger segments of the population under the medical care provisions, with each expansion accompanied or followed by rate increases, until virtually the entire population would be included. Thus, H.R. 3920 is a foot-in-the-door type of proposal. It inevitably would lead to much higher social security tax rates on employees, employers, and the self-employed.

I have also noted testimony by Mr. Wilbur Cohen, Assistant Secretary of Health, Education, and Welfare, that the earnings base for social security taxes might have to be increased as high as $7,200 under certain circumstances, even without this medicare proposal. Senator Ribicoff has said, as I mentioned, that

he doesn't think the people will go for more than a 10-percent tax on payrolls ,a level we are already approaching. These taxes are growing burdensome on many persons, and are likely to become much more so. These taxes constitute a potential, if not a present, drag on the economy. But, based on the history of the social security program, I believe it is safe to predict that if H.R. 3920 is enacted social security taxes will not only substantially exceed 10 percent of payrolls but will be applied to a considerably higher earnings base than the $5,200 a year provided in the bill.

It would be unwise to burden our social security system by the addition of this program for which large but indeterminate future costs would have to be financed, resulting in social security taxes being raised to levels that will become more burdensome to more and more persons.

The following State citizen-taxpayer research organizations join me in this statement:

Arizona Tax Research Association.
Colorado Public Expenditure Council (see brief additional comment below).
Connecticut Public Expenditure Council.
Florida Taxpayers Association.
Associated Taxpayers of Idaho.
Taxpayers Federation of Illinois.
Iowa Taxpayers Association.
Massachusetts Federation of Taxpayers' Associations.
Minnesota Taxpayers Association.
Missouri Public Expenditure Survey.
Montana Taxpayers Association (see brief additional comment below).
Nebraska Tax Research Council.
Nevada Taxpayers Association—Has also submitted a separate statement to the committee.
New Jersey Taxpayers Association (see brief additional comment below).
The Taxpayers Association of New Mexico.
Citizens Public Expenditure Survey of New York.
North Carolina Citizens Association.
Ohio Public Expenditure Council.
Oklahoma Public Expenditures Council—Has also submitted a separate statement to the committee.
Oregon Tax Research (see brief additional comment below).
Rhode Island Public Expenditure Council.
Tennessee Taxpayers Association.
Utah Taxpayers Association (see brief additional comment below).
Wyoming Taxpayers Association.

Five of the foregoing organizations have made brief additional comments which follow:

"Colorado Public Expenditure Council is concerned about increasing tax burdens at all levels of government, regardless of the nature of the new programs proposed. Inasmuch as your statement is based primarily on this concern for increased taxes, you are authorized to add our organization to those who approve your statement."—Colorado Public Expenditure Council.

"This is another instance where attempts are being made to interject the Federal Government into local and State affairs. Traditionally, care of the aged in various forms has been the responsibility of (1) parents and relatives; (2) counties and corresponding governmental units; (3) State governments. Inevitably, programs are now being administered within the States and along with voluntary hospitalization and medical insurance are meeting the needs of the aged and others needing medical care.

"Credit should also be given to the medical profession for their assistance at the local level in solving the problems of caring for those unable to pay usual fees. The proponents of these various bills fail to admit or recognize that it is the American tradition to take care of your own problems and help one another. This is being done by families and local communities and these efforts should be recognized by Federal officialdom."—Montana Taxpayers Association.

"The New Jersey Taxpayers Association opposes Federal legislation designed to provide medicare under the old-age, survivors, and disability insurance program. It holds that such legislation would move the Federal Government further into a field in which American business has demonstrated its ability to meet individual needs. It would thus constitute a further step toward socialization, unnecessarily larger government, and the erosion of private opportunity, while

at the same time increasing the already mounting costs of the social security system."—New Jersey Taxpayers Association.

"A sizable number of our citizens, 65 and older, can and are taking care of their medical needs. History has already demonstrated that if such a program is made available, every Tom, Dick, and Mary will fall quickly into line for his share of a Government handout. Look about you and see how few have refused to accept their social security checks."—Oregon Tax Research.

"The measure under consideration by your committee is one with built-in escalators to increase taxes—not reduce them. While at this time the increase may be nominal, all recognize that over the years increases will be very substantial indeed."—Utah Taxpayers Association.

STATEMENT OF THE AMERICAN OSTEOPATHIC ASSOCIATION, SUBMITTED BY CARL E. MORRISON, D.O., CHAIRMAN, COUNCIL ON FEDERAL HEALTH PROGRAMS, WASHINGTON, D.C.

The American Osteopathic Association appreciates this opportunity for comment on certain hospital care insurance bills pending before this Senate Committee on Finance, particularly, S. 880, S. 2431, and S. 2705 for your consideration in connection with the House-passed bill, H.R. 11865, cited as Social Security Amendments of 1964.

The association is a nonprofit, tax-exempt federation of divisional societies of osteopathic physicians and surgeons. Its objects as set forth in its constitution are to promote the public health, encourage scientific research, and maintain and improve high standards of medical education in osteopathic colleges. Its policies are determined by an elective house of delegates, which meets annually, chosen by the respective divisional societies.

The house of delegates on July 10, 1961, resolved as follows:

"Whereas the American Osteopathic Association, recognizing that increased costs of medical care creates a grave socioeconomic problem in certain groups; and

"Whereas preventive medicine has brought about an increase in the number of our aging population; and

"Whereas a significant number of these persons have insufficient income to meet the increasing cost of medical care: Therefore, be it

"*Resolved*, That the American Osteopathic Association, recognizing the need for suitable health plans, offers its assistance and cooperation to all agencies concerned with providing adequate health care to our citizens and urges immediate steps be taken to alleviate these growing problems."

The above resolution after annual reconsideration by the house of delegates, remains unchanged. Implicit in our position is the commitment of the osteopathic profession and institutions to work with other private organizations and with Government agencies at all levels for the advancement of the health care and welfare of the aged. Our committee on health care for the aging and committee on medical care plans operate to stimulate and coordinate corresponding committees at State and local levels.

The osteopathic profession is legally authorized in all the States. Thirty-nine States and the District of Columbia license osteopathic graduates to perform major operative surgery and to administer all drugs.

The five osteopathic schools of medicine grant the degree of doctor of osteopathy (D.O.). In common with the other medical schools they participate 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.

Before being considered eligible for admittance to an otseopathic college, students must spend at least 3 years in an approved college or university. Most matriculants have baccalaureate degrees. The professional curriculum of an osteopathic college requires at least 5,000 hours of instruction over 4 college years.

After receiving the D.O. degree, 99 percent of graduates serve a 12-month internship in an osteopathic hospital approved for such training. Certification in a specialty field requires about 5 additional years of training, including residency and supervised study. Osteopathic specialties include surgery, radiology, anesthesiology, obstetrics and gynecology, pediatrics, physical medicine

and rehabilitation, psychiatry, internal medicine, dermatology, proctology, ophthalmology and otorhinolaryngology and pathology.

The Nation's 310 osteopathic hospitals are, for the most part, general hospitals treating patients of all ages and with all types of illness. Eighty-nine of these hospitals are approved by the American Osteopathic Association for the training of interns and residents. Statistics compiled annually by the American Osteopathic Hospital Association show that at present there are an estimated 15,800 available beds in osteopathic hosiptals. During 1963, about 650,000 patients were admitted to these hospitals and received more than 4,200,000 patient-days of care. The average length of stay was 6 days. More than 110,000 new babies were born in these hospitals and more than 310,000 operations, ranging from a simple tonsillectomy to a total gastric resection, were performed.

Minimum standards of organization and practice for hospitals staffed by osteopathic physicians and surgeons were first established, and inspection and approval procedures adopted, by the American College of Osteopathic Surgeons about 1928. In 1935, the Bureau of Hospitals of the American Osteopathic Association assumed joint responsibility with the American College of Osteopathic Surgeons. Since 1949, the American Osteopathic Association has had full responsibility, which it now exercises through a committee on hospitals.

The Committee on Hospitals of the American Osteopathic Association is composed of four representatives of the osteopathic profession at large and a representative from each of the specialty colleges of surgery, radiology, internal medicine and obstetrics and gynecology. They are thoroughly familiar with all phases of hospital administration and are charged with the formulation of hospital standards which are formally approved by the Board of Trustees of the American Osteopathic Association.

Any hospital desiring accreditation must submit to a rigid annual examination by the committee. If the hospital passes this examination it can be officially listed as registered. Hospitals which are approved for internship or residency training must pass an annual inspection even more comprehensive than that for registered hospitals. State and Federal agencies have recognized AOA accreditations.

S. 880, the Hospital Insurance Act of 1963, otherwise known as the Anderson-King bill, was introduced on February 21, 1963, by Senator Clinton P. Anderson, of New Mexico (for himself and Senators Hubert Humphrey, of Minnesota; E. L. Bartlett, of Alaska; Birch Bayh, of Indiana; Daniel B. Brewster, of Maryland; Quentin N. Burdick, of North Dakota; Robert C. Byrd, of West Virginia; Frank Church, of Idaho; Joseph S. Clark, of Pennsylvania; Paul H. Douglas, of Illinois; the late Clair Engle, of California; Vance Hartke, of Indiana; Daniel K. Inouye, of Hawaii; Henry M. Jackson, of Washington; the late Estes Kefauver, of Tennessee; Edward M. Kennedy, of Massachusetts; Edward V. Long, of Missouri; Mike Mansfield, of Montana; Eugene J. McCarthy, of Minnesota; Gale W. McGee, of Wyoming; George McGovern, of South Dakota; Thomas J. McIntyre, of New Hampshire; Lee Metcalf, of Montana; Frank E. Moss, of Utah; Edmund S. Muskie, of Maine; Gaylord Nelson, of Wisconsin; Maurine B. Neuberger, of Oregon; John O. Pastore, of Rhode Island; Claiborne Pell, of Rhode Island; Jennings Randolph, of West Virginia; Abraham Ribicoff, of Connecticut; Harrison A. Williams, Jr., of New Jersey; Ralph Yarborough, of Texas, and Stephen M. Young, of Ohio).

S. 880 would establish within the social security system a program of hospital, nursing home, home health, and outpatient diagnostic services to persons 65 or over eligible to receive (or receiving) social security or railroad retirement benefits financed by an increase in taxes for workers and employers under these systems, and similar benefits out of Federal general revenue for certain uninsured individuals 65 or over.

Inpatient hospital services would be provided, but these would not include medical and surgical purposes except services provided in the field of pathology, radiology, physiatry, or anesthesiology, and except "services provided in the hospital by an intern or a resident-in-training under a teaching program approved by the Council on Medical Education and Hospitals of the American Medical Association (or, in the case of an osteopathic hospital approved by a recognized body approved for the purpose by the Secretary)." (Lines 15-22, p. 8.)

We respectfully request that the parenthetical part of the above quotation be revised to read as follows:

"(or, in the case of an osteopathic hospital, approved by the Bureau of Professional Education, Committee on Hospitals of the American Osteopathic Association)."

The elements of protection and assurances to the public and to the institutions involved which warrant specification of the American Medical Association as the recognized approval agency in the case of hospitals staffed by doctors of medicine likewise warrant specification of the American Osteopathic Association as the approval agency in the case of hospitals staffed by doctors of osteopathy.

Current precedent is provided in the U.S. Civil Service Commission qualification standards for medical officers, medical officer series GS-602, page 8, published March 1963, as follows:

"A. Use of Terms.

"1. *Approved internship.* This is training in a hospital or other institution approved by the Council on Medical Education and Hospitals of the American Medical Association or by the Bureau of Professional Education, Committee on Hospitals of the American Osteopathic Association for internship training.

"2. *Approved residency.* This is training in a hospital or other institution approved by the Council on Medical Education and Hospitals of the American Medical Association or by the Bureau of Professional Education, Committee on Hospitals of the American Osteopathic Association for training in the specialty.

"3. *Internships and residencies.* The 9-month wartime approved internships and residences during the period from December 31, 1942, to July 1, 1947, will be accepted as the equivalent of 1 year.

"4. *Accredited preceptorship training.* Preceptorship training is training under the direction of an individual physician who is recognized in the specialty concerned. Such training is not necessarily obtained in the hospital setting. In order to be accredited, applicants must furnish a certificate of acceptance by an approved American specialty board in the specialty concerned.

"5. *An approved American specialty board* is one which has been approved for the particular specialty by the Council on Medical Education and Hospitals of the American Medical Association or by the Bureau of Professional Education, Advisory Board for Osteopathic Specialists of the American Osteopathic Association."

The suggested language is already included for the same purpose on page 5 of the Health Care Insurance Act of 1964 (S. 2431), introduced on January 16, 1964, by Senator Jacob K. Javits, of New York (for himself, and Senators Kenneth B. Keating, of New York; Clifford P. Case, of New Jersey; John S. Cooper, of Kentucky; Thomas H. Kuchel, of California; and Margaret Chase Smith, of Maine), to provide health care for persons 65 years of age and over through contributory social insurance, and a complementary basic national private insurance plan.

Under both S. 880 and S. 2431, automatic eligibility upon agreement to furnish hospital services under the program is granted only to hospitals accredited by the Joint Commission on the Accreditation of Hospitals, subject to the requirement of a utilization review plan. The same eligibility should be extended to osteopathic hospitals accredited by the Committee on Hospitals of the American Osteopathic Association. Specifically, we respectfully request that immediately following the words "Joint Commission on Accreditation of Hospitals", line 3, page 30 of S. 880, or line 5, page 24 of S. 2431, there be inserted the words: "or, by the Committee on Hospitals of the American Osteopathic Association", and that after the word "Commission" page 30, line 7 of S. 880 or line 9, page 24 of S. 2431, there be inserted the words "or Committee", and that after the word "Hospitals", page 30, line 11 of S. 880 or line 13, page 24 of S. 2431, there be inserted the words "or the Committee on Hospitals of the American Osteopathic Association".

S. 880 and S. 2431 provide that unaccredited hospitals in order to participate would have to show that the institution:

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

"(2) maintains clinical records on all patients,

"(3) has bylaws in effect with respect to its staff of physicians,

"(4) continuously provides twenty-four-hour nursing service rendered or supervised by a registered professional nurse,

"(5) has in effect a hospital utilization review plan which meets the requirements of subsection (e),

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

"(7) meets such other of the requirements prescribed for the accreditation of hospitals by the Joint Commission on the Accreditation of Hospitals, as the Secretary finds necessary in the interest of the health and safety of individuals who are furnished services by or in the institution."

We respectfully request that immediately following the words "Joint Commission on the Accreditation of Hosptials," as referred to in the above paragraph numbered (7), and found on page 20, line 6 of S. 880 or line 5, page 13 of S. 2431, there be inserted the words "or by the Committee on Hospitals of the American Osteopathic Association in the case of osteopathic hospitals."

S. 2705, Health Insurance for the Aged Act, to amend the Social Security Act so as to provide Federal financial assistance for establishing and maintaining State programs of voluntary health insurance for the aged, was introduced on April 1, 1964, by Senator Leverett Saltonstall, of Massachusetts (for himself and Senators J. Glenn Beall, of Maryland; Norris Cotton, of New Hampshire; Thruston B. Morton, of Kentucky; and Hugh Scott, of Pennsylvania).

The definition of "physician" on page 23 of S. 880, page 17 of S. 2431, and page 15 of S. 2705 provide for osteopathic participation by incorporating by reference section 1101(a)(7) of the Social Security Act, adopted in 1950, which expressly includes doctors of osteopathy in the definition of "physician" under the general provisions of the Social Security Act (64 Stat. 559).

It was through application of the criterion that in order to qualify for inclusion under the term "physician" as used in the Social Security Act generally, one must be trained in the practice of the healing art in all its branches, that this committee in 1950, based upon the evidence submitted, found that graduates of the osteopathic schools of medicine so qualified and included them under section 1101(a)(7).

The Congress similarly defined the terms "physicians" and "medical care" and "hospitalization" as inclusive of osteopathic physicians and hospitals under the provision of the U.S. Employees Compensation Act in 1938 (52 Stat. 586).

Previous to that, in 1929, the Congress, in regulating the practice of the healing art in the District of Columbia, provided: "The degrees docor of medicine and doctor of osteopathy shall be accorded the same rights and privileges under governmental regulations" (45 Stat. 1329).

Osteopathic physicians and hospitals generally participate in Blue Cross and commercial insurance programs. They are also utilized in the Medicare program for dependents of members of the uniformed services, and by the Bureau of Employees Compensation, and in the Federal employees health benefits program.

The osteopathic profession and its institutions can be relied upon to employ their best efforts to provide and safeguard quality care and to pursue their traditional role of cooperation in the public interest.

We will be pleased to aid the committee in any way we can.

(The locations of our proposed amendments are shown in italic in the attached excerpts from S. 880.)

EXCERPTS FROM S. 880—HOSPITAL INSURANCE ACT OF 1963

(Proposed osteopathic hospital amendments shown in italic)

"DESCRIPTION OF SERVICES

(Page 7.)

"SEC. 1703. For purposes of this title—

"INPATIENT HOSPITAL SERVICES

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

(Page 8.)

"(1) bed and board,

"(2) such nursing services and other related services, such use of hospital facilities, and such medical social services as are customarily furnished by the hospital for the care and treatment of inpatients, and such drugs,

biologicals, supplies, appliances, and equipment, for use in the hospital, as are customarily furnished by such hospital for the care and treatment of inpatients, and

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

"(4) medical or surgical services provided by a physician, resident, or intern, except services provided in the field of pathology, radiology, physiatry, or anesthesiology, and except services provided in the hospital by an intern or a resident-in-training under a teaching program approved by the Council on Medical Education and Hospitals of the American Medical Association (or, in the case of an osteopathic hospital, approved by [a recognized body approved for the purpose by the Secretary] *the Bureau of Professional Education, Committee on Hospitals, of the American Osteopathic association*), and

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

(Page 9.)

"SKILLED NURSING FACILITY SERVICES

"(b) The term 'skilled nursing facility services' means the following items and services furnished to an inpatient in a skilled nursing facility, after transfer from a hospital in which he was an inpatient, and (except as provided in paragraph (3)) by such skilled nursing facility—

* * * * * * *

"(6) medical services provided by an intern or resident-in-training of the hospital, with which the facility is affiliated or under common control, under a teaching program of such hospital approved as provided in subsection (a)(4), and * * *

(Page 10.)

"HOME HEALTH SERVICES

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

* * * * * * *

"(6) in the case of a home health agency which is affiliated or under common control with a hospital, medical services provided by an intern or resident-in-training of such hospital, under a teaching program of such hospital approved as provided in subsection (a)(4); * * *

"USE OF STATE AGENCIES AND OTHER ORGANIZATIONS TO DEVELOP CONDITIONS OF PARTICIPATION FOR PROVIDERS OF SERVICE

(Page 28.)

"SEC. 1707. In carrying out his functions, relating to determination of conditions of participation by providers of services, under section 1706(a)(7), section 1706(b)(8), or section 1706(c)(6), the Secretary shall consult with the Hospital Insurance Benefits Advisory Council established by section 1712, appropriate State agencies, and recognized national listing or accrediting bodies. Such conditions prescribed under any of such sections may be varied for different areas or different classes of institutions or agencies and may, at the request of a State, provide (subject to the limitation provided in section 1706(a)(7)) higher requirements for such State than for other States.

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

(Page 29.)

"SEC. 1708. (a) The Secretary may, pursuant to agreement, utilize the services of State health agencies or other appropriate State agencies for the purposes

of (1) determining whether an institution is a hospital or skilled nursing facility, or whether an agency is a home health agency, or (2) providing consultative services to institutions or agencies to assist them (A) to qualify as hospitals, skilled nursing facilities, or home health agencies, (B) to establish and maintain fiscal records necessary for purposes of this title, and (C) to provide information which may be necessary to permit determination under this title as to whether payments are due and the amounts thereof. To the extent that the Secretary finds it appropriate, an institution or agency which such a State agency certifies is a hospital, skilled nursing facility, or home health agency may be treated as such by the Secretary. The Secretary shall pay any such State agency, in advance or by way of reimbursement, as may be provided in the agreement with it (and may make adjustments in such payments on account of overpayments or underpayments previously made), for the reasonable cost of performing the functions specified in the first sentence of this subsection, and for the fair share of the costs attributable to the planning and other efforts directed toward coordination of activities in carrying out its agreement and other activities related to the provision of services similar to those for which payment may be made under this title, or related to the facilities and personnel required for the provision of such services, or related to improving the quality of such services.

(Page 30.)

"(b)(1) An institution shall be deemed to meet the conditions of participation under section 1706(a) (except paragraph (5) thereof) if such institution is accredited as a hospital by the Joint Commission on the Accreditation of Hospitals, *or by the Committee on Hospitals of the American Osteopathic Association in the case of osteopathic hospitals.* If such Commission *or Committee*, as a condition for accreditation of a hospital, hereafter requires a utilization review plan or imposes another requirement which serves substantially the same purpose, the Secretary is authorized to find that all institutions so accredited by the Commission, *or Committee*, comply also with section 1706(a)(5).

"(2) If the Secretary finds that accreditation of an institution by a national accreditation body, other than the Joint Commission on the Accreditation of Hospitals, *or the Committee on Hospitals of the American Osteopathic Association*, provides reasonable assurance that any or all of the conditions of section 1706 (a), (b), or (c), as the case may be, are met, he may, to the extent he deems it appropriate, treat such institution as meeting the condition or conditions with respect to which he made such a finding.

"DEFINITIONS OF PROVIDERS OF SERVICE

(Page 19.)

"SEC. 1706. For purposes of this title—

"HOSPITAL

"(a) The term 'hospital' (except for purposes of section 1704(d)(2), section 1709(f), paragraph (6) of this subsection and so much of section 1703(b) as precedes paragraph (1) thereof) means an institution which—

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

"(2) maintains clinical records on all patients,

"(3) has bylaws in effect with respect to its staff of physicians,

"(4) continuously provides twenty-four-hour nursing service rendered or supervised by a registered professional nurse,

"(5) has in effect a hospital utilization review plan which meets the requirements of subsection (e),

(Page 20.)

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

"(7) meets such other of the requirements prescribed for the accreditation of hospitals by the Joint Commission on the Accreditation of Hospitals, *or by the Committee on Hospitals of the American Osteopathic Association in*

the case of osteopathic hospitals, as the Secretary finds necessary in the interest of the health and safety of individuals who are furnished services by or in the institution.

* * * * * * *

"DESIGNATION OF ORGANIZATION OR PUBLICATION BY NAME

(Page 50.)

"SEC. 1719. Designation in this title, by name, of any nongovernmental organization or publication shall not be affected by change of name of such organization or publication, and shall apply to any successor organization or publication which the Secretary finds serves the purpose for which such designation is made."

STATEMENT BY NATIONAL ASSOCIATION OF SOCIAL WORKERS

Mr. Chairman and members of the committee, the National Association of Social Workers welcomes this opportunity to present its views on H.R. 11865 (the Social Security Amendments of 1964) and express its convictions as to the importance of amending this legislation to include provisions for hospital care for the aged.

The National Association of Social Workers is a professional organization with 40,000 members employed in governmental and voluntary health, welfare, and recreational agencies who meet specific requirements as to education and experience in the social work field. The association since 1956 has endorsed at its biennial delegate assemblies the provision of hospital care for the aged through contributory social insurance. This delegate assembly, composed of representatives of the association's 165 chapters throughout the country, is the principal legislative body of the association. Attached to this statement are the recommendations on comprehensive social insurance and related recommendation on a national health program contained in the association's "Goals of Public Social Policy" last revised and adopted at the 1962 delegate assembly.

The association supports provisions of H.R. 11865

While the association supports the general benefits increase provided in H.R. 11865 we have urged in the past and urge again that Congress give consideration to amending the Social Security Act so as to assure continued adjustment of benefit payments to higher wage levels, national productivity, and a rising cost of living. Had some such formula been available, it would not have been necessary to wait 6 years as in the instance of the present legislation to provide some recognition of the financial needs of OASDI beneficiaries. We support the provision in the House-approved legislation which extends the age of eligibility for children to receive survivors benefits, while they are in school, to ages 18 to 21.

We support also the provisions in H.R. 11865 which would extend minimum benefits to persons over 72 who have had at least three quarters of social security coverage since the beginning of the social security system.

Importance of providing hospital care for the aged

The association holds that a hospital care program for the aged should be added on top of H.R. 11865. We believe that the minimum desirable program for such hospital care is represented in King-Anderson legislation—H.R. 3920 and S. 880. There is little debate any longer on the following points as describing the situation with respect to the substantial number of the aged.

(*a*) Their poorer health produces the need for more units of medical care;

(*b*) Per capita expenditures for their medical care are larger as a result of their greater volume of services;

(*c*) Their lower-than-average cash incomes that limits their purchasing power;

(*d*) Their relatively fixed cash income in a period when units of medical care are rising in price and widening disparity between their available dollars and the cost of the needed units of service.

Consequently, substantial bipartisan agreement has developed that the great unmet need of older persons is for some provision for the costs of health care. There also seems to be substantial agreement that these needs cannot be adequately met without some governmental program of financing.

It is the view of our association that the most effective and efficient governmental mechanism for meeting this need is the social security system. Because

we favor providing the costs of such care as a matter of right, we cannot endorse any proposals which require investigation of income and other resources. Support of the principle of health insurance for the aged as a matter of right overweighs the possibility that a relatively small proportion of the aged who are well to do would also receive these benefits.

The cost of the provisions contained in the King-Anderson legislation would demand somewhere in the order of 0.6 percent increase in the tax rate above the tax rate projected in H.R. 11865 and by 1970 would produce a combined tax of 10.2 percent on employer and employee. At the most, however, this would represent about $25 a month for an employee earning $5,400 for a full social security coverage. We know of no private insurance plan that for $25 a month (less than $1 a day) would provide protection for a widow and children, retirement benefits and basic hospital, nursing home, and home health services for the employee at age 65 and beyond.

Moreover, it has been repeatedly demonstrated that less than 50 percent of the workers today have all earnings taxed and credited toward benefits in contrast to almost 90 percent of the workers in the early days of the program when the wage base was $3,000. We understand pushing the earnings base up to $6,600 or even $7,200 together with a minimal tax increase above the rate proposed in H.R. 11865 would make it possible to add King-Anderson on top of H.R. 11865. We understand, further, that not until the wage base moves up to at least $9,600 would as high a proportion of workers have all their earnings taxed and credited toward benefits as was true in the early days of the act.

We hold that no really significant solution toward meeting the health care needs of the aged will occur until legislation containing essentially the benefits of King-Anderson is enacted. The Congress has demonstrated in its rapid action on the Economic Opportunity Act of 1964 (S. 2642) its conviction about the Nation's obligation to the poor. But this Economic Opportunity Act is primarily and properly directed toward children and young people and cannot and should not produce any benefits for older people. We urge a similar concern for older people.

H.R. 11865 does provide an increase in cash benefits last afforded by Congress in 1958 but it is our judgment that the key problem of the elderly poor and the elderly who become poor because of the costs of hospital care, is the lack of any provisions of paying for the costs of such hospital care without the necessity of these elderly persons becoming the "certified poor," the label placed upon them under either a program of medical assistance tied in with old-age assistance or Kerr-Mills.

The President in his March 1964 message on the war on poverty quite properly described the provisions of health care for the aged through social insurance as a basic measure in combating poverty aimed at the elderly of whom only about 20 percent have an annual income of over $2,000—$1,000 below the floor for poverty established by the Council of Economic Advisers.

The association appreciates this opportunity to place its views before the Finance Committee.

[Attachment]

FROM THE "GOALS OF PUBLIC SOCIAL POLICY" STATEMENT ON SOCIAL INSURANCE

1. A COMPREHENSIVE PROGRAM

All workers, including civilian and military personnel, governmental and railroad employees, and self-employed persons, should be protected by a single system against loss of income due to retirement, death of breadwinner, and permanent disability. Included in this system should be provision for medical services to covered persons and their dependents. Supplemental systems to provide more adequate protection should be encouraged. Wage earners and salaried persons should also be protected against loss of income due to unemployment and temporary disability.

FROM THE "GOALS OF PUBLIC SOCIAL POLICY" STATEMENT ON HEALTH

1. NATIONAL HEALTH PROGRAM

A coordinated comprehensive national health program which will assure full health care to all persons in the population through provision of all the facilities and medical services necessary to provide full and comprehensive health care is endorsed. Such a program should be geared to the promotion and maintenance

of health, the prevention of disease and disability, case discovery, treatment, and restorative services. A program applying the principles of contributory social insurance, tax support, and of group payments is endorsed and recommended. Services under such a program should assure full health care without discrimination.

STATEMENT OF THE AMERICAN PUBLIC HEALTH ASSOCIATION

The American Public Health Association, founded in 1872, has 13,000 members plus an additional 23,000 members of State facilities. These members work in public and voluntary agencies—local, State, and National—devoted to safeguarding the health of the public by measures to promote health, prevent illness, treat the victims of disease, and rehabilitate them to social usefulness. The members of the association represent a wide variety of health disciplines, including physicians, dentists, nurses, engineers, laboratory and social scientists, nutritionists, health educators, social workers, and medical care and hospital administrators—men and women who are daily confronted with the health needs of individuals and the organizational and administrative problems which must be solved if those needs are to be met.

Support of S. 880

The American Public Health Association supports the principles embodied in S. 880 as major steps in improving the health of the aged. The governing council of the association, at its annual meeting in November 1961, resolved that "the American Public Health Association support appropriate proposals, including social insurance mechanisms, to provide for the sound financing of adequate health services, to be available to the aged individual without a means test and on a paid-up basis without additional fees or payments for covered services, in institutions, outpatient departments, and organized home care programs."

The position taken by the association was based on the recognition that "good health care is becoming more expensive to provide for the aged because of their high illness and disability rates, the increasing complexity and rising costs of good care, the growing number of aged persons and their relatively small personal financial resources."

The American Public Health Association supports S. 880 because it realizes that, just as the needs of the aged for food, clothing, shelter, and other necessities of life could not be met by public assistance, so the urgent need of the aged for health care—which looms so large in the life of the aged that it is almost an understatement to call it a necessity of life—cannot be met by public assistance. In 1953, the Congress recognized this need for other necessities of life by enacting the Social Security Act; S. 880 extends this now traditional approach to include health care, which is, for the aged, not only a necessity but a determinant of life, a service the presence or absence of which can often mean the difference between life and death.

S. 880 and Kerr-Mills are complementary

For the aged today, public assistance is a "residual" or supplementary program, necessary for those without social security or other insurance protection, for those with insufficient income from these and other sources, and for those who would otherwise be able to manage but whose resources are depleted by large expenditures for health service. S. 880 would likewise make public assistance for health care of the aged a "residual" or supplementary program, necessary for payment of costs for physicians' and other health services which are not covered by the social insurance program, by private insurance, or the individual's financial resources.

The American Public Health Association believes therefore that it is unsound to counterpose social insurance health care for the aged and the Kerr-Mills and other public assistance medical care programs. Just as for the other necessities of life, social insurance for health care is designed as the basic means of financing for the aged, while the role of public assistance is to meet the needs which remain uncovered. Both programs are necessary and complementary. For this reason the American Public Health Association, in the resolution referred to previously, also declared its support for "additional appropriate Federal, State, and local efforts to improve the financing and adequacy of health services for needy and medically needy aged persons through the supplementary public assistance programs and through other means such as medical care programs

administered by health departments, and for all aged persons through public health and related programs."

The Kerr-Mills program needs to be implemented in all of the States, to have greater State financial participation, to have less stringent eligibility provisions, and to provide more adequate benefits. Passage of S. 880 would make it possible for Kerr-Mills and the old-age assistance programs to be relieved of the tremendous burden of hospital costs and to devote more resources to physicians' services and other elements of health care which would not be covered by social insurance.

Importance of noninstitutional care

The American Public Health Association also pointed out in its resolution that "adequate financing is essential to support comprehensive health care of high quality for the aged." S. 880 provides some but not all elements of such comprehensive care; it includes inpatient hospital services, skilled nursing facility services, organized home health services, and outpatient hospital diagnostic services, but it excludes other elements such as physicians' services and outpatient hospital treatment services.

The need to develop a program to finance such services as the latter has been well stated by the recent report of the National Committee on Health Care of the Aged, which was formed in 1962 under the chairmanship of Arthur S. Flemming, and which recommends a complementary program of private health insurance to cover the major clusters of expense for physician care and other noninstitutional services for the aged. The American Public Health Association believes that adequate financing of comprehensive health care of the aged requires serious attention to the problems of financing physicians' services. It therefore urges careful study of the recommendations by the National Committee on Health Care of the Aged and all other proposals to assure more adequate financing for this major component of the costs of health service.

However, we oppose the recommendation by the National Committee on Health Care of the Aged that the services of home health agencies in the social insurance program be limited to those provided under the supervision of a hospital. Organized home health services in the United States are provided today primarily by visiting nurse associations, local health departments, and combination agencies using the resources of these two types of agencies; programs supervised by hospitals are few and far between. The services provided by these nonprofit voluntary and public agencies are of demonstrated high quality; they serve the entire community, including patients who have been cared for in all hospitals in the community, and provide a program which is beyond the capacity of many community hospitals. To exclude such programs from the benefit structure of S. 880 would delete an essential part of health care for the aged and would increase the total costs of the program by restricting benefits almost exclusively to expensive and often inappropriate institutional care.

S. 880 represents, in the opinion of the American Public Health Association, a distinct improvement over the previous administration's proposal (87th Cong.) in a number of ways. We shall comment briefly on several of these.

Deductibles

The bill permits individuals to elect 45 days of hospital care without a deductible rather than 90 days with the deductible. This election must be made at the time the individual becomes eligible, and the choice is irrevocable. Although this is a step in the right direction, we believe it would be preferable to make the 45 days without deductible the standard benefit, and the 90- and 180-day benefits with deductibles elective. The bill as presently written will probably result in most aged persons being covered by the 90-day-deductible standard benefit. We reiterate our conviction that the deductibles for inpatient and outpatient hospital services will prove harmful to the health of aged persons. Many older persons will thereby be deterred from seeking health care when needed, and the result will be the postponement of care until illness is far advanced. We also urge, therefore, that the deductible for outpatient diagnostic services be deleted.

Eligibility of skilled nursing facilities

The bill limits eligibility of skilled nursing facilites to those affilated or under common control with a hospital. In our statement on the previous proposal (S. 909, 87th Cong.) we urged adoption of the same criterion that is used for home health agencies; namely, limitation to public and private nonprofit organizations. We find the present criterion acceptable in that it will exclude the large number of markedly substandard nursing homes from eligibility. It will

also encourage many suitable nursing homes to become affiliated with hospitals, with a consequent improvement in the quality of care provided.

Role of State health agencies

The bill expands the potential role of State health agencies in the program by permitting inclusion, through agreements with the Secretary of Health, Education, and Welfare, of functions beyond the determination of eligibility of institutions and agencies and the provision of consultative services to them. These added functions include planning and other efforts directed at coordination, as well as other activities related to the provision of services, the facilities and personnel required for their provision, and the improvement of the quality of such services.

We consider these additions of the utmost importance, for we believe it highly desirable for each State to plan for the development of services. Such planning should be concerned not only with the simple availability of services but should aim toward continuity of care and other desirable features designed to improve the quality of health services for the aged. The favorable effect of such planning can be seen in the hospital planning and construction program whereby many States have moved far in the direction of rational development of facilities for health care.

The American Public Health Association, in its resolution on financing health services for the aged, urged utilization "of the strong Federal-State-local health department relationships to assure the best planning and administration at the State and local level and the highest quality of service throughout the country." We believe that the added potential role of State health agencies permitted by the bill can, if given vigorous cooperative implementation by the Secretary of Health, Education, and Welfare and the State departments of health, result not only in obtaining more adequate financing of health services for the aged but also in filling the gaps in personnel, facilities, and services more rapidly, in facilitating continuity of care for the individual patient, in achieving greater emphasis on preventive and rehabilitative services, and in markedly improving the quality of health care for the aged.

STATEMENT OF G. E. LEIGHTY, CHAIRMAN OF THE RAILWAY LABOR EXECUTIVES' ASSOCIATION

Mr. Chairman and members of the committee, my name is G. E. Leighty. I appear here on behalf of the Railway Labor Executives' Association, which is an unincorporated association of the chief executive officers of the standard national and international railway labor organizations, representing virtually all railroad employees in this country, pursuant to the provisions of the Railway Labor Act.

The Railway Labor Executives' Association is vitally concerned with the administration of the Railroad Retirement Act, which provides for a social insurance system covering the railroad industry. Although the coverage of the Railroad Retirement Act and the Social Security Act is, in general, mutually exclusive, the two systems are closely coordinated with respect to certain financial and benefit provisions. Because of this, existing law provides that any increase in tax or benefit rates for the social security program would result automatically in a like percentage increase in tax rates, and in some increase in certain benefits, for the railroad retirement program.

The bill H.R. 11865 ignored these two essential coordinating provisions (1) by failing to include (as it has included many times in the past) the necessary conforming amendments for benefit purposes and (2) by adopting, instead, an amendment (sec. 16(d) of the bill) which would preclude the taking account of the social security tax increases, proposed by the bill, for the automatic railroad retirement tax increase.

Analysis of the amendments proposed by Senator Douglas

Taxes.—Section 5(k)2 of the Railroad Retirement Act provides that the social security trust funds be left in the same financial position in which they would have been had railroad service been employment subject to the Social Security Act and the Federal Insurance Contributions Act. This is generally referred to as the financial interchange provision between the two systems. To give effect to this provision the railroad retirement account is charged with the taxes that would have been paid in support of the social security systems under the hypothesis described above, and the social security trust funds are charged with

the benefits that would have been paid from these funds under the same hypothesis. Every year the Board and the Social Security Administration reach an agreement as to the necessary transfers to give effect to this provision. Transfers are then made accordingly from the social security trust funds to the railroad retirement account, or contrarywise, if the determination so requires. However, in the past several years substantial transfers have been made to the railroad retirement account and it is anticipated that the transfers will be in favor of the railroad retirement account for some time to come. Because the financial condition of the railroad retirement system, as determined on an actuarial basis, is thus affected by the effective social security tax rate in years to come, existing law provides that the tax rates established by the schedules in the Railroad Retirement Tax Act would be automatically increased by the amount which the effective social security tax rate for the current year exceeds 2¾ percent.

Section 16(d) of the bill H.R. 11865, however, would amend the Railroad Retirement Tax Act so that the automatic increases referred to above would be geared solely to the social security tax schedule under existing law. This means, of course, that changes in the social security tax rates schedules effected by H.R. 11865, or any other legislation enacted in future years, would have no effect either to increase or decrease the railroad retirement tax rates. The majority of the Board believes that this would have a serious adverse effect on the railroad retirement system, for the reasons set forth above.

The amendment offered by Senator Douglas would delete section 16(d) from H.R. 11865 and thereby cause H.R. 11865 to have no adverse effect on the Railroad Retirement Tax Act.

Social security minimum provision of the Railroad Retirement Act

In recognition of the fact that the tax rates paid by employees in support of the railroad retirement system are higher than the social security tax rates, and other considerations, existing law provides that benefits for a month based on an employee's service shall in no case be less than 110 percent of the amount, or the additional amount, which would be payable to all persons for that month under the Social Security Act if the employee's railroad service had been employment subject to the Social Security Act. About 90 percent of the benefits for survivors under the Railroad Retirement Act and about 15 percent of benefits payable during the lifetime of an employee are paid under this minimum guarantee provision. This provision is very important to railroad employees and reliance upon it is widespread. To weaken the application of this principle to any extent, or to depart from it in any way, would, in my view, constitute a breach of faith with the railroad employees.

In the application of this provision under H.R. 11865, benefits under the Social Security Act would have to be calculated in the amounts that they would have been under the Social Security Act without the changes H.R. 11865 would make. Thus the 5-percent across-the-board increases in social security benefits and the increases resulting from the raise of the yearly wage base to $5,400 could not be taken into account with respect to benefits under the Railroad Retirement Act payable under this guarantee provision.

To remedy this situation, the proposed amendments would amend section 1(q) of the Railroad Retirement Act to make references in the Railroad Retirement Act to the Social Security Act as amended in 1964, rather than to that act as amended in 1961, as section 1(q) now provides. Similar changes in section 1(q) have been made as a matter of course, on many occasions in the past, through bills approved by this committee, without the formality of a request from the Board.

Annual earnings for calculating survivor benefits

Benefits for survivors of railroad employees, with an exception not material here, are paid either under the Railroad Retirement Act or under the Social Security Act, but not under both. In general, benefits are paid under the Railroad Retirement Act where the employee had a current connection with the railroad industry at the time of his death. In the payment of these survivor benefits, credits for railroad service and for employment subject to the Social Security Act, are combined in determining eligibility for, and the amount of, benefits. It is apparent that many railroad employees also have substantial employment credits under the Social Security Act.

In the calculation of survivor benefits under the regular railroad retirement formula, as much as $5,400 in compensation for railroad service for a year may

be used. However, although the bill H.R. 11865 would increase the present maximum wage base from $4,800 to $5,400, the bill would limit the social security wage credits that can be used to bring the combined earnings only to $4,800, the present maximum creditable wage base under the Social Security Act. The proposed amendments, however, would permit the use of wage credits to bring the combined creditable earnings for a year to $5,400 instead of $4,800 as at present. This would be effected by a change in 5(l) 9 of the Railroad Retirement Act.

Benefits for children over age 17 while attending school

The bill H.R. 11865 provides benefits for children who are over age 17 but less than age 22 while they are attending, on a full time basis, a recognized school.

Under present law, children over age 17 can be eligible for benefits only if they are disabled. It is apparent that the children of deceased railroad employees should have the same rights. The proposed amendments would provide rights to benefits under these circumstances for children of railroad employees.

The Railway Labor Executives' Association strongly urges the adoption of these amendments proposed by Senator Douglas.

We are informed that the total effect of the bill with Senator Douglas' amendments on the financial condition of the railroad retirement system would be to increase the costs of the system by $6.4 million a year causing the projected deficit to be $25.4 million a year, or 0.60 perecnt of taxable payroll, as compared with the present deficit of about $19 million a year or 0.43 percent of taxable payroll. In the light of the importance of these changes, the slight increase in the deficit is, in my opinion, justified.

I am authorized to say that a majority of the Railroad Retirement Board is in favor of the amendments proposed by Senator Douglas.

(Whereupon, at 11:50 a.m., the committee adjourned to reconvene at 10 a.m., Thursday, August 13, 1964.)

SOCIAL SECURITY; MEDICAL CARE FOR THE AGED AMENDMENTS

THURSDAY AUGUST 13, 1964

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

The committee met, pursuant to recess, at 10:10 a.m., in room 2221, New Senate Office Building, Senator George A. Smathers presiding.

Present: Senators Smathers (presiding), Gore, Talmadge, Ribicoff, Williams, Carlson, Bennett, and Curtis.

Also present: Elizabeth B. Springer, chief clerk; and Fred Arner and Helen Livingston, of the Education, and Public Welfare Division, Legislative Reference Service, Library of Congress.

Senator SMATHERS. The committee will come to order.

We are happy to welcome as our first witness this morning Dr. Norman A. Welch of the American Medical Association, accompanied by Dr. Edward R. Annis, from the State of Florida.

We are delighted to have them both here. Would you gentlemen come up here and warm up that microphone so that everybody might hear you?

When you are ready, Doctor, you just go right ahead in your own style and in your own fashion.

STATEMENT OF NORMAN A. WELCH, M.D., PRESIDENT, AMERICAN MEDICAL ASSOCIATION; ACCOMPANIED BY DR. EDWARD R. ANNIS, IMMEDIATE PAST PRESIDENT OF THE AMERICAN MEDICAL ASSOCIATION

Dr. WELCH. Mr. Chairman and members of the committee, I am Dr. Norman A. Welch of Boston, president of the American Medical Association on whose behalf I am appearing here today.

I am here to reaffirm the AMA's long-standing opposition to the compulsory coverage of physicians under social security, and will explain the profession's views on this issue.

With me is Dr. Edward R. Annis of Miami, Fla., immediate past president of the AMA. At the conclusion of my statement, Dr. Annis will testify on the vital question of providing Government health care for all the Nation's aged regardless of their financial need through increased payroll taxes on the American workingman and his employer.

On both of these issues, Mr. Chairman, we are expressing the position which has been taken by the AMA House of Delegates, the policy-making body of our association. The house speaks for the AMA membership which now exceeds 200,000, representing over 70 percent

of the physician population of the United States. Delegates to the house are democratically chosen by the constituent State societies. Membership also includes delegates from the armed services, the Public Health Service, the Veterans' Administration, and AMA's scientific assembly.

As long ago as 1949 the AMA House of Delegates went on record as being opposed to the inclusion of physicians under title II of the Social Security Act. In June 1954, the house adopted the AMA's present policy specifically opposing compulsory coverage, and it has reiterated this stand at almost every meeting since then. We believe the reasons for such action are clear and readily understandable.

The arguments for compulsory inclusion of all physicians in the system at one stroke, regardless of their personal desires, simply cannot be applied to individual members of the medical profession. A self-employed doctor can rarely count on retiring on becoming 65.

Physicians who are able to work prefer to keep right on practicing medicine. This is because they can still utilize their knowledge and skill to minister to sick people, and because sick people still want these physicians to continue to serve them. The physician doesn't suddenly lose his ability when he reaches age 65. Nor does the intimate physician-patient relationship suddenly come to a halt. His concern for his patients continues beyond his birthday and, similarly, the patients' needs for his care bear no relationship to a retirement age written into a law.

To repeat: Any program which is built around a 65-year-old retirement age simply does not fit the life pattern of most doctors.

It has often been said that the only way a self-employed physician can actually retire is to move out of the community in which he has practiced. This observation was published in the printed hearings of this committee 10 years ago, on July 6, 1954, when other social security amendments were being considered.

A survey of physician retirement has shown that over 85 percent of the doctors between the ages of 65 and 72 are in active practice. Over 50 percent of the physicians who retire do so after the age of 74. Most of them are well able to care for themselves during their remaining years and to provide for their widows.

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. On the other hand, the same pressures to continue work do not exist for most gainfully employed persons in other occupations. Upon retiring at, or near, the social security retirement age, they stop paying the tax and begin to draw their pensions. For the self-employed physician, this would constitute an inequitable situation.

We recognize that the proposal under consideration would carry survivorship benefits for a physician's widow and minor children, in addition to its retirement features. Quite frankly, our information is that most members of the profession prefer to continue to protect their families through existing private insurance mechanisms.

There is no doubt that many older physicians entering the system now would eventually reap windfall benefits—the difference between what they paid in and the cost of their pensions to the Government. But as official spokesman for the profession, I can say here today that physicians as a group do not seek "bargains" of this kind at the expense of younger taxpayers and future generations.

Plainly, the retirement needs peculiar to the medical profession require an altogether different approach. Mindful of this fact, the AMA strongly supported enactment of Public Law 87-792, the Self-Employed Individuals Tax Retirement Act of 1962. This law is designed to provide prepaid pensions for all who are willing to save. It enables self-employed persons to set aside a portion of their current earnings, on a tax-deferred basis, for themselves and their employees, for their retirement.

We have said before, Mr. Chairman, and we repeat: We believe that our country is so diversified and that the people earn their livings under so many different conditions that it is wise public policy for the self-employed to be accorded the opportunity to participate in a flexible retirement system on a voluntary basis. It fits the economic pattern of their lives.

For the reasons outlined here, we submit that section 8 of the pending legislation represents action which would be both unnecessary and unreasonable. We urge the committee to reject it.

And now with your permission, Mr. Chairman, Dr. Annis will continue our presentation.

Senator SMATHERS. Doctor, did you make the statement with repect to section 8 relating to your position with respect to coverage of doctors before the House Ways and Means Committee?

Dr. WELCH. I don't think this came up. It did not come up, Senator.

Senator SMATHERS. The matter did not come up before the House Ways and Means Committee?

Dr. WELCH. Not at the time that we were having our hearing.

Senator SMATHERS. Yes.

Senator RIBICOFF. Mr. Chairman, I wonder if we couldn't ask a few questions on this phase before we go to the second phase.

Senator SMATHERS. Yes, indeed.

Senator Gore, do you have any questions?

Senator GORE. Doctor, could not the same statement you have just made, except for the patient-doctor relationship, be made with respect to lawyers?

Dr. WELCH. I suppose it could be, Senator.

Senator GORE. What about architects?

Dr. WELCH. Well, I am not familiar enough with the architects' situation to be able to answer your question.

Senator GORE. With the exception of teachers, the members of most professions will be at the peak of their earning capacity in their sixties. That would certainly be true of lawyers, would it not?

Dr. WELCH. Well, again I couldn't be sure. I would assume you are probably correct, Senator, but I could not be sure about it. I don't know the various age categories or income levels of attorneys.

Senator GORE. Well, my knowledge is not precise either. I was merely trying to indicate to you that many other groups, particularly professional groups, would have earning-age situations not unlike that of doctors.

I agree with you that if a doctor maintains his health, he is very useful and very much in demand at 65, even at 70. Unfortunately, doctors have no more assurance of being in good health at 65 or 70 than most of us do.

There are few certainties in this life. This was the only point I wished to make, Mr. Chairman.

Senator SMATHERS. Senator Carlson, do you have any questions?

Senator CARLSON. Dr. Welch, how recently have you conducted a referendum on the feeling or thinking of the physicians as to inclusion under the social security program?

Dr. WELCH. We have not conducted a so-called poll of physicians by the American Medical Association. Our decision in this matter has been made by the house of delegates which is representative of physicians throughout the United States and is selected on the basis of 1 delegate for each 1,000 members of the American Medical Association in each State.

We feel this is a representative type of government, and these individuals hold hearings on the subject in what we call reference committee meetings which are similar to the hearing which you are holding here today. The most recent of these was the middle of June, less than 2 months ago, when the house voted against inclusion of physicians in the social security program.

Senator CARLSON. I would state that the doctors and physicians in my own State, by writing, have certainly expressed, generally expressed, their opposition to inclusion.

However, we had some testimony before this committee within the last day or two that questioned the method and the reliability of the referendum or poll that you have taken.

Have you anything to say on that?

Dr. WELCH. Well, we actually, as the national association, have not taken a poll. There have been polls taken in various States, the results of which are a little bit difficult to interpret because of the difference in the way that the question was asked in the poll.

For instance, in one State there was a vote for inclusion of physicians by the vote of the majority opposing it if a bill like the Keogh bill were passed. The Keogh bill has been passed, so the actual situation in that State would be in opposition to inclusion of physicians.

Senator CARLSON. That is all, Mr. Chairman.

Senator SMATHERS. Senator Ribicoff?

Senator RIBICOFF. You say, Doctor, that physicians aren't in favor of being covered by social security.

How about the doctors in Massachusetts?

Dr. WELCH. The doctors in Massachusetts——

Senator RIBICOFF. That is your home State.

Dr. WELCH. Yes, it is, Senator. The doctors in Massachusetts have voted in a poll for social security coverage.

Senator RIBICOFF. The vote in Massachusetts was 3,253 to 988, is that right?

Dr. WELCH. You may be right, Senator, I don't know.

Senator RIBICOFF. So basically when you talk about how doctors feel you are not talking about doctors' feeling in your own State of Massachusetts.

Dr. WELCH. This would be true, but again, Mr. Senator, I am not sure how the question was asked. At times a question has been asked, Are you in favor of inclusion under social security? and when a second question has been asked, Are you in favor of voluntary inclusion? the question is answered differently. Therefore, I can't answer you as to just exactly how this question was asked in the poll taken in Massachusetts.

Senator RIBICOFF. How do you think doctors feel in the State of Connecticut, right next to Massachusetts?

Dr. WELCH. I would have to rely on you for that, Senator.

Senator RIBICOFF. Would it surprise you to know that in a poll in Connecticut that doctors voted 1,391 to 504 for inclusion in social security?

Dr. WELCH. It wouldn't surprise me if you say so, Mr. Senator.

Senator RIBICOFF. How about the State of Illinois?

Dr. WELCH. I can't give you the figure.

Senator RIBICOFF. 3,964 to 1,962 to include—to be included under social security.

Senator SMATHERS. What State was that?

Senator RIBICOFF. Illinois.

Senator SMATHERS. Do you have Florida there, just as a matter of curiosity?

Senator RIBICOFF. Yes.

The vote in Florida was 957 for, 714 against of those who replied.

Dr. ANNIS. Mr. Smathers, may I——

Senator SMATHERS. I wonder if the distinguished Senator from Connecticut would tell us who took this poll?

Senator RIBICOFF. Well, these polls were taken by different methods, by different groups, and different people.

They were discussed by Senator McNamara in the Congressional Record of June 13, 1963, at pages 10217–10219. These are the figures that I am taking out of Senator McNamara's statement placed in the Congressional Record. I would like to include the poll results in the record at this point.

I believe that one of the physicians who testified the other day also submitted for the purpose of the record some statistics.

Senator SMATHERS. Without objection, we will put that in the record.

(The figures referred to follow:)

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	4,013
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	2,820	7,823
Minnesota	817	1,030	1,847	4,080
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 21,015 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.

Senator BENNETT. Does that show the year in which each of these polls were taken?

Senator RIBICOFF. No, they don't. They don't show the years as I see it, Senator Bennett. They came over a period of time, I would say, different times during the last 4 or 5 years.

Dr. WELCH. Mr. Chairman——

Senator SMATHERS. Yes, sir, Doctor.

Dr. WELCH. Florida is one State in which the expression changed pending the passage of the Keogh bill. So that if the Keogh bill were passed, 58 percent of the physicians would then oppose social security.

Senator RIBICOFF. Are you aware of a publication called Medical Economics?

Dr. WELCH. Yes, sir, I am.

Senator RIBICOFF. Is it a reputable magazine?

Dr. WELCH. I would say it is a very widely read magazine on the particular subject with which it deals.

Senator RIBICOFF. On the different phases of medical economics?

Dr. WELCH. Yes, that is true.

Senator RIBICOFF. Does it have a fairly wide circulation among doctors?

Dr. WELCH. Yes, it does.

Senator RIBICOFF. Would it surprise you or do you recall that an independent poll conducted by Medical Economics showed nearly 2-to-1 majority in favor of coverage under social security by the doctors?

Dr. WELCH. Again, I would not be able to comment on this, not knowing the number of people who replied to the poll and not knowing the type of question that was asked.

Senator RIBICOFF. What I am curious about is, why hasn't the AMA the courage to poll its own members, under your own auspices by a questionnaire that you send to them? I am curious after so many years yours is the only expression excluded, and why you have never undertaken to poll your own members of the AMA.

Dr. WELCH. Senator, I don't think it is a matter of courage. There is a great deal of education involved in this. I will tell you of a little experience I had 2 weeks ago that illustrates the education that would be necessary to conduct a poll that would be worth anything. I sat down to lunch in a drugstore next to a doctor whom I had known for a great many years who is approximately my age. He said, "Why doesn't the American Medical Association favor the inclusion of physicians under social security?"

I asked him, "When are you going to retire?"

He said, "I am not going to retire."

He had a mistaken idea that if he were included under the social security program when he got to be 65 years of age he would automatically begin to get a check.

I think this illustrates very graphically the problem which the American Medical Association would have in polling the physicians throughout the country, just the same as I believe the Congress of the United States would have difficulty in having a referendum on every subject which was being considered.

Senator RIBICOFF. Doctor, do I understand you to say that the doctors of America have a lower standard of intelligence than the average person in America?

Dr. WELCH. Oh, no, I wouldn't say that at all, Senator. I think a lack of information does not involve a matter of intelligence of the individual.

Senator RIBICOFF. Well, don't you think the doctors know about as much of what goes on as the average worker in America, all of whom are covered?

Dr. WELCH. Well, this depends upon, when you say what goes on, what you are talking about.

Obviously this physician had no appreciation of what the social security system is.

Senator RIBICOFF. But a man who works with a pick and shovel or works in a grocery store or insurance office does not get an automatic retirement benefit if he works after 65 either; isn't that correct?

Dr. WELCH. Yes, this is true.

Senator RIBICOFF. So in this respect he is exactly the same as the doctor.

Dr. WELCH. This is true. I am just answering your question about why we have not had the courage to hold a poll. It has nothing to do with courage, it is a matter of judgment, a matter of decision of the house of delegates which represents the physicians of this country.

Senator RIBICOFF. Well, how about the wives and children of doctors?

Dr. WELCH. You mean protecting them?

Senator RIBICOFF. Yes.

Dr. WELSH. Well, I think——

Senator RIBICOFF. Under survivorship.

Wr. WELCH. Yes, I think this is important to some individuals. I think when a young physician dies and leaves a family of small children, this becomes a very important consideration to the people who know him. But I think again you weigh the advantages in these particular situation against the overall picture, and you cannot be swayed by the emotion that occurs in an occasional case of this type——

Senator RIBICOFF. Have you ever known of a doctor aged 35, 37, or 40 who has died, leaving a widow with two or three children?

Dr. WELCH. Yes, I have, naturally. I have been in practice for 35 years in a large metropolitan area. Physicians that I have known personally have died at a young age. I have known of those unfortunate situations.

Senator RIBICOFF. And certainly between 35 and 40 a doctor hasn't been in practice long enough to start having put aside a nest egg.

Dr. WELCH. Generally, I would agree with you. However, many of them do have a substantial amount of life insurance.

Senator RIBICOFF. But many of them don't.

Dr. WELCH. Yes, I would agree with you.

Senator RIBICOFF. At that age.

Dr. WELCH. I would agree with you, Senator.

Senator RIBICOFF. Don't you think that the widows and orphans of doctors are entitled to as much protection as the widows and orphans of dentists and architects and day laborers and clerks and plumbers?

Don't you think that the family of doctors are entitled to protection?

Dr. WELCH. Well, you put this again on an emotional basis.

Senator RIBICOFF. I am not putting it on an emotional basis at all, Doctor. I am putting it on a very practical basis that covers every widow and every orphan of every occupation and protection in America with the exception of doctors, and I am just asking you why there should be a difference to those widows and those orphans.

Dr. WELCH. Well, theoretically there shouldn't be any difference, but as I said, we are looking at the practical overall picture with respect to a tax program. This is, I believe, the reason why the American Medical Association House of Delegates has taken a stand against it as a practical measure, notwithstanding the existence of cases that would involve a great deal of sympathetic emotion.

Senator RIBICOFF. No further questions, Mr. Chairman.

Senator SMATHERS. Senator Williams?

Senator WILLIAMS. Doctor, what was the vote in your own organization among the delegates?

Dr. WELCH. I think it was approximately 50 percent of the doctors in the State. There were 3,253 in favor, 988 against. The total number of physicians in Massachusetts is 9,838.

Senator WILLIAMS. I didn't mean that. I meant in the national organization; you said you had 1 representative for each 1,000 doctors.

Dr. WELCH. Yes.

Senator WILLIAMS. It is those representatives, as I understand it, who took the vote against the inclusion; what was the vote among those delegates represented in your own organization?

Dr. WELCH. I can't give you the exact figures. The best I can tell you is it was approximately 2 to 1.

Senator WILLIAMS. Thank you.

Senator SMATHERS. Senator Carlson, you have already asked your questions.

Senator Bennett?

Senator BENNETT. The questioning of my colleague from Connecticut interests me. He assumed, or he raised the question as to whether or not doctors were stupid because a doctor said he assumed social security would bring automatic benefits at 65.

Senator RIBICOFF. Just a personal privilege. I didn't use the word "stupid" at all. I think it is unfair for the Senator from Utah to put words in my mouth that I did not use.

Senator BENNETT. What was the inference?

Would you repeat the words you did use?

Senator RIBICOFF. I think the stenographer could read it. The point was made that they had to educate doctors and I raised the question that the doctors so far as I was concerned were just as intelligent as the rest of the population and the inference was by the witness that the doctors didn't know as much as the rest of the population, and I take—I have a contrary point of view.

I think doctors are just as intelligent as the rest of the population, I think they are more intelligent.

Senator BENNETT. I will withdraw the word "stupid" and against the background of the explanation from my colleague, isn't there this difference? A man who accepts a job in industry has no choice as to whether or not he is going to be in social security. He is in, and he is in most industries, he is required to retire at 65. So most men in industry are entitled to believe that automatically at 65 they will get the

benefits of social security. They don't have to reason whether this is wise or otherwise, they are automatically members of the system.

Now, the thing that popped into my mind when this colloquy took place is an experience I had a few years ago with a scientist who has a Ph. D., who is an employee of a large industrial organization, who came to 65 and was retired. Certainly you wouldn't call him unintelligent, but they retained him on a consultative basis and, of course, he didn't get his social security because they were paying him more than $1,200 a year, and I was immediately called on the telephone.

"The social security people have deceived me. They have denied me my right. I am entitled to social security at 65."

I quote this as an example of the fact that many people assume that there is automatic coverage at 65 and they are entitled to their money.

So, it isn't a question of their intelligence in my opinion, but it is a question of the fact that these people not being automatically covered, make the same assumption that the man does who is automatically covered, that all he has to do is reach age 65 and the social security is available, and there still exists in my hometown of Salt Lake a very bitter scientist who assumed he had paid in all these years for the right to get this money at age 65, and the fact that he was retained as a consultant robbed him of the thing he thought he had bought.

So, I think there is a rather more widespread misunderstanding about the effect or the value of a social security retirement benefit as it relates to age, and automatic coverage.

I just offer that as an example of the fact that it isn't necessarily intelligence that is involved here. It is the pattern of social security operation, of the operation of the social security system for the average beneficiary. It is automatic to him and everybody, or many people automatically assume that it becomes automatic to everybody else.

You and I have dealt with it on a legislative basis and we know what is in the law, but these other people don't.

Senator RIBICOFF. While we have dealt with it, and we know it is in the law, and people do have misunderstanding, yet we don't advocate the repeal of social security.

Senator BENNETT. Well, but, nor do we have a right I think to assume that a physician is not intelligent if he assumes that the coverage is automatic.

Senator RIBICOFF. I am not assuming.

Dr. Welch wants to assume it. I don't want to assume it at all. But I can't see the difference between a doctor and, as Senator Gore suggests, a lawyer.

Lawyers are covered and they are automatically covered as those who get a job in industry or a dentist, in the same category of professions.

Senator BENNETT. The Senator was not on the committee when we went through the same process with the lawyers and the dentists.

They kept themselves out for many years and when they came to the committee affirmatively and made a showing, that as represented by their national organizations, that they now wanted to be covered, the committee covered them, and I am sure the committee would cover the doctors immediately without question.

Senator RIBICOFF. I would feel a lot better about that, Senator Bennett, if I had felt from my experience that the AMA actually spoke for all the doctors instead of out of the office in Chicago.

Now, that is what surprises me, that the AMA has never polled their own doctors on this issue. Independent polls have been taken, some State medical societies, some independent organizations, Medical Economics have done so, but it would be so simple for the AMA to poll their own doctors by sending out a coupon with a yes or no or whatever questions they wanted to ask the doctors who comprise the AMA.

They have got the list. You don't have it, neither do I and it is not our duty to do so.

Senator BENNETT. We are getting now into a question of the philosophy of their organization. You and I are here as representatives of the people of our States.

Senator RIBICOFF. And our States include doctors, too.

Senator BENNETT. I am not concerned about that. But you and I face a lot of problems on the floor of the Senate, and we don't expect to poll the citizens of our States before we make our decisions.

We were sent here to represent them and if they don't like us, they can get rid of us, and if these doctors in these States don't like the men who represent them in the house of delegates they can get rid of them and get people who support them.

Otherwise, are we going to assume that all decisions in the United States have to be made on the basis of national polls?

I think we have had some pretty good illustrations in the last few weeks, preceding a particular political convention, that the polls were wide of the mark.

Senator RIBICOFF. That may be so if the delegates were chosen on a democratic basis.

Senator SMATHERS. I wonder if we can elicit some answers from the witnesses. We will be able to direct questions to ourselves many times in executive session.

Dr. Annis, do you wish to say anything on this?

Dr. ANNIS. Mr. Chairman, and members of the committee, I would like to call attention to a very important factor involved in these polls on social security for physicians.

In my absence from my own county of Dade in Florida, a poll was taken after an intensive campaign by a small group of men who appeared at the county medical society meeting and expressed themselves. This was the only time such a poll passed at such a meeting.

Subsequently, as the rest of the membership of the county society became aware that they were on record as having been for something that most oppose, a second meeting was held. The earlier vote was reevaluated and on this occasion it was overwhelmingly reversed.

There is a big reason for this.

I have here a recent publication sent to me as a Florida physician from the Physicians' Forum. Physicians' Forum is a relatively small group of physicians in the East, in New York, that has long opposed AMA on many policies, and they have long campaigned for social security for physicians.

Now, in the 28 years that I have been a member of the American Medical Association, I have never received any literature or anything else from the AMA as to why I should oppose social security.

There has been no campaign or anything, but repeatedly this kind of newsletter has raised a campaign issue. This one was received within the past week. It points out that the older doctor can get retirement benefits up to $200 a month for himself and his wife for paying only six quarters. It points out that the self-employed physicians will pay $307.80 and that for about $450 of invested income, a physician now in his 64th or 65th year can anticipate an immediate bonanza of $200 a month.

I have talked to some of these physicians who have agreed on polls that they would accept social security for physicians. They thought it was a good idea. But after you talk to them a little bit they realize, as Senator Bennett stated, it is not something automatic at a certain age. Then they change their position. But because Senator Ribicoff did quote the Florida figure, I would like to give the total report on this matter as we reviewed the record with our executive director in Jacksonville, and the reports of our survey, which was conducted in February of 1959. The whole story hasn't been told.

To the question, and this is without any advance information or education of whether they favored social security coverage for physicians, 57 percent responded that they would favor it, and 42 percent said they would oppose it.

However, the very next question asked whether they would favor social security coverage for physicians if the Keogh bill passed, so they could do it themselves, and here 58 percent of the physicians said they would then oppose social security coverage and only 41 percent would still favor coverage.

Senator GORE. That is a slightly inaccurate description of the Keogh bill. You say, "so they can do it themselves." What the Keogh plan really involves is payment by the U.S. Government of a generous portion of the benefits.

Dr. ANNIS. The point, Mr. Gore, is, that the physicians that I have contacted in my State and around the country, have indicated their willingness to provide for themselves and their own families. And given the opportunity they would continue to do so themselves on a voluntary basis.

Great numbers of our physicians are active at 70 and 75 years of age. Many continue as extremely capable consultants after this age.

So that what is reflected by the action of the House of Delegates of Florida was reflected by the AMA house of delegates which Dr. Welch referred to. The reference committee heard all physicians from any place in the country, and there were some 15,000 in attendance, who had any views on this matter.

The reference committee, by virtue of the opinions expressed by physicians around the country—those who are not members of any committees or holding any offices—reflected and made a recommendation to the house of delegates to the effect that social security coverage not be approved. This action was overwhelmingly approved without dissent on the floor of our house.

Senator SMATHERS. Doctor, I think there is a shortage of doctors, I would not like to see a situation develop which would encourage doctors to retire even though they were not physicially required to retire.

Would it be your judgment that if doctors were covered by the social security program that there would be a tendency on their part

to stop practicing medicine even though they might have some more useful years left in their lives in which they could practice medicine?

Dr. ANNIS. No, sir, it has been my opinion and my observation that the older physicians who continue to practice do so because they are doctors, and because they want to continue to take care of people, and financial considerations are not among the major reasons for this.

Senator SMATHERS. All right.

Now, Dr. Welch, as I understand it are you through with your part of the testimony?

Dr. WELCH. Yes, I am.

Senator GORE. I would like to ask a question of the doctor.

Senator SMATHERS. All right, sir.

Senator GORE. As a doctor, take a good hard look at me. Do you think I am likely to need social security?

Dr. WELCH. Well, you are asking me a very difficult question, Senator, I don't know. Looking at you, you look pretty healthy to me and I hope you are going to be around for a great many years.

Senator GORE. Of course, none of us knows. But my own feelings are that I will never need social security benefits.

On the other hand, I have never objected to paying the tax because many will need the benefits, and I may need them. I wish that all members of the medical profession would feel the same way, but some of them do not. Some of them do.

Senator SMATHERS. Do you have any further questions?

Doctor, do you want to turn the microphone, I understand Dr. Annis wants to make some comments.

Dr. WELCH. Yes, that is right.

Dr. ANNIS. Mr. Chairman, and members of the committee, at the outset Dr. Welch and I would like to submit to the committee a complete, carefully prepared, and carefully documented statement from the American Medical Association so the reference and source material to the statements which I shall make will be available in detail for your consideration. (See p. 453.)

We appreciate the privilege that has been extended to us to appear before the committee today.

We are here, as Dr. Welch has noted, to state medicine's views on certain proposals with which you are familiar. These are the measures aimed at the single objective of a vast new Federal program—a program to provide hospitalization and related benefits for the entire over-65 population.

We believe that any of these proposals, though it may differ in detail and method, is subject to the same objections. Each would mark the first step in an unpredictably expensive, unnecessary and dangerous venture by the Federal Government into the field of health care.

Let me address myself briefly, for time is limited, to those fundamental points.

In the years of debate and public discussion of this issue, it has been impossible to pin down reliable cost estimates of this program. I have gone over the transcripts of the earlier days of these hearings and I have observed that members of the committee, too, are seriously concerned over this matter. This is as understandable as it is encouraging.

Until we know the cost, no wage earner and no employer can possibly know what he faces in the way of reduced income because of the

program. And in the final analysis, all cost estimates must be based on the degree to which the covered benefits will be used.

On the basis of the limited data available, we submit that it is well nigh impossible for anyone to make an accurate prediction of use, hence provide the Nation with a true picture of the financial burden the program would entail.

We believe, Mr. Chairman, that the record bears us out on this assertion. As recently as last year, the Social Security Administration acknowledged, in its actuarial study No. 57, that a proposal then under active consideration would require, in a dynamic economy, periodic increases in the taxable wage base, if the program were to remain solvent.

Actually, no one really tries very hard any more to conceal the fact that it would be necessary to take from the pay envelopes of the Nation's wage earners periodically increasing amounts in order to cover the mounting benefit costs.

A year ago, we were talking in terms of a raise in the tax base to $5,200. More recently a figure of $5,400 has come into the foreground in connection with other proposed revisions in the Social Security Act. In the last few days a figure of $6,600 has been mentioned in this chamber as a possible social security tax base.

Contrary to the impression that proponents of these proposals seek to convey, we are not dealing here with a minor program of "infinitesimal" cost to taxpayers. We are dealing with a program of limitless possibilities and a tax increase of major proportions.

Before you is legislation to finance higher social security cash payments for 20 million beneficiaries, financed by raises in both the base and the rate. It follows that the payroll tax to underwrite a Federal health care plan out of social security would be on top of this increase, adding a further burden to employees and employers to finance benefits for millions of Americans who are able and willing to take care of their own personal needs. There can be no doubt about it—as has been so pointedly noted here—the average American worker is facing the day when he will be required to pay more taxes to social security to support Federal welfare programs than he will to support all the rest of the parent Government, including the Defense Establishment.

Approximately one-fifth of today's American families do not pay income taxes because their yearly wages are too low. But many of them pay social security taxes which begin at the first dollar of earnings. For them, a Federal hospitalization program would mean a deeper cut in an already small paycheck to finance a benefit for millions of elderly who have already provided for their own health care needs. We know, for example, that approximately 60 percent of the 18 million aged, or about 10 million, have already protected themselves through insurance from the cost of serious illness. And they are purchasing this protection at a rate which exceeds that of the rest of the population. We know further, that while no one disputes the fact that some older citizens still require help in meeting their medical expenses, an effective means for assisting them already exists through the Kerr-Mills law.

Nevertheless, the proponents have supported their case from the beginning of this long controversy by suggesting that Americans over 65 are universally sick and impoverished and only a Federal aid program can provide them with the health care they need. Statistics,

most of them from the Government's own files, refute these allegations. These are included in our detailed statement.

Most of the older people are in reasonably good health, and really poor health is concentrated among a relatively few. While the aged are more susceptible to chronic conditions than the population as a whole, they are less likely to suffer acute illness or to require surgery.

And the word "chronic," it should be pointed out, defines duration, not severity. It includes such nondisabling afflictions as near-sightedness and partial hearing loss.

Available information on the finances of the aging population further explodes the arguments of the need for the program. As a group, numerous studies and surveys show, most over-65 Americans are self-reliant and independent. They are in control of their economic destinies.

The President's Council on Aging has forecast further improvement in the economic status in the years ahead as social security checks grow larger and as more and more workers who do reach retirement age are covered by private pension plans.

Clearly, we are dealing with a diminishing problem which belies the crisis propaganda of those supporting a Federal health care program.

Turning now to the minority of older citizens who do need help in meeting medical expenses, it is satisfying to be able to salute the Kerr-Mills law for its outstanding contribution in enabling the Government to fulfill its responsibility toward its less fortunate citizens. The law, enacted less than 4 years ago, has set a high standard of progress and achievement, reflected in a remarkable record of acceptance by the States.

Medical assistance for the aged programs (to help those who are ordinarily self-supporting but who cannot meet the cost of serious or prolonged illness) are in operation or have been authorized in 43 States and 4 other jurisdictions. Kerr-Mills also provides means for improving health care under existing old-age assistance programs (that is, for those on public welfare rolls). Vendor payment medical programs for OAA recipients are now in effect in all 50 States and the 4 territories.

The number of aged helped by MAA has increased steadily. According to figures of the Department of Health, Education, and Welfare, 172,736 older persons received MAA benefits costing $34.7 million an average of $201 an individual, in March 1964. This represented increases of some 70,000 MAA beneficiaries and $11.5 million in benefit costs in comparison with May 1962.

In the first 2 years of the program, almost 350,000 cases had been approved for MAA. While we have no information relative to later cumulative totals, we do know that monthly caseloads have increased consistently; by March 1964, they were over 1½ times the load in September 1962.

The amounts spent have similarly increased: By September 1962, roughly $323 million had been spent to aid MAA recipients; from October 1962 to March 1964, the next 18 months, about $497 million was spent.

Again and again, Mr. Chairman, as we examine this subject, the point is driven home: There is no need for the proposed amendments.

Now, because we are physicians and because concern for the health care of our patients is deeply ingrained in the fiber of our professional lives, we want to take the few moments remaining to us to alert the committee to the dangers inherent in these proposals to our free system of medicine and the quality of health care it provides.

American medicine today is universally recognized as the finest in the world in all aspects—research, education, training, and the end result, clinical application of the highest standards of care and prevention of disease for the American people.

The proposals which are being advanced here would impose on the system a permanent pattern of tax-paid, Government-regulated health care—a pattern inevitably subject to expansion. For if such a measure became law, the pressure would go on for lowering the age limits, and increasing the types of benefits beyond the limits now proposed. There could be only one eventual outcome: an alien system of medicine, controlled by the Government and financed by an increasing tax burden on the Nation's work force.

Even with a Federal health program in its earliest beginnings, the Government would have to establish controls over the expenditure of public funds. With its eye on the budget, where, indeed, it must be, Government could only hold down costs by tightening the reins on services.

With quantity thus restricted, the quality of care would inevitably decline. As physicians, we must emphasize again we want to be responsible for our patients to the limit of our competence; we want to take care of their needs beyond any other considerations; we know that the highest quality of medical care cannot be attained when some medical decisions must be based on the availability of budgeted funds.

Mr. Chairman and members of the committee, we are convinced that proposals to finance, under social security, health benefits for the aging present a clear and present danger to the vitality and the promise of our unparalleled medical care system.

We urge that they be rejected. And we urge, again, that the provision with respect to the inclusion of physicians under the social security program, for the reasons stated by Dr. Welch, be deleted from H.R. 11865.

We again want to thank you for this opportunity to be heard. Dr. Welch and I will be pleased to try to answer any additional questions that you may have.

Senator SMATHERS. Senator Gore?

Senator GORE. Doctor, perhaps you could be of some assistance to me in answering and replying to this letter.

I am 68 years old. * * *

I am in need of hospitalization care and treatments, and need to be certified under Kerr-Mills Act but am told by the department of public welfare * * * that I am not eligible because I get $1,914 a year social security payments. * * *

My wife Mary D. is 64 years old and under doctor's care all the time for high blood pressure and arthritis and just to buy her drugs costs us $50 a month out of $159.50 which we draw together.

I am getting down in my back and legs and was advised to go in hospital at once for a lot of expensive tests which I am unable to pay for, the way they charge.

So please give me your advice on same and work for higher benefits and something broader than the Kerr-Mills act as it is not much, as it is being dominated by AMA.

Dr. ANNIS. Senator, I appreciate your asking me the question.

As to the gentleman himself who needs the kind of care that he has, I am certain if you sent it to one of your physicians in Tennessee, they will have that investigated for you.

If the man is being denied what is available in your State today, an investigation will bring it to the fore. Very often someone in these State offices doesn't understand the intent or the workings of the law.

Similar requests from other Senators, when followed up, have indicated either that the facts were not as stated in the letter, or that care is available.

As to the gentleman's wife who is 64, the trouble with high blood pressure and arthritis, the mechanism of the Kerr-Mills law makes it possible for any State to provide benefits, including the drugs that she needs. This is available in my State, for example, where our drug bill approximates $400,000 a month. We know that people outside of the hospital often need care that is not available and should not be given in an institution.

I would remind the Senator, however, that King-Anderson would do nothing for this woman.

But Kerr-Mills makes it possible for any State to provide for her assistance in or out of the hospital.

Senator GORE. Well, this gentleman seems to be better informed than you assume, because he sent along with his letter to me a pamphlet supplied to him by the Tennessee Department of Public Welfare, and he has marked those particular sections which disqualify him.

One disqualification in Tennessee is receipt of an old-age assistance grant.

Dr. ANNIS. Senator, if he receives old-age assistance then he qualifies under the first part of Kerr-Mills by law.

Senator GORE. No. 5 of these listed disqualifications is income, if a married couple, of more than $150 a month. Here is an old couple, both sick, one 68, and one 64, with an income of $159.50 to live on, pay rent, buy groceries, clothing, medicine, drugs, and pay for hospitalization.

How does a couple live on $159.50, particularly when one is under a doctor's care all the time?

Dr. ANNIS. Senator, we are not in disagreement. I agree with you that at least, if the facts are as stated and they do need help, it should be given and it can be given today.

If in Tennessee you have restrictive legislation, which does not make the full impact and import of the Kerr-Mills law available, then the correction should take place in the State of Tennessee.

Other States, as they have evaluated their programs, have realized that their initial program—and no one can criticize legislators for starting a minimal program not knowing what it will cost—was too stringent, and their demands were too great. On the basis of this experience, their legislators have changed their programs, repeatedly—in some instances as much as seven times—to make a better program available for those who need it.

But I would suggest to the Senator that none of the proposals before the Senate at the present time would provide for the needs of these people. King-Anderson would provide only institutional care, only in a hospital or nursing home, and would not provide for most of the needs outlined in those letters.

Senator GORE. So you say the remedy is for the Tennessee legislature to amend the State law and provide matching funds which would make greater benefits available on a more liberal basis.

Dr. ANNIS. If this is what is required in the State of Tennessee. This has been the condition in other States.

Senator GORE. Well, let me read you what the requirements are and see if you think that is what would be needed in the State of Tennessee.

Here are the eligibility requirements.

One, be 65 years of age or over.

Two, be living in Tennessee.

Three, not be living in a public institution.

Four, not be receiving an old-age assistance grant.

Five, not have yearly income of more than $1,300 if single, or $1,800 if married and living with husband or wife.

Six, not exceed personal property limitations of $1,000 for a single person or $1,500 for a married couple.

I would like to digress to say I don't know where you could find many couples who had as much as a refrigerator and a stove, and the bare furnishings of a house, who wouldn't have as much as $1,500 in personal property.

Seven, not have more than an $8,000 equity in real estate, the total value of which may be no more than $10,000.

Eight, not have sold or given away property within the last 12 months in order to qualify for medical assistance.

Now, with those qualifications before you, what would you say would be the needed action in the State of Tennessee?

Dr. ANNIS. Senator Gore, if the person who wrote that letter owns a $10,000 home and has the income that you have referred to, and has the assets that you have referred to and they live up on top of Lookout Mountain, it is just possible that they might be able to provide for themselves, or to provide for themselves through the mechanism of insurance.

But I can assure you if they are not so protected, that in Tennessee today, this particular case can be run down and a factual report made to you. If the facts are as presented, Tennessee today has programs comparable to what we have in Florida to provide for their health care needs.

Senator GORE. Well, as I understand these requirements, Doctor, any one of the eight will be disqualifying. I don't know what you mean by referring to someone living on Lookout Mountain with a home worth $10,000. I don't think that will make a downpayment on many up there.

Dr. ANNIS. There are quite a few up there.

I just came from there. They get along very well. I am also acquainted with physicians in the area who, when they have received letters of this kind, as I have from my Senators, upon investigation have found that either the facts were unknown to the people themselves, they were improperly evaluated by those to whom they appealed, or the facts were not as presented.

And where there is a program or where a need has existed, in no instance has this need not been met by the cooperative action of the physicians and others involved.

Senator GORE. Well, I have given you an actual case here of an old couple with an income of $159.50 per month, and I have read you the eligibility requirements from the law and regulations in Tennessee. I have asked you how this person could qualify, and if not, what is the remedial action.

You first indicated that a liberalization of the law in Tennessee is needed. Is that still your view?

Dr. ANNIS. I merely stated, Senator, in any State, because the financial requirements in a State for living costs and everything else vary, that if a State program is inadequate, the correction lies within that State. This has been done in a number of our States around the country when they have found, on the basis of experience, that they need more liberal benefits.

This is possible under existing law, whereas those proposed would not provide for these people at all.

Senator GORE. In other words, you are saying that there are no requirements in the Federal law which would prevent this old man from receiving——

Dr. ANNIS. More income; this is correct.

Senator GORE. Not more income.

Dr. ANNIS. More assistance.

Senator GORE. But they are unable to receive hospital care?

Dr. ANNIS. That is correct.

Senator GORE. What are the limitations in the Federal law?

Dr. ANNIS. The Federal law is rather liberal, in fact this is often used as a criticism of the Kerr-Mills law.

Senator GORE. Do you know of any limitations in it? Can you name me a disease, an infirmity, a condition, mental, psychological, physical, for which the Kerr-Mills Act would not provide full and complete benefit if a State provides the necessary matching funds?

Dr. ANNIS. As I recall the statement printed in the Congressional Record by Senator Byrd in presenting the Kerr-Mills law to the Senate, his words were essentially these:

"This is a good law. This will make it possible for any State to provide for any or all of the needs of their needy citizens."

And then he outlined it. It can provide inpatient, outpatient care—to read specifically from the law it states that—

for purposes of this title the term "medical assistance for the aged" means payment of part or all of the costs of the following care and services * * * for individuals 65 years of age or older who are not recipients of old-age assistance but whose income and resources are insufficient to meet all of such costs; * * * in-patient hospital services, skilled nursing home services, physician's services, out-patient hospital or clinic services, home health care services, private duty nursing services, physical therapy and related services, dental services, laboratory and X-rays, prescribed drugs, eyeglasses, dentures and prosthetic devices, and any other medical care or remedial care recognized under State law.

My observation is the same as Senator Byrd's, and I have used it in discussing this matter with elected representatives of many of the States, with committees appointed by Governors to look into the problems of senior citizens, and with many members of State legislatures who had no real comprehension of what could do done under the existing Kerr-Mills law. On the basis of the needs of their people, they have expanded their requirements to do an even better job to meet their needs.

This we think is sound. We feel that people with high blood pressure or arthritis or diabetes should not be forced into a hospital in order to get help.

This is one of the real merits of the Kerr-Mills law. It makes it possible for a State to render assistance to people without pushing them into a hospital or a nursing home, and this essentially is what was outlined by Senator Byrd as he presented it to the Senate.

Senator GORE. It seems to me that, as I remember the bill, and as you have referred to it, that the Kerr-Mills bill provides on the part of the Federal Government unlimited treatment and care, medical assistance, hospitalization, for just about every imaginable condition.

Dr. ANNIS. It makes it possible to the State.

In essence it says, "Well, we will help you carry out any program for the needy in your State."

That is correct.

Senator GORE. It leaves it to the State to determine who is needy.

Dr. ANNIS. This is correct.

Senator GORE. So——

Dr. ANNIS. Because they are closer to the problem and they better understand the needs. The financial needs of someone in rural Tennessee would be quite different from the financial needs of someone living in Metropolitan New York. For this reason, it is left to the States. They know and understand better the problem of their people.

Senator GORE. Then, as you describe the measure—which I think is an accurate description—there are no practical limits to the amount of aid or to the condition of aid, for which the Federal Government will pay its share.

I agree with your description.

Now let me ask you if there is any manner of financial responsibility provided. Is there any source of funds to pay for these unlimited benefits?

Dr. ANNIS. Yes, sir.

In your State and in mine and others.

Senator GORE. I am speaking now of the Federal Government.

From what source does the Federal Government receive the funds to pay for these unlimited benefits in those States which provide unlimited benefits.

Dr. ANNIS. Well, Senator Gore, you use the word "unlimited." It is limited. The intent of the law is put in the words "for those whose income and resources are insufficient to meet all such costs."

But the real limitation is made by the members of the individual State legislatures. These are the ones who are not going to misuse State funds and be profligate with their use. This is one of the values of the Kerr-Mills law. When the Federal Government expresses its willingness to participate on a percentage basis with any State in caring for its old or elderly, the State itself has to raise moneys through taxation. For this reason we have the restraints of local people who are elected at home and spending local dollars.

Senator GORE. It is left to the State to determine—what was that phrase you used—if it could pay for all of the costs?

Dr. ANNIS. The eligibility requirements or the needs in a State are left to the State, this is correct.

Senator GORE. So this comes back to the point, which you have accurately described, that the Kerr-Mills bill provides unlimited benefits insofar as the Federal Government is concerned.

Dr. ANNIS. No, sir.

This is not what is stated nor is it the intent of the law.

Senator GORE. Will you point out a limitation?

Dr. ANNIS. Yes. The limitation is implied——

Senator GORE. Are you talking about one that is implied? I am talking about one that is stated, one you can read in the law.

Dr. ANNIS. You can read it right there, Senator.

Senator GORE. Yes, but you say it is implied. It is not stated?

Dr. ANNIS. Then let's say what it says.

Senator GORE. All right, go on.

Dr. ANNIS. It says:

For individuals 65 years of age or older who are not recipients of old-age assistance but whose income and resources are insufficient to meet all of such costs.

This immediately limits the case in which any State may apply Federal dollars in the provision of health care to those whose assets and income are inadequate to meet their needs.

In one instance, for minor problems, they may need no assistance. In another instance, for catastrophic illness they may need extended assistance.

Senator GORE. Let us read the whole paragraph.

For purposes of this title, the term "medical assistance for the aged" means payment of part or all of the cost of the following care and services if provided in and after the third month before the month in which the recipient makes application for assistance, for individuals 65 years of age or older who are not recipients of old age assistance but whose income and resources are insufficient to meet all of such costs:

1. Inpatient hospital services.
2. Skilled nursing home services.
3. Physician's services.
4. Outpatient hospital or clinic services.
5. Home health care services.
6. Private duty nursing services.
7. Physical therapy and related services.
8. Dental services.
9. Laboratory and X-ray services.
10. Prescribed drugs, eyeglasses, dentures, and prosthetic devices.
11. Diagnostic screening and preventive disease services.
12. Any other medical or remedial care recognized under State law.

and,

It would be pretty hard to find a condition for which, under these broad terms, the Federal Government would not pay.

Now, here is a law which some people describe as favoring private enterprise, or private medicine—I don't know in just what terms it is described. But actually as you have agreed, and as I have read from the law, just about all the physical or mental impairments and conditions which the author of the bill could imagine were stated, and then, in case they had overlooked something, in the last category they said, "Any other medical care" or remedial care.

So, if they forgot anything they took care of it with that 12th category; didn't they?

And yet Kerr-Mills provides no system of financing except that the costs are added to the public debt. But this is described as the sound program. It is described as the conservative program. It is described

as the financially responsible program. How do we make night appear to be day?

On the other hand, a bill to provide limited benefits, placed on a pay-as-you-go basis, which does not pay a doctor's fee while Kerr-Mills does——

Dr. ANNIS. May I remind you, Senator, both in your State of Tennessee and in the State of Florida, no physician is paid under these laws. The physicians of both States——

Senator GORE. I am speaking of the Federal law.

Dr. ANNIS. Merely to have the record straight, you would leave the impression that doctors are paid in Tennessee, for example, or in Florida. They are not.

Senator GORE. I beg your pardon.

Dr. ANNIS. They may be.

Senator GORE. I do not seek to leave such an impression. I am speaking now of Federal legislation.

Unlike you, I am not discussing 50 different State laws; I am talking about Federal law. I am a Member of the U.S. Congress, not the Tennessee Legislature. And as I read it here, the No. 3 item for which the Federal Government will pay unlimited amounts——

Dr. ANNIS. Is willing to pay?

Senator GORE. No. 3 is physicians' services.

Dr. ANNIS. Senator, this is not true. This is subject always to the action of the individual State legislatures.

Senator GORE. I understand that.

Dr. ANNIS. And is limited to those whose income and resources are insufficient to meet their needs.

You are talking about a program that is limited to the needy sick.

Senator GORE. I am talking about the Federal law, Doctor.

Dr. ANNIS. That is what I am talking about.

Senator GORE. And if you and I could just stay on that——

Dr. ANNIS. I was reading directly from the law.

Senator GORE. If we can talk about the Federal law, I think we will understand each other and maybe those who read the hearings can find them more meaningful.

The Kerr-Mills Act provides that the Federal Government will pay its share of doctor's fees for whatever amount the State provides for and certifies.

Dr. ANNIS. The law provides that the Federal Government is willing to pay its part in the care of the needy sick as determined by the State.

Senator GORE. Well now, I don't believe that the law provides that the Federal Government is willing.

Dr. ANNIS. The Federal law does not require that doctors must be paid or should be paid.

Senator GORE. I didn't say that, Doctor.

Dr. ANNIS. But that is why I said the Government, the law says they are willing to. I just pointed out, Senator——

Senator GORE. I am really not trying to get into a semantic argument.

Dr. ANNIS. Well, it sounds like it, because in Tennessee any doctor's fees are not paid under this law.

Senator GORE. Doctor, can we agree to talk about the Federal law?

Dr. ANNIS. Yes.

Senator GORE. We are now considering a bill proposed to become a law.

Dr. ANNIS. But your words were that the Federal law would pay doctors, and I merely said they would be willing to participate in the payment if that is done by the State.

Senator GORE. Are Federal funds used to pay doctors' fees in any State under the Kerr-Mills bill?

Dr. ANNIS. I believe they are, yes.

Senator GORE. Would the King-Anderson bill provide for the payment of doctors' fees?

Dr. ANNIS. No. Except those doctors who work in hospitals.

There are some 50,000 who would be involved directly or indirectly through the payment to hospitals.

Senator GORE. And, of course, public health officers. But the practicing——

Dr. ANNIS. But for the average practicing physician, the answer is "No."

Senator GORE. Then we understand each other and we are talking about the Federal law now.

Dr. ANNIS. That is correct.

Senator GORE. The Federal law provides that the Federal Government will—and you say "will be willing," so I will accept your term if that will get us out of this semantic argument—I am not concerned about that.

Dr. ANNIS. All right.

Senator GORE. There is provision in the Federal law for paying doctors' fees, the Federal share of doctors' fees. Is that correct?

Dr. ANNIS. This is correct.

Senator GORE. You don't think that is socialized medicine?

Dr. ANNIS. No, sir, because——

Senator GORE. But you think that a program that is on a pay-as-you-go basis under social security would be socialized medicine?

Dr. ANNIS. When it puts a tax on one class that works, to provide for 18 million who are going to benefit whether they are rich or poor, yes, sir.

Senator GORE. Then you describe the King-Anderson bill as socialized medicine?"

Dr. ANNIS. I didn't bring up the term, Senator, but since you ask me, it would fit into that category——

Senator GORE. Have you used that term?

Dr. ANNIS. No, sir.

Senator GORE. You have never used that term?

Dr. ANNIS. Perhaps in response to questions such as yours. I have never voluntarily used the term. I think the term is misunderstood by many people.

Senator GORE. I agree, I agree.

Dr. ANNIS. I am glad we agree on something.

Senator GORE. It seems to me that insofar as fiscal responsibility is concerned a program which by law levies a tax to put the program on a pay-as-you-go basis and which provides for limited benefits should be judged as more responsible fiscally than a program which provides unlimited benefits and no means of financing whatsoever, except an addition to the deficit.

Dr. ANNIS. Senator, that isn't quite in accord with the facts. Your criticism first of the Tennessee program is——

Senator GORE. I am not criticizing the Tennessee program.

Dr. ANNIS. May I remind you that your criticism of a program——

Senator GORE. You want to criticize the Tennessee program?

Dr. ANNIS. May I say your criticism of a program is that it is limited in its scope for some who need it.

Now, you speak of the King-Anderson bill which has a very limited program and I would agree. Paying a limited part of a rich man's bill hardly solves his problem, but paying only a limited part of a poor person's bill leaves him impoverished and considerably without help.

Kerr-Mills is designed for people who need help; the financing comes from general revenue.

Now, in this case, all sources of income are taxed, including stock and bonds and oils. But under social security financing, all sources of income are not taxed. The working man and his employer will pay that tax. But stocks and bonds and oils will pay no increased tax and the benefits will go to everyone, rich and poor, just because they have had a birthday.

If we are going to talk about a program to provide for the needy—people such as you have referred to in your letter—isn't it wise to establish a good program to provide for all of their needs to the extent of their needs, rather than a limited program providing limited benefits for the rich as well as the poor just because they have had a birthday?

Senator GORE. Now, please understand, I do not object to doctors' fees being paid by a sound program of medical care. Doctors are an essential part of that medical care, but what I was trying to get your opinion on was how a program which provides for governmental payment of doctors' fees, is not socialistic, while one which does not provide for such payment is socialistic.

Dr. ANNIS. Well, Senator, you are distorting the real story.

Senator GORE. I don't mean to distort.

Dr. ANNIS. But you are doing it.

Senator GORE. How am I distorting it now?

Dr. ANNIS. You see, in many States physicians don't want to be paid by the Government, and they are not. On the other hand, there are many areas of our larger communities of this Nation, in big metropolitan areas where physicians have been practicing for many years. As the area in which they practice has declined in its economic income and people have moved out, they have been left with the poor and the needy.

Many of these physicians have as their practice mainly people who are on marginal or submarginal income.

Programs to provide health care for this class of people would have no physician there if these doctors weren't paid. But we are talking of the needy. We are not talking about doctors in practice, and doctors' incomes have nothing to do with our support of Kerr-Mills, which we think is sound in principle, or our opposition to King-Anderson, which we think provides limited care and would not cover those who really need care tothe extent of their needs.

Senator GORE. Well, Doctor, please understand that I am not being critical of doctors. The doctors I have personally known are among

the most generous people on earth. They have given, to my personal knowledge, generously of their time and their talents for people who need care.

I hope that nothing I say will interpreted by you or anyone else as being critical of doctors, and so far as I am concerned I would favor the inclusion of a provision for the payment of doctors' fees. The Kerr-Mills Act does so.

Now, with respect to the number of States in which doctors' fees are paid by Kerr-Mills, I would like to read to you a paragraph from the report issued in 1963 by the Subcommittee on Health of the Elderly.

Twenty-eight of the twenty-nine jurisdictions include some kind of services of physicians in their programs, although in three of them (Maine, Puerto Rico, and South Carolina) such care is available only in outpatient clinics, and in two others (District of Columbia and Pennsylvania only through a "home care" or "home-hospital" program. The exception is Tennessee which does not pay for physicians' services.

I don't know why our doctors in Tennessee were discriminated against.

Dr. ANNIS. They asked to be, Senator. They didn't want to be included. They were willing to volunteer their services.

Senator GORE. They are a very generous group.

Now, I would like to get to the main question, which is the adequacy of Kerr-Mills.

This colloquy began, I think, when I asked you to help me in answering this letter from an elderly constituent, with your statement to the effect that what was needed in the case of those States which did not provide adequate benefits was a liberalization of such programs within the States.

I think I am stating you fairly and correctly.

Dr. ANNIS. Yes, sir.

Senator GORE. You would agree with that?

Dr. ANNIS. Yes.

Senator GORE. Fine.

The more understanding we can have the easier it is for each of us to make our points, and those few people who may read this will more easily ascertain our points of view.

Now, I would agree with that, and I would further agree with your statement that some States have enacted programs which take great advantage of the Kerr-Mills law.

I would like to read a paragraph about that.

"Five States—California, Massachusetts, Michigan, New York, and Pennsylvania,"—it would be hard to find five more wealthy States, wouldn't it?

Dr. ANNIS. Nor five larger States in total number in population, wealthy as well as poor.

Senator GORE. Five States more able to provide State matching.

Dr. ANNIS. Correct.

Senator GORE. These five States, Doctor, according to this report—

received 88 percent of the $189 million in Federal funds expended from the inception of the program through December 1962. However, only 32 percent of the older population of the Nation resides in those States. * * * Only 10 percent of the Nation's aged live in the State of New York. New York, however, received 42 percent of the $189 million.

Now, this is a basic fallacy of the Kerr-Mills Act. Where the need is greatest, where the financial resources are least, the smallest benefits are going.

Why?

Because the States are simply unable to provide the matching funds. So what we have in Kerr-Mills is a Federal program which benefits most the wealthiest States which are in turn best qualified to provide medical care for their own.

This is a basic fallacy upon which Kerr-Mills is hung.

Dr. ANNIS. Senator, the record is no longer accurate. May I bring the figures up to date?

Senator GORE. I wish you would. I was reading the most recent ones I have.

Dr. ANNIS. Yes, well, I have more recent ones than that and we will give you the sources.

Senator SMATHERS. May I ask one question right there which I think would add some more meaning even though this is very meaningful, to this particular dialog: Is it not a fact that under Kerr-Mills there is a matching fund of 50 percent to some States but the less wealthy States, the more impecunious States, the poorer States, that Kerr-Mills will actually go as high as 80 percent of the cost of the program in those States?

Dr. ANNIS. That is correct.

Senator SMATHERS. Am I right or wrong?

Dr. ANNIS. This is correct.

Senator SMATHERS. I wanted to know about it.

Dr. ANNIS. There are a number of factors involved and with your permission I would like to add this to your record.

This criticism of the Kerr-Mills in a program has been the three, four, of five States have been getting too large a share of the Federal aid under it.

Senator GORE. Would you mind telling us from what you are reading?

Dr. ANNIS. This is from our testimony that is submitted in detail. I am merely calling attention to it here because it is so pertinent.

HEW Assistant Secretary Wilbur J. Cohen has charged that four States—California, Massachusetts, Michigan, and New York—"receive about 88 percent of the money spent" under MAA programs.

Our first comment on this statement is that this is an outdated percentage, becoming more outdated monthly. But it is not surprising that a few large States have been getting a large part of Federal MAA matching funds.

From the start of the program until June 1961—9 months—Massachusetts, Michigan, and New York were by far the largest States involved. The three States had comprehensive medical programs in effect for the needy aged. They already had the experience, the staff, and the caseload to operate large-scale medical programs. It was not the least surprising that, in the early stages of MAA, about 90 percent of the expended funds were expended in these three States.

Beginning with June 1961 the percentage in the three States began declining, but, in December 1961, California began its program for long-term care which is a high-cost-per-case program. Then it became "four States" instead of "three States" that were using the major share of MAA Federal funds.

In May 1963 the President's Council on Aging added Pennsylvania and had five States accounting for 88 percent of total MAA expenditures in the calendar year 1962.

These are figures you have just referred to.

But other States have implemented MAA since then. States with no previous experience with vendor payments have gained experience. The aging in other States have learned of the existence of the program. Consequently, the percentage of funds going to a few States has been less nearly every month.

However, it is true that the five States cited—California, Massachusetts, Michigan, New York, and Pennsylvania—will receive a considerable amount of MAA funds even after all the other States have good programs going. In fact, in March 1964, with 45 MAA programs in operation, these 5 States accounted for 76 percent of MAA expenditures.

Why? Simply because they have large numbers of older people as residents, and hospital and medical costs are higher in these States. The association last year made a statistical study of these points, comparing the 5 States cited with the other 20 States which had MAA programs in effect by the end of 1962.

They contained about 5.9 million, or 57 percent of the 10.5 million over-65 residents in this 25-State sample. The average hospital stay was longer in the 5 States than in the remaining 20 (8.1 days to 7.1 days, voluntary short-term general hospitals); the average per diem cost of hospital care was higher ($41.69 to $37.51). In fact, if every over-65 person in the 25 MAA States as of the beginning of last year had a hospital stay of the average length and cost for his State, more than 62 percent of the cost would have been incurred in these 5 States.

These then are the major factors accounting for the high percentage of MAA funds in these five States: early implementation, organized medical programs before MAA, a large aged population, and higher costs.

In the State of New York, for example, Governor Rockefeller admitted this, when he took the people who were on old-age assistance programs and immediately carried them over to the medical assistance to the aged programs where he would get a larger Federal payment.

All of this was reflected in States that were, as you have said, the big States. They are States with adequate income, they already had extensive programs to provide for their needy, and so they were immediately able to take advantage of the Federal program.

But as State after State has established good programs for their needy sick, the percentage going to these larger States has declined. It will never decline to the percentages of less wealthy States because of the higher cost of medication, the prolongation of stay and the rest.

You know it takes a little longer to get over some diseases in New York, in Massachusetts, and New Jersey than it does in Tennessee, or Georgia, or Florida, and the convalescent rate on many major illnesses differs from the Northeastern States.

All of these are factors which enter into the total dollar costs—prolonged stay as well as numbers of people who reside there.

Senator GORE. Doctor, you then advise old people to move to California instead of Florida?

Dr. ANNIS. Well, California is getting a big share but we still manage to get some of our own. Eleven percent of our people are over the age of 65. And it is interesting, Mr. Gore—you just reminded me—when I appeared before my legislature last year with Congressman Herlong, our State welfare and our public health people reported to us on our program in Florida as compared with what exists in your State. That for every person over 65 that we helped in Florida in 1963, we helped four under 65.

We have found that age is not a determinant of need, or of help from your fellow man. Many younger people acquiring families and paying mortgages need help when they have accidents and illnesses.

Senator GORE. You mean they get sick younger in Florida?

Dr. ANNIS. They get sick younger every place. But our problem has been that even in Florida were 11 percent of our people are over 65, our senior citizens are not the ones who require more dollar help.

Senator GORE. I think that one member of this committee is having high blood pressure right now.

Dr. ANNIS. Oh, no, this Senator is well aware of this. He is also aware that many times we have received letters from his office such as you have received and in every instance they have been run down.

In most instances the Senator had not been given the facts, and when the facts were known the record was clear. But in a few instances, where need actually existed, merely by bringing this need to the attention, not only of physicians but of the welfare workers of our State, many people were able to obtain help that they did not know existed. I feel that the mere passage of a law does not make it work and that is why the physicans of this Nation have tried to educate themselves and legislators in all of our legislative assemblies to pass good legislation to provide for the needy sick.

We are convinced it can be done under existing legislation, under the Kerr-Mills law.

Senator GORE. Well, returning to the principal theme, after these facetious remarks——

Senator SMATHERS. May I make an observation right there, not with respect to Florida or Tennessee. I think Dr. Annis expressed it well when he said that actually there is a better recovery period, even though he was kind enough to include Tennessee, Georgia, and Florida——

Dr. ANNIS. They are our neighbors.

Senator SMATHERS (continuing). Than in the Northeastern States.

I would like to make one comment with respect to the questions being asked by the Senator from Tennessee stating one limited area, I agree with him and I want to make an observation which I have been making frequently about this whole legislation.

The Senator from Tennessee has asked questions which are calculated to show that as a matter of fact the Kerr-Mills bill is more generous to elderly people who fall within its provisions than is the King-Anderson bill.

He further makes——

Senator GORE. No; more generous in Federal funds to the old people in those States, which will provide with sufficient generosity.

Senator SMATHERS. I will just say that I gathered that the Senator was talking about it was more generous even in its coverage, even in that which it will cover, because I think it is.

Senator GORE. I don't know how it can be more generous.

Senator SMATHERS. Exactly. I agree with the Senator. I think it is more generous.

Senator GORE. Insofar as the Federal law is concerned.

Senator SMATHERS. That is right, and in its application. It is more generous, it will cover more things, it will give more help to people who are in need than undoubtedly the King-Anderson bill and as a matter of fact, it will be. I do believe in some instances it is going to end up to be, considerably more costly in that it makes no provision for the payment of its operation and the costs which would be incurred in connection with its application.

Which leads me to make the statement that I have been making recently about this whole program. I have never understood in the light of the fact that the King-Anderson approach from the point of fiscally responsible, more conservative, more limited in its coverage, how it is that the labor organizations, how it is that the workingman who has to pay a tax, under the King-Anderson approach, how it is that the people who are now the great leaders in the forefront of this battle for King-Anderson can be for it when it seems to me they would want to be for Kerr-Mills, and the people who are for Kerr-Mills, with the possible exception of the doctors, but most well-to-do people, who believe in a sound fiscal program and a program that is properly financed ought to be for King-Anderson. I never have understood how it is that the one group which wants and needs it most wouldn't be for Kerr-Mills because it doesn't take anything out of their pocket at any time. They can get more help than they can under King-Anderson. Why they are not for Kerr-Mills, and the more well-to-do, the more conservative business and professional people actually are not for King-Anderson.

Senator GORE. I will give you one more paradox. I don't know how one is free enterprise medicine and the other is socialized medicine either.

Dr. ANNIS. Mr. Smathers——

Senator SMATHERS. I will agree on this point. Very frankly, I don't understand how, if you use the word "socialism" and I say this with all respect to my good friend who is testifying for whom I do have a great affection and respect, how we can even infer that King-Anderson is socialized medicine and that Kerr-Mills isn't.

Frankly, because Kerr-Mills takes it directly out of the Treasury and covers everything, where King-Anderson, at least, has somebody contributing to their own welfare and well-being when they get to be 65 years old. It is a great paradox to me how one group can so avidly support King-Anderson, when as a matter of fact, their best interests lie on the other route, and the group that is opposing King-Anderson, ought to be supporting it. It ought to be just the reverse, in my judgment, and that is what I have concluded about it a long time ago and still feel that way.

Dr. ANNIS. Mr. Smathers, may I point out there are several big differences.

Senator SMATHERS. All right.

Dr. ANNIS. The Kerr-Mills law is designed to take care of the needy sick, which we feel is a just responsibility of government. Socialized medicine is where the government provides for people where it has no logical responsibility to provide for them.

There is no logical responsibility for the government, the Federal Government or any government, to provide for the rich and those well able to provide for themselves just because they had a birthday.

But I think one reason that you will find increasing opposition to the King-Anderson program for rich and poor, is, for example, in the State of Michigan, where they have a pretty good program, and which costs them around $20 million under Kerr-Mills.

Under social security taxes the first year in that State, the tax increase would be $120 million or six times more.

In the State of California, Governor Brown admitted that last year for the 27,500 people they took care of at a cost of around $46 million,

that this was a lot of money for Kerr-Mills. But it still went to the needy of California. But in that State, with great industry, and many payrolls, the first year's tax under social security, under the existing tax base, would exceed $201 million. This is better than five times as much.

So that the worker in Michigan, and the employer in Michigan, the worker and employer in California, are realistic in understanding that the Federal Government doesn't have any money it doesn't first take away from them. It is cheaper to do a good job for those who need it in Michigan and pay a $20 million bill than it would be to increase the wage taxes by $120 million in a year, to provide for rich and poor, because they have had a birthday.

And additionally, as has been pointed out under Kerr-Mills, it is possible to provide for all of their needs. It can provide for them in or out of a hospital, and if the State so desires.

Senator GORE. For how long? They can provide for them, so far as the Federal law is concerned—you just said, Kerr-Mills will provide Federal funds to provide for them either in or out of the hospital.

Will you add for how long?

Dr. ANNIS. And I stated, Senator, as you interrupted me, in accordance with the needs as found in the States as they better evaluate the needs of their people.

Senator GORE. Is there any limit to the duration?

Dr. ANNIS. Here again it is up to the State.

Senator GORE. I am asking you questions, Doctor, about the Federal law, the law of the United States. Is there any time limit? Can a 65-year-old person go to a hospital and stay until he is 95?

Dr. ANNIS. Oh, I think so.

Senator GORE. Thank you, go ahead.

Dr. ANNIS. If the State, that has to be a part of the operation, made it possible.

Senator GORE. I understand that. There is a State-Federal program. But insofar as the Federal law is concerned there is no limit on time.

Dr. ANNIS. This is correct.

Senator GORE. I believe the King-Anderson bill provides for 90 days, doesn't it?

Senator SMATHERS. Ninety days in nursing home, 90 days——

Senator GORE. Yet one is socialized medicine and the other isn't. Which one is?

Dr. ANNIS. Senator Gore, you are the one who is continuing to bring up that question and that term.

Senator GORE. I didn't coin that phrase.

Dr. ANNIS. May I point out, Mr. Smathers, for the record, when you mentioned the 90 days, that since initiating the medical assistance to the aged program, the great State of Tennessee has raised its income ceiling for eligibility, has increased hospitalization from 10 to 20 days, and has added up to 90 days of nursing home care, and has expanded the list of authorized drugs.

So Tennessee, like many other States, on the basis of need, as it has been demonstrated for the care of their needy, has expanded their program.

Senator GORE. Well, I would like to read a postscript on this letter from this elderly gentleman. He says:

I do not want to be a ward of the Tennessee Welfare Department for I know how things are with the real poor old people.

He is apparently well off with $159 a month.

But to cover another phase, as I read your testimony before the House Ways and Means Committee, and the report of the Senate Committee on Health of the Elderly, I found some differences.

I believe you said in your testimony that more than 2 million aged were covered under individual insurance company mass enrollment plans.

Was that your testimony or was that the testimony of someone else?

Dr. ANNIS. More than how many?

Senator GORE. More than 2 million. Maybe it was someone else's testimony.

Dr. ANNIS. I don't believe that was our testimony. I don't recall this testimony, Senator Gore.

Senator GORE. I think, Mr. Chairman, that we have not reached a meeting of minds on how the problem can best be solved most equitably, but at least the witness and I have reached, I think—and this colloquy will reveal it—a meeting of minds on what the Kerr-Mills Act is, and that its implementation, the extension of benefits, the extension of any benefit under it, depends upon a State matching program, and that presently five States are getting a disproportionate share of the benefits.

The latest figures I had showed that the five States were receiving 88 percent. You gave statistics which you have described as more recent which showed they are receiving 76 percent.

Now, whether 88 or 76, I think many old people who are in dire need of hospital care and treatment, and medical care, are being discriminated against by the kind of program that will give 76 percent of Federal benefits to five of our richest States and leave the people living in the States with the least economic ability to provide the matching funds without their fair share of the benefits from the U.S. Government.

To me this is not a fair law. This is not an equitable law. It is not an answer to the problem. It is wholly inadequate. That is my view, and I have tried to state the positions, not the conclusions, on which the witness and I have found agreement.

That is all, Mr. Chairman.

Senator SMATHERS. All right.

Thank you, Senator Gore.

Dr. Annis, with respect to the allegation and the established fact that a great proportion of the money has gone to four States, is it not a fact that most of the money in those days went to the biggest States where the old-age assistance program was first started?

Dr. ANNIS. This is true, and for a much longer period of time before some of the other States caught up.

Senator SMATHERS. And is it not your contention that once this program has been in operation and the States which do not usually have legislatures meeting but every 2 years, that when they understand how the program operates that in time this imbalance with respect to the payment of Federal funds will be rectified?

Dr. ANNIS. Yes, sir; this is our opinion.

Senator SMATHERS. Why is it that we still continue to hear the charge that the Kerr-Mills bill, as such, is not working well, and that even though it has started in 43 States that nevertheless it does not meet the real demand of elderly people for medical care and attention?

Dr. ANNIS. This is not the statement of those with whom I have met and talked in my travels, whether they are physicians or working with the State governments or those operating them. These statements generally come from the same sources that said Kerr-Mills wouldn't work before it was passed. They said it wasn't going to do a good job, and then in saying it isn't doing a good job, first they said that it was only operating in six States, then in a dozen States, and, after the legislatures had met, saying that it was only operating in half the States. Now, after it has been implemented in 43 States, they say it hasn't been operating in all the States. This has been consistent and it all emanates from the same source.

The truth of it is, and the records are there, last year in attempting to meet with physicians around this Nation to see that they became interested in seeing that Kerr-Mills does work and that needy citizens everywhere are not denied medical care, it was my privilege to speak for the doctors and meet with 22 Governors (and with 18 of those we discussed this matter in detail), and to discuss it with State legislators. It has been my experience that legislators with many problems, just as they have here, were unaware of what could be done even in their own States. But wherever they are aware of it and really want to do a good job, increasingly across this Nation we are seeing an honest effort to make Kerr-Mills work. We feel if a person is poor and he is sick for 90 or 190 days or 9 years, these are our responsibilities. This is what we have been trying to sell.

Senator SMATHERS. Doctor, do you have the feeling that the Department of Health, Education, and Welfare, which obviously has not been for the Kerr-Mills bill, and those who work in that Department of Government on the general health care and the old-age assistance programs, have not encouraged the operation of the Kerr-Mills bill even though it is the law of the land?

Dr. ANNIS. Not only have I had the feeling, but across this land and on more than one occasion, official spokesmen and under assistant secretaries of that Department have consistently campaigned across the Nation saying that Kerr-Mills won't work, that we must have this other bill to which they have been politically committed.

This has happened not once, but many times, and I feel very strongly. I have not observed it as much during the past 8 to 10 months, but up until that time, the opposition from officials of the Department was very outspoken, it was very positive, and it was omnipresent.

Senator SMATHERS. Doctor, turning to another subject, I understand that you have recently been elected as president of the World Medical Society or the World Medical Association or——

Dr. ANNIS. No; I have recently completed 1 year as president of the World Medical Association.

Senator SMATHERS. In your travels throughout the world, how has the medical program worked with respect to elderly people in, let's say, Great Britain or Canada? What has been your experience?

What has been your conclusion with respect to how those programs have worked and is there any similarity between those programs and that which is envisioned under King-Anderson bill?

Dr. ANNIS. No; they are totally different programs from beginning to end. King-Anderson would be a small step in that direction.

But this I can say: Having visited extensively in certain countries, having had appointments with ministers of health, those running the institutions of medicine, doctors in practice in and out of government and institutions, I found there is no other country that can approach the extent of quality care, the distribution of quality, and the availability of quality medicine that this country has.

In some cities abroad, from some doctors, in some hospitals, some people get high quality medical care.

Emergency care is generally available wherever there are doctors. If you have a heart attack, or a stroke, or break a leg, if there is a doctor there, he will do his best no matter what his language, no matter where he is from.

But in the overall quality of medicine which is available across this Nation, no other nation can touch it.

In England, for example, their system is suffering. There in July, the British Medical Journal had their second editorial in 2 years on the emigration of British physicians who are leaving the country because they do not have the opportunity to practice the quality of medicine for which they have been trained. This is a long and another story we can provide, but basically there is no other country that can approach the type of medical care, the type of educational facilities, the expansion of facilities for the production of doctors, and the expansion of hospitals and medical institutions to give them the tools of modern science which exists in this country.

Senator SMATHERS. I congratulate you on your candor. I gather from what you say is that the King-Anderson bill should not be equated with the type of program which they have in Great Britain where apparently the type and quality of medicine has deteriorated since they put in whatever program is that they now have?

Dr. ANNIS. That is correct.

Senator SMATHERS. Doctor, as you know, many people say that the basic objection they have to the Kerr-Mills law is that it requires a means test. In other words, people do not like to go down before some board and state the extent of their poverty from which they are suffering.

What is your response to that?

Dr. ANNIS. The fundamentals of good health are good food, clothing, and shelter. These are basic to good health. But no one proposes that we provide food, clothing, and shelter; pay the grocery bills for everybody over the age of 65.

But we do provide it for two and a quarter million people over 65, because they are unable to provide for themselves.

Now for whom do we provide? For those who are in need, and a means test demonstrates their need for Government assistance. We provide low-cost Government housing for whom? For those whose income and assets put them into the position where they need aid and assistance from Government.

We have one program after another to provide for people unable to provide for themselves, and we determine this by a means test, just like when you go to borrow money, you pass a means test.

Senator SMATHERS. Do you know of any other Government program where a means test is required?

Dr. ANNIS. No—you mean any other government where it is required?

Senator SMATHERS. No; any other Government program which we have in the United States today?

Dr. ANNIS. Where a means test is required?

Senator SMATHERS. Yes.

Dr. ANNIS. Yes, sir. Old-age assistance; aid to needy families with dependent children; aid to the blind; aid to the permanently and totally disabled; aid to the aged, blind, or disabled; medical assistance for the aged; low rent public housing; rural housing loans; school lunch programs; veterans' pension; veterans' hospitals; and domiciliary medical care programs. The surplus food program distributed last year was in the neighborhood of $200 million.

Now, people can't load up their children in a station wagon and go down and say, "We have got a lot of mouths to feed, fill her up."

They say, "Where do you live? how much is your house worth? what is your mortgage? where do you work? how much income do you have?"

But if you need it for yourself or your children, the Government surplus food program is available.

All a means test determines and says to the taxpayer is, "We will not take from you your wages in the form of taxes and give them to someone else except on the basis of their need for it". The need attached to Kerr-Mills is merely the same need that we attach to such provision as food, clothing, and shelter. If it is reasonable to say it is beneath a person's dignity to ask for help for health care, and that therefore we must provide for all 18 million over 65, the rich as well as the poor, at the workers' expense, then why is it not equally reasonable to say that people shouldn't have to ask for food and therefore we should pay the grocery bills for everyone over the age of 65.

Senator SMATHERS. Doctor, turning once again to Kerr-Mills with respect to its costs, do you know how much it cost the Federal Government to operate Kerr-Mills this past year?

Dr. ANNIS. I don't have that figure.

Senator SMATHERS. Is it your judgment as more and more States begin to utilize it that the cost of the aging problem will increase?

Dr. ANNIS. I believe it will increase for some years until they catch up where they are not covered at the moment or where the coverage is inadequate or incomplete, but I believe once having reached that stage it will be a declining rather than an increasing problem.

This is true in your State, this is true in many States where we take care of fewer people today under old-age assistance and assistance to people over 65 than we did 10 years ago, even though our population has almost doubled since then.

Senator SMATHERS. Doctor, you have associated with leading figures in political life both Federal and State. Has it not been your observation that men who run for public office are much inclined to

outdo each other with respect to how generous he is going to treat his constituents and on that assumption with which I am sure you would agree, would you not have the fear that each State or each legislator will say: "Well, if my opponent is willing to make the limit under which a family or person can receive free medical care $3,600, I am willing to make it $4,000," and then the third fellow who is running will say: "Well, I will make it $5,000," and eventually they move this means test to the point where in practical consideration it is no means test at all.

Everybody will get free medical care under Kerr-Mills who has $8,000 or less. Do you envision that or do you not envision that prospect?

Dr. ANNIS. No, sir; because of the check at the State level. You see, it is rather difficult for the fellow at home to control what you might do up here in Washington.

It is much less difficult for him to control what they do in the State legislature, and he is much closer to his legislator at the State level than he is at the National level.

You may be busy around the clock now and around the calendar, whereas these men are home, except for the 2 or 3 months that the legislature meets every year or two. These people at home realize that no Federal-State program on a matching basis can operate without increasing taxes at the local level. I believe that this is one of the wise checks and balances built into the Kerr-Mills law, whereby we limit the dollars to be expended to those who need them. We limit the program through the taxes which are levied at the local and State level.

Senator SMATHERS. You will agree, however, that as the States begin to implement the Kerr-Mills program more which, as I understand, you advocate, that obviously costs to the Federal Government will increase?

Dr. ANNIS. Mr. Smathers, in the one State that I am sure of the record, the senior citizens of our State over the age of 65 have more than doubled in the last 12 years, but we have fewer people on relief, fewer people receiving old-age assistance, fewer people receiving medical assistance now than we had 12 years ago.

In other words, the mere fact that we are adding more and more people over the age of 65, does not mean that they are dependent. More people have their social security checks, more people have pensions, more people have lived a longer period of time, and they are better able to provide for themselves through insurance and other funds. We are not getting an increasing number of senior citizens who are dependent, even though we are getting an increasing number of senior citizens.

I believe the program costs will level off as soon as we have caught up and have a fairly good program across the Nation.

Senator SMATHERS. Do you not agree, however, that the cost of medical attention in the light of the fact that hospital costs, for example, have increased to something in the neighborhood of $40 a day, that the general costs for medical care will go up and that even though more and more of our people do have higher and higher incomes after they are retired, will result in increased costs to the Federal Government and the States, if they are to take care of this program?

Dr. ANNIS. There isn't any question about it: With increased knowledge and skills. The cost of medicine which depends upon

personal care will rise. Across the Nation 70 percent of hospital costs is the labor cost. When the average hospital bill is paid, $70 out of every hundred is for men and women who work in that hospital, not counting doctors, equipment, and drugs. As we increase knowledge and skills, we have to hire more people, and medical care costs will go up. This is true.

But the limitation on Kerr-Mills is that more and more people are providing for themselves through voluntary insurance and prepayment plans. More and more of our senior citizens are providing for themselves, especially catastrophic care, through insurance. So they will not be an increasing burden, and they will be able to meet these increasing dollar costs, because of these policies.

I do not envision an increasing number of dependent senior citizens who will call for an inordinate increase of total expenditure from Federal sources.

Senator SMATHERS. Well, Doctor, I have no further questions to ask.

Senator GORE. Mr. Chairman, I have.

Senator SMATHERS. Senator Gore.

Senator GORE. I find one other paradox in this whole situation, Mr. Chairman.

Dr. Annis has just lauded the use of the insurance principle by a growing number of our citizens, yet he is unalterably opposed to a plan which would apply the insurance principle to all of our citizens.

Dr. ANNIS. I know of no such program, Senator.

Senator GORE. Well, the overwhelming proportion. You will accept that?

Dr. ANNIS. No. If you are referring to Anderson——

Senator GORE. Yes.

Dr. ANNIS. You see, King-Anderson is not just an extension of social security except as it is an extension of the tax. King-Anderson will provide a service, rather than dollars with which you can look ahead and know exactly how many will have to be spent. King-Anderson purports to provide a service which, as Senator Smathers has just indicated, will continue to go up in cost as medical knowledge and science advances.

This service is to be paid for by increasing taxes levied on those who work and, as you are well aware, under this bill, the 18 million people who are already over the age of 65, would never have paid any of its costs, but would benefit as long as they lived.

Senator GORE. Well, you found, as I understand you, that a larger number of citizens were currently providing some security through the purchase of private health insurance plans.

Dr. ANNIS. This is correct.

Senator GORE. And you think the more who do that, the better?

Dr. ANNIS. Yes, sir.

Senator GORE. I think I would agree with that. But then you do not want at all an actuarially sound program based upon similar insurance principles operated through and by the social security system?

Dr. ANNIS. But you are talking about something different. No one benefits from insurance policies unless he and his family have been participants in the purchase of these insurance policies and have paid for its premiums.

You are talking about a program under which 18 million people would immediately benefit, but under which not one of those who paid the costs would benefit.

You see the total costs for these——

Senator GORE. The people who pay the costs are entitled to the benefits. Are you only objecting because a number of people would become eligible for aid immediately?

Dr. ANNIS. No, sir.

Senator GORE. That couldn't be your objection.

Dr. ANNIS. No; my impression is, this is the Finance Committee of the Senate and for this reason is involved primarily in costs.

Our major objection is that under this bill, these services would be provided only in hospitals under contract with the Federal Government, operated under rules and regulations from Washington.

We are opposed to this kind of central control of medical institutions. We have not dealt with that phase of it, because this is primarily a hearing in the field of finance, and we do feel it is important to the workers of this Nation and their employers to realize that this is a new program, promising benefits of unknown cost, and which is to be paid for by an increase in the payroll taxes of those who work.

Senator GORE. You think there is any way to forecast what the costs will be under Kerr-Mills?

Dr. ANNIS. I know that in the past 3 years, the administration itself has continued to upgrade what they think it will cost.

Senator GORE. But if you condemn one program with the uncertainty of future costs, both must stand upon the same charge.

Dr. ANNIS. No, on the contrary. When you buy insurance in an insurance system, the cost for your premium is actuarially established on the basis of costs and claimants. But you are talking, under King-Anderson, of promising to provide a service for which no such projection has been made.

Senator GORE. I beg your pardon, a projection has been made.

Dr. ANNIS. May I say that the figures of the Department of Health, Education, and Welfare have been constantly upgraded for 3 consecutive years. And yet the promise made to the worker is that it will not cost him more than a dollar a month during his working career.

These things just are impossible to jibe.

Senator GORE. Fortunately or unfortunately, the cost of most things is going up, including medical care and hospitalization and drugs.

Dr. ANNIS. And under such a program——

Senator GORE. And more and more of our people are unable to meet the costs. You have, without dodging around the bush in any way, applauded the insurance principle in one respect but condemned it in another.

Dr. ANNIS. On the contrary. Social security is a tax and has so been designated by the court.

Senator GORE. Of course it is a tax and it is paid into a trust fund.

Earlier today you said that the—I won't undertake to quote you, but if I misstate your meaning I hope you will correct me—I understood you to say that the Federal Government had no duty to provide for people merely because of a birthday.

Dr. ANNIS. This is correct.

Senator GORE. I have stated the meaning of your remarks?

Dr. ANNIS. We were talking of health care and I said we had no obligation to provide merely on the basis of a birthday.

Senator GORE. Well, then, the social security program itself would have to stand condemned by the same yardstick?

Dr. ANNIS. No, they are totally unrelated, Senator. The social security program was set up to benefit people on the basis of their contributions into the system over their working lifetime—for this they get x number of dollars when they reach a certain age.

Senator GORE. According to what they paid in.

Dr. ANNIS. On the basis of what they paid in, that is correct. And every time you have increased the total number of dollars that you give in benefits, you have increased the taxes to provide them.

But under King-Anderson you are not saying that we are going to give you $5 a year extra across-the-board for everybody, or $5 a month, or whatever it is. Under King-Anderson you promise to provide a certain service, and you have no way of knowing how much the service will cost except that it will continue to increase.

We are merely calling attention to the fact that as the cost of services increases and the cost of paying for them, the tax on workers and the payroll will have to go up.

Senator GORE. I would like to read you a quote:

> Many Blue Cross plans have, at least heretofore, offered subscribers protection on the basis of the care provided—that is, service benefits.

You applaud the Blue Cross plan, don't you?

Dr. ANNIS. I think Blue Cross has done a very good job, by and large.

Senator GORE. I am a subscriber to it.

Dr. ANNIS. So am I, among others.

Senator GORE. But you don't think it would be well to have a social security program that would have similar service benefits?

You condemn that for a social security program but subscribe to it for Blue Cross?

Dr. ANNIS. On the contrary, Senator. I have sat on the Blue Cross board.

Senator GORE. You have said on the contrary so much——

Dr. ANNIS. Yes, that is correct, because you are putting words in my mouth that I did not say or did not intend.

Senator GORE. I beg your pardon, I haven't put words in your mouth nor have I attempted to, but merely repeated the words you have uttered.

Dr. ANNIS. Blue Cross has repeatedly, because of increasing costs of hospitalization, gone before insurance commissions to ask for increases in their rates, because, with the increased costs and the increased demand for services, they have had to charge more to those who subscribe.

The proponents of King-Anderson have been on many programs, including nationally televised ones, and have promised the workers of this country, and I quote: "It will not cost you more than $1 per month during your working career to pay for these benefits."

Now if what Mr. Smathers referred to—and you and I agreed to—was that costs will go up, as medicine expands in its knowledge, then the money has to come from somewhere. I merely hope that the people of the Nation are impressed with the fact that they cannot buy

something with an undisclosed price tag, something which in the light of the past will continue to go up, without having to pay more than they have been told they would have to pay. Others have said: "No employee will pay more than a dollar per month increase in his taxes during his working career," and "No employer would pay more than a dollar per month or $12 a year."

This is the thing that we wish to highlight. There is no such thing as something for nothing.

If we are going to provide these benefits, it will be with increased costs. I have no conflict with anyone who argues for the point as long as they give the impression to the people who must inevitably pay all Government costs, that it will call for an ever-increasing tax on their wages, which is necessary to justify and to support such a program.

Senator GORE. I do not know, of course. You may have made, or may have had access to statements which you have quoted. I have not.

I would like to read to you further, "* * * the larger plans have traditionally made service benefits available to their subscribers."

I think that every life insurance policy I have ever read provides benefits in specified amounts. But I think the history of our economy shows that the cost of medical care, just like the price of gasoline, or the cost of sending a person to a hospital, like sending one to college, has constantly increased.

But I don't understand why you would condemn one plan by stating these facts but then say that in some way it doesn't apply to the other.

It seems to me it applies to all.

Dr. ANNIS. Senator, I don't condemn them except to the point that many of the proponents of this program are telling the workers of this country, "If you vote for this it will not cost you more than a dollar a month during your working career."

Senator GORE. Are you opposed to the bill because of its provisions or because of what somebody says about it?

Dr. ANNIS. I am opposed to the bill for several reasons, but I think that anyone trying to sell it should tell the whole story and not just fabricate a part of it and not tell people they are going to get a whole lot for a little.

Senator GORE. I would agree with that. But you wouldn't be opposed to a bill if it were sound and equitable in its provisions merely because some advocate had oversold it?

Dr. ANNIS. No, this is correct. We are hopeful that the American people will not buy something on the basis of a promise that they are going to get unlimited medical care which will never cost them more than a dollar a month. I think this is dishonest selling.

Senator GORE. I know time for lunch has arrived and I will not persist.

I do want to say that in addition to the basic fallacy in Kerr-Mills, to which I have already referred, there is another principal fallacy with which I thoroughly disagree, and that is the means test. The fact that this old gentleman who writes me must take his hat in his hand and show that he and his wife have less than $150 a month income in order to be eligible for hospitalization under a program of the Gov-

ernment of the great United States of America is something that I do not endorse.

Dr. ANNIS. Senator Gore, the man's letter states he is on old-age assistance. He had to go——

Senator GORE. I beg your pardon, he does not.

Dr. ANNIS. I was under the impression that you stated that he was denied help because they told him he was receiving old-age assistance.

Senator GORE. Not old-age assistance, social security.

Dr. ANNIS. I misunderstood. I thought the words you used were old-age assistance.

Senator GORE. No, I only used the words "old-age assistance" when discussing one of the points of eligibility.

Dr. ANNIS. I was under the impression that his letter indicated because he was under old-age assistance, neither he nor his wife was able to obtain benefits. I can be in error on that.

The point is, those who receive old-age assistance also have to go to a governmental agency to justify their asking for assistance.

Senator GORE. Well, I—if you misunderstood, why I can understand; all of us do sometimes.

But I specifically read the words "social security payments."

I would like to allude to one thing lest a wrong impression be left but before doing so I wish explicitly to have it understood that I think we must find our own solution to our own problems in our own peculiar way.

I certainly do not advocate a system of medicine or social security or medical benefits for our country which exists in any other.

I wouldn't want the impression to remain, however, that doctors are the only people who are emigrating from Great Britain. One of the motivating factors may be the higher income that doctors can earn in other countries, but doctors are not the only category of trained people whose loss Great Britain is suffering.

Only last year there was a considerable debate in Parliament about scientists and engineers coming to the United States.

This immigration of doctors to the United States from Great Britain may be for causes other than that which you have stated.

Now, I have visited hospitals in a number of countries. I find the quality of medical care rather high in the Western World. It is very, very poor in Africa, some other places that I have visited, southeast Asia.

In some respects I think ours is better than any but we certainly can't claim superiority in all areas. For instance, could you cite us the infant mortality rates in Norway and Sweden and the United States?

Dr. ANNIS. Yes, sir. If you had the figures for this which were given at the World Health Organization, it was pointed out that there is a fallacy. When I was in Norway in June and in Stockholm, Sweden, and in Helsinki, Finland, this was one of the figures that I reviewed with physicians there.

You see, the figures for infant mortality are computed differently in different countries.

In Sweden, for example, no child is considered born alive unless it shows absolute evidence of having fully expanded its lungs. In the United States, however, a child is considered alive if there was an

audible sound prior to the child having been delivered through the birth canal, if there is a pulsation of the cord, any evidence of capillary circulation, and many other things which are not considered in other countries; and because the standards and the requirements are not the same in different countries, these births are not recorded.

Secondly, in great numbers of these countries, the birth is recorded often a week or two after the delivery. In one of the Western European countries, for example, they don't even record the birth certificate until the second 24 hours, and most babies who were not alive then are recorded as stillborn. So the Health Organization figures are frequently quoted in an attempt to discredit the United States as not having good-quality medicine. The physicians in these countries have admitted there is no reason for such comparison, where the standards or the criteria for a live birth are not the same.

Senator GORE. I actually do not have the figures with this explanation and qualification. Would you mind stating the figures?

Dr. ANNIS. I would have to look up the exact figures.

Senator GORE. Will you supply them, would you be so kind as to supply them for the record?

Dr. ANNIS. I would be very happy to, sure.

(The material referred to follows:)

[Committee report from the Journal of the American Medical Association, July 27, 1964]

HOW IS A NATION'S HEALTH LEVEL MEASURED?*

IMPLICATIONS OF INFANT MORTALITY RATES

Recent articles in lay and medical publications have stressed the fact that the infant mortality rate in the United States is somewhat higher than rates found in certain other developed nations. These articles exclude reference to the other indexes for determining health level on a statistical basis—the general mortality rate, the maternal death rate, and the estimated life expectancy at birth.

Whether meaningful comparisons can be made between nations by interpretation of vital statistics is conjectural. Comparisons based only on rates, ratios, or averages have little meaning unless differences in the demographic, social, and economic structure of the nations being compared are noted.

Vital statistics must be viewed carefully to avert erroneous conclusions. Any comparative study must take into account differences between nations in view of the ethnic, economic, and geographical characteristics particular to each.

VITAL STATISTICS

Data collection

Because of the many factors operative in the collection and use of statistics, errors of content can occur in the several stages of compilations and processing. In addition, errors of coverage include differences in the completeness of registration, in tabulation procedures, and in definitions of vital events.

Any indexes or definitions used for appraisals or comparisons should be clearly indicated and examined for reliability and validity.

The reliability of vital statistics varies widely because no uniform legal specifications for the collection of data exist. In some countries registration of vital events is compulsory for only part of the population. For example, Australia does not include statistics for its nomadic aborigines. Other countries regularly exclude data for a segment of the population in which registration is not complete, though compulsory. The fragmentary nature of the resulting data is an important limitation in the use of vital statistics.

Variables in compilation

A number of countries tabulate vital statistics by date of registration rather than by date of occurrence. Thus, any delay in registration must be considered as a variable.

*This report was prepared by the staff of the Department of Community Health and Health Education in collaboration with the Committee on Maternal and Child Care and its special consultants.

Definitions of vital events vary, and it is important to determine the uniformity and definitiveness of a statistical criterion for recording an event and for differentiating between events in a particular study. There are, for example, differences in criteria for registering fetal deaths and live births. In most countries, "any sign of life," including respiratory effort, pulse, heartbeat, or voluntary movement is the criterion for registration of live birth. However, in some countries a more restrictive definition ("breathing" only) is used. The same event might be listed as a live birth and infant death in one country and as a stillbirth or fetal death in another.

The 1962 United Nations Demographic Yearbook states that "complete vital statistics are judged to be those which represent at least 90 percent of the total births, deaths, etc., which actually occurred in a year." [1] This definition introduces still another variable—that of the completeness with which the vital events are reported and registered—into the reported vital statistics, a factor of unreliability which ranges as high as 10 percent.

Specific criteria

Table I shows statistical data for nine countries, each of which has a population of over 300,000, uses the World Health Organization definitions of vital events, and has relatively complete reporting as defined by the United Nations Demographic Yearbook.

General mortality.—Expressed as a crude death rate, general mortality is based on the number of deaths per 1,000 persons, with the exclusion of fetal death rate. The general mortality column in table 1 reveals a high of 11.5 per 1,000 and a low of 7.6. Although this is a rather large difference, it is difficult to make general comparisons because of the effects of ethnic, social, and population variables between the countries. It would also be erroneous to make specific comparisons of these crude death rates without relating the rates to specific age groups. Further, if the general mortality rates are examined over the last 15 years, they show little more than slight trends and small differences from the present rates.

TABLE 1.—*3 aspects of vital statistics in 9 countries* [1] *(1960 data)*

	General mortality rate per 1,000 population [2]		Maternal mortality rate per 10,000 live births [3]		Average life expectancy at birth [4]
	Number of deaths	Rates	Number of deaths	Rates	
Netherlands	87,248	7.6	93	3.9	73.0
Sweden	53,620	10.0	38	3.7	73.0
Norway	32,623	9.1	26	4.2	72.9
Finland	39,861	9.0	45	5.5	66.6
Denmark	43,519	9.5	23	3.0	72.1
Switzerland	72,556	9.7	54	5.7	68.7
United Kingdom	603,842	11.5	331	3.6	69.9
Ireland	32,591	11.5	27	4.4	65.8
Federal Republic of Germany	606,731	11.4	957	10.1	69.3
United States	1,711,982	9.5	1,579	3.7	70.3

[1] Sources: Appropriate tables from Demographic Yearbook 1962, 14th issue, New York: United Nations, 1962, p. 13.
[2] Population figures found in table 2.
[3] Live birth figures found in table 2.
[4] Based on most recent census figures available.

Maternal mortality.—A computed rate involving only the number of deaths due to certain diseases of pregnancy, childbirth, and puerperium in relation to the number of live births during the year, maternal mortality is generally assumed to have a special significance as an index of prenatal, obstetrical, and postnatal care. When the maternal mortality rates in table 1 are considered, however, the U.S. rate (3.7) is bettered only by Denmark (3), and the United Kingdom (3.6). The U.S. rate is identical with that of Sweden and is lower than that of the Netherlands, Norway, and Finland. These rates indicate rather small variations between the United States and eight of the nine countries.

An exception occurs with the Federal Republic of Germany, whose rate (10.1) is a marked deviation and has considerable significance, although the causative factors for this deviation have not been determined.

[1] Demographic Yearbook, 1962, 14th issue, New York: United Nations, 1962, p. 13.

Life expectancy at birth.—This measure reflects the current mortality rates at all ages, regardless of causes of death. Examination of the average life expectancy rates in table 1 reveals a range of from 73 to 65.8 years. Although this difference appears significant, a better method of analyzing life expectancy is on the basis of the average increase in life expectancy each year over a given period. A significant qualification to be considered when comparing such data is the baseline age: a high-life-expectancy baseline in a population limits improvement, whereas a low baseline allows for more dramatic improvement.

The greatest single factor in increasing life expectancy seems to be the general reduction in infant mortality. Other contributing factors are the improvements in general nutrition and the conquest of infectious diseases.

Infant mortality.—The number of deaths for infants (less than 1 year of age) per 1,000 live births—the infant mortality rate—has decreased significantly in Western countries since the beginning of the present century. Before 1900, infant mortality rates of 100 to 150 per 1,000 live births were common in Sweden, England, and Germany. Now the rates are in the low thirties and below.

Infant mortality rates vary widely throughout the world. From available data differentials in the rates may be found according to classification for income, occupation, social class, country, race, and other factors. Since infant mortality is responsive to a multitude of conditions, it becomes difficult to isolate specific factors influencing a given mortality rate.

INTERPRETATIONS AND IMPLICATIONS

National health levels

Inherent errors in data compilation and differences in methods and definitions of criteria make absolute comparisons of vital statistics between populations difficult. (In some situations the effect of these differences can be substantially reduced—for example, where vital statistics are tabulated by date of registration rather than by date of occurrence, the differences can be diminished by using periods of several years as the basis for comparison.)

It is doubtful whether statistical variations and differences among countries are significant enough to indicate meaningful relationships by casual observation alone. Before any valid comparisons of general and maternal mortality rates and estimates of life expectancy can be derived, the many variables and margins of error must be taken into account.

The effects of geographical, social, and economic factors on the general and maternal mortality rates and the average life expectancy may be illustrated by calculating combined rates for the nine countries listed in table 1. These combined rates become 10.8 for general mortality, 6.2 for maternal mortality, and 69.9 for life expectancy, with which the U.S. rates of 9.5, 3.7, and 70.3 compare favorably.

Calculating combined rates for the nine selected countries is like adding apples and turnips together. To compare a heterogeneous population with a homogeneous one, without reasonably accounting for the widely divergent origins, racial characteristics, and geographic, socioeconomic, and cultural differences, is equally questionable. The populations of the 50 individual States of the United States differ as widely in these factors as do the populations of the 9 selected countries. If comparisons are to be made, therefore, the limiting factors must be taken into consideration.

Infant mortality rate

Interpretation of the infant mortality rates found in table 2 requires an understanding of the circumstances of the origin of the data. The limitations in comparing rates, discussed with reference to other measurements, apply to an even greater degree to statistics on infant mortality.

TABLE 2.—*Infant mortality in 9 countries compared with the United States*[1] *(1960 data)*

	Population	Live births	Infant deaths	Infant mortality rate per 1,000
Netherlands	11,480,000	238,789	3,947	16.5
Sweden	5,362,000	102,219	1,699	16.6
Norway	3,585,000	61,880	1,167	18.9
Finland	4,429,000	82,129	1,727	21.0
Denmark	4,581,000	76,077	1,636	21.5
Switzerland	7,480,000	94,372	1,993	21.1
United Kingdom	52,508,000	918,286	20,678	22.5
Ireland	2,834,000	60,735	1,777	29.3
Federal Republic of Germany	53,222,000	947,124	31,974	33.8
United States	180,675,000	4,257,850	110,873	26.0
White only		3,600,744	82,479	22.9
Nonwhite		657,106	28,394	43.2

[1] Sources: Appropriate tables from "Demographic Yearbook 1962," 14th Issue, New York: United Nations, 1962, p. 13. "Statistical Abstract of the United States: 1963," 84th ed., Washington, D.C.: U.S. Bureau of Census, 1963.

These limitations are summed up in the major source book for international data on vital statistics, the 1962 U.N. Demographic Yearbook, as follows:

"Perhaps the most important and widespread limitation on the comparability of infant mortality rates is that resulting from compiling statistics of infant deaths and live births by date of registration rather than date of occurrence of the event. Where these procedures obtain a large increase, for whatever reason, in the number of live births registered in any one year may introduce sizable errors into the infant mortality rates, especially since deaths tend to be more promptly reported than births.

"If the delay in the registration remains nearly constant and is approximately the same for births and deaths, the rates are not affected in any appreciable degree. But if—*as* is the case in many countries—a large proportion of the births are not registered until many years after occurrence, then infant mortality rates obtained by relating infant deaths for any one year to births which occurred over a period of years have little validity * * *."

This factor is of special importance since the live-birth incidence is the denominator of the infant mortality rate. The yearbook adds—

"Even on a date-of-occurrence basis, underregistration of births and infant deaths also affects the infant mortality rates unless the proportion registered is the same for both components * * *. As noted above, differences in levels of completeness between the two components of the infant mortality rate, i.e., the infant deaths and the live births, will bias the rates upward or downward, the direction of bias depending on which component is more fully registered * * *.

"Another factor which has a bearing on the completeness of live birth and infant death registration is that concerned with the statistical definition of the event to be reported. The exclusion from both the live birth and death register of live born infants who die before 24 hours of age or before registration of birth, may distort the statistics to some extent, tending to give the rates a downward bias. Failure to register as a live birth each infant death which occurs during the first few weeks of life may also be a factor in the lack of comparability among infant mortality rates, but the effect, if any, would be toward upward bias."[2]

[2] Ibid., p. 4.

Specific differences in reporting of data for the countries in table 2 and a follows:

Netherlands	Does not list as infant deaths those infants who die before registration of birth. This sometime is as long as a week. Babies born alive who die within 3 or 4 days would be listed as stillbirths. Includes births and deaths occurring abroad if listed on Netherlands population register.
Sweden	Until 1960, the only evidence of life recognize in establishing live births was the act of breathing.
Finland	Infants weighing less than 800 gm are not included in the still born statistics. Includes data on Finnish nationals temporarily outside of country.
United Kingdom	Data tabulated by year of occurrence for England and Wales and by year of registration for North Ireland and Scotland. Births before 2 weeks gestation are recorded as stillbirths.
Ireland [3]	Data on events registered within 1 year of occurrence.

Shapiro and Moriyama [4] recently studied the restricted difinition used in Sweden where breathing is the only criterion of life and the practice in the Netherlands of excluding from birth or death registration a live-born infant of less than 28 weeks gestation who dies before registration. They indicated that differences in definitions and statistical practices in certain countries may result in an understatement in the infant mortality rate of from 1 to 3 percentage points compared with rates of other countries. There is an even greater uncertainty about measures of fetal loss, which also affect the infant mortality rate.

Other variants must be recognized when making comparisons of infant mortality rates. When the gross relationships between infant mortality and various socioeconomic factors are examined, positive correlations are found between low infant mortality rates and high income, high social status, and well-paying occupations. For example, in a review of perinatal mortality (fetal and neonatal mortality) in Great Britain for each year from 1911 to 1950, a consistent decline in rates for all social classes was found; however, the differential between the various social classes did not substantially change through the years.[5,6]

It is obvious that, with all the variables to consider, a smaller country, such as Sweden, with its homogeneous ethnic, socioeconomic structure, should not be directly compared with a vast heterogeneous nation, such as the United States. The effect of comparing two relatively heterogenous populations can be illustrated effectively by combining the data for the countries in table 2 and calculating a simulated infant mortality rate for this combination. When this is done, the computed rate for the combined countries is 27, as compared with the U.S. rate of 26.

The effect of comparing infant mortality between homogenous populations can be illustrated by comparing the rate for a population within a small area of the United States with that of a similar homogeneous population in Europe. When, for example, the white populations for Minnesota and Wisconsin are combined and are compared with the combined data for Norway and Finland, the infant mortality rates are 21.3 and 20.1 respectively (table 3). Another comparison can be made between Minnesota and Wisconsin combined (white data only) with Switzerland—rates of 21.3 and 21.1 respectively. Although in these instances the rates are similar, it is important to emphasize that the populations cannot be considered equivalent.

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[3] Data tabulated by year of registration rather than occurrence.

[4] Shapiro, S., and Moriyama, Iwao M.: "International Trends in Infant Mortality and Their Implications for the United States," Amer. J. Public Health 53: 749 (May) 1963.

[5] Morris, J. N., and Heady, J. A.: "Mortality in Relation to the Father's Occupation," 1911–50, Lancet 1: 554–560, 1955.

[6] A more complete discussion of this study and other variables will be reported by the AMA Committee on Maternal and Child Care of the Council on Medical Service in a subsequent communication.

TABLE 3.—*Comparison of infant mortality rates by homogeneous regions*[1] *(1960 data)*

	Population (white only)	Live births (white only)	Infant deaths (white only)	White rate only
Minnesota	3,371,603	85,957	1,853	21.5
Wisconsin	3,858,903	95,626	2,030	21.2
Total	7,230,506	181,583	3,883	21.3
Norway	3,585,000	61,880	1,167	18.9
Finland	4,429,000	82,129	1,727	21.0
Total	8,014,000	144,009	2,894	20.1
Switzerland	7,480,000	94,372	1,993	21.1

[1] Sources: Appropriate tables from the "Demographic Yearbook 1962," 14th issue, New York: United Nations, 1962, p. 13. "Statistical Abstracts of the United States: 1963," 84th ed., Washington, D.C.: U.S. Bureau of Census, 1963.

What if the rate of a single State is compared selectively with the rate of a single nation? For example, if Connecticut's (white population) rate is compared with Ireland's, the rate for Connecticut (20) appears to be more favorable than for Ireland (29.5). If Oregon's rate (white population) is compared with a nation which is frequently referred to as healthy—New Zealand—little difference is found between the rates for Oregon (23.7) and New Zealand (22.6) (table 4).

These comparisons demonstrate the fallacy of comparing infant mortality rates without giving consideration to the multitude of variables involved. Selective grouping of populations to simulate comparable characteristics tends to produce comparable infant mortality rates, but certainly more is involved.

Race is a factor which appears to affect the infant mortality rate in the United States. The rate is 43.2 for the nonwhite population and 22.9 for the white population. The difference is more attributable to socioeconomic factors, however, than to the implied racial rate. Better rates are found for nations which exclude nonwhites in their vital registries, have few nonwhites, and have little or no significantly depressed areas in their populations.

The significance of this variable is shown by the fact that in 1960, 88.6 percent of the U.S. population was white, whereas the white population for Sweden was 99 percent, for Norway 98 percent, and for the Netherlands practically all of the population. If only the white infant mortality rate for the United States is considered, the rate is reduced from 26 to 22.9. When this rate is compared with the combined nine-nation rate of 27, a distinct difference appears. This implies that the nonwhite factor exerts a strong influence on the U.S. rate. This is not, however, the only problem involved, since over the years, the rates have declined substantially for both white and nonwhite groups, with the decline for the nonwhites more marked than that for the whites.

TABLE 4.—*Comparison of infant mortality rates by single States and nations*[1] *(1960 data)*

	Population	Live births (white only)	Infant deaths (white only)	Rate
Connecticut	2,423,816	53,112	1,062	20.0
Ireland	2,834,000	60,735	1,777	29.3
New Zealand	2,372,000	62,850	1,420	22.6
Oregon	2,751,000	37,078	879	23.7

[1] Sources: Appropriate tables from the "Demographic Yearbook 1962," 14th issue, New York: United Nations, 1962, p. 13. "Statistical Abstract of the United States: 1963." 84th ed., Washington, D.C.: U.S. Bureau of Census, 1963.

Geographical variations in infant mortality also influence the total mortalit rate for the United States. The 1960 rates varied considerably among the ind vidual States.[7] Utah had the lowest rate (19.6), followed by Connecticut (21.1 and Minnesota and Massachusetts (21.6). The highest rates were recorded i Mississippi (41.6) and Alaska (40.5).

The pattern of geographic variation is also greatly influenced by the rac composition of the population in various States. The infant mortality for th white population of Utah was 18.8, compared with Mississippi's white rate o 26.6. In contrast, Utah's 18.9 percent nonwhite population had a 54 rate, an Mississippi's 42.3 percent nonwhite population had a 54.3 rate. The lowest rat for a white population was 17.8, recorded by Delaware, and the highest was 30.9 in New Mexico—the latter undoubtedly influenced by the large number of per sons of Mexican origin. South Dakota, with a rather large American Indian population, had the highest rate for a nonwhite population: 76. New Hamp shire, with only one nonwhite infant death, recorded a low rate for nonwhit infant mortaltiy of 10.6.

Infant mortality rates have increased recently in most large urban area with a concentration of low-income groups. For example, New York City's district-by-district birth and infant mortality records show that two districts with a very high concentration of low-income groups have a very high rate when compared with districts of middle-income groups. The central Harlem area rat of 48.9 and Brooklyn's Bedford Stuyvesant district rate of 43.6 can be contrasted with a 16 to 19 rate recorded in the middle-income districts of the Bronx, Brooklyn, and Queens.

COMMENT

It is interesting to speculate about the reasons for differences found in infant mortality rates among populations, but the real causes of these differences are unknown. Only partial answers are available to assist in reducing infant mortality. Present data, when adequately analyzed for trends and fluctuation within a specific population, does yield helpful information.

Because impairments and deformities make some of the newborn exceedingly poor risks for survival, reducing the infant mortality rate to "zero" is probably impossible. Nevertheless, it is essential to set as a present goal the reduction of environment hazards contributing to infant mortality rates.

Present knowledge indicates that as the infant mortality rate approaches the irreducible minimum, the social and environmental factors become less operative and the "personal" factors of "maternal efficiency" become more important. Since the infant mortality rates are declining to low levels in many areas, the next steps in research might be directed toward studying the relationships of infant mortality and morbidity to maternal factors. Specific research on infant care practices, intelligence, and other personal factors of the mother is now essential. This research could contribute toward further reducing infant mortality and morbidity.

CONCLUSION

General, maternal, and infant mortality rates, and the estimated life expectancy are not reliable measures of health levels among nations. These statistics are products of many variable factors and are essentially crude measurements; extreme caution should be used in drawing conclusions from them.

Vital statistics do, however, yield useful information for public health purposes when they are carefully analyzed in terms of trends within a specific geographical and cultural setting.

Senator GORE. From my limited knowledge, Doctor, it is my belief that medical science is more advanced in the United States than in any other country, but certainly I don't think we have a right to claim a monopoly on competency of physicians or efficiency of hospitals.

Dr. ANNIS. Mr. Gore, this is true. There are fine physicians, dedicated physicians, great scientists all over the world. I alluded to this in talking to Mr. Smathers, wherein I stated in some cities, with some doctors, in some hospitals you can get quality medical care comparable to the best. The difficulty is where they have one, we have

[7] "Statistical Abstract of the United States: 1963," 84th ed., Washington, D.C.: U.S. Bureau of Census, 1963.

a hundred. Where they have 10 such physicians, we have a thousand; this is the difference.

By virtue of the type of system under which we operate, we have no claim on intelligence and devotion that others don't have. But they do not have the opportunity in any of these other lands to which we have referred for the growth and the development of young people and young brains and young ideas because of the lack of tools.

In England, the education of physicians is marvelous. They have very fine physicians, but I spoke to many in their hospitals who have no place to go because they have not built a new hospital; the older physicians live for many years in practice and there is no place for the new physician under the system. They not only come to the United States, but go to other countries, Australia, New Zealand, and countries in continental Europe. England has been turning out fine physicians with knowledge and skills. Yet not making available the tools of modern science—laboratories, X-rays, hospitals, and research institutions—would be like turning out a great number of good cabinetmakers and yet denying them the woods or the tools necessary.

We have no single market on brains. The reason that we have expanded so—and I said not that we have the greatest quality—is that we have more high quality.

Our distribution of quality across this land is not found in any of these countries. In their major centers you find marvelous doctors doing marvelous work.

But in some of these countries only one center may exist, for example, for diseases of ear, nose, and throat: whereas in this country we have them up and down the land, and this is the difference.

It is not they don't have dedicated, fine, scientists and physicians, but we have unlimited opportunities and are constantly making more so that we put to use the very fine brains. We are happy to say, that we have opened 9 new schools since the war, we have 6 more being built today, 10 more being planned, and in addition to all of our own schools, we have 10,000 students today from other lands here as residents and fellows studying to improve their knowledge. America is benefiting because great numbers of these stay here, not because they wouldn't prefer to go home, but if they go home, they don't have the tools which are available here, with which they can continue to be fine scientists, fine researchers, fine teachers, and fine physicians.

Senator GORE. I thank you for your appearance.

I have enjoyed the colloquy with you. You are well informed, you are frank, and we have arrived at different conclusions as to how this pressing problem of our people could be solved. But I think we have found a wide area of agreement as to what the facts are. And after all this is one of the purposes of a public hearing, and I thank you, sir.

Dr. ANNIS. Thank you.

Senator SMATHERS. If there is no objection I would like to put in the record the figures from the Federal budget with respect to the number of jurisdictions with programs starting in 1960 and running up to 1964, and also the cost which shows that in 1963, for example, there was spent under the medical assistance for the aged program by the Federal, State, and local communities, $289 million; 1965 it is projected that they will spend $451 million.

The Federal share of that in 1963 was $147 million, and in 1965 will run to $235,200,000. If there is no objection I want to make that a part of the record.

(The figures referred to follow:)

TABLE II.—*Medical assistance for the aged*

	Number of jurisdictions with programs	Number of recipients	Payments to recipients	
			Total	Average
1960: December	4	14,662	$2,870,015	$195.75
1961:				
June	9	46,428	9,312,876	200.59
December	18	72,159	13,919,808	192.90
1962:				
June	27	101,634	17,415,814	171.36
December	28	109,815	22,514,732	205.02
1963:				
June	29	136,336	26,612,990	191.20
December	32	150,162	30,212,901	201.20
1964: May	35	181,056	35,219,429	194.52

Source: Social Security Bulletins.

The following financial data on the program is from the Federal budget for fiscal year ending June 30, 1965:

Medical assistance for the aged

	1963 actual	Fiscal year	
		1964 estimate	1965 estimate
Number of different recipients during year	338,200	452,600	532,100
Average annual payment per recipient on whose behalf payments were made	$855	$863	$863
Total expenditures for assistance—Federal, State, local (millions)	$289.2	$390.6	$451.4
Federal share (millions)	$147.4	$201.1	$235.2

Senator SMATHERS. Doctor, just one other question and then we will let you go.

I know it is getting late. You stated a moment ago that because you were before the Finance and Taxation Committee you were directing most of your arguments against the King-Anderson bill because of its cost and because of the tax which would be borne by employers and employees and because of your belief that this tax would have to be increased substantially as the years went by.

Then you said, in answer to Senator Gore, that your real objection to the King-Anderson bill was because you felt that it it were adopted and administered by the Department of Health, Education, and Welfare, which would pay out the money to hospitals, it would control the hospital and in time control the medical profession. Did I understand you correctly that that was your major objection?

Dr. ANNIS. That is correct.

Senator SMATHERS. Do you think it would be possible, or why would it not be possible, if we pass such a law, as is envisioned by King-Anderson and had social security financing of this program, for us to put some restriction in the law which would have any moneys that are paid by the Federal Government for health care under King-

Anderson, or whatever we finally end up calling the bill, paid totally to some State official whom we might call for lack of a better name, the commissioner of health of Florida, and that State commissioner would take these funds and make such distribution as he thought was necessary.

Would that then not relieve your fear that the Federal Government from Washington would control the hospitals?

Dr. ANNIS. This is what we do today under Kerr-Mills. The Federal Government sends its money into the State where they are matched with other dollars to provide for the needy.

So our opposition is twofold: first, that the bill as written would put the Federal Government in control of our medical institutions; and second, that the bill as written would provide this limited hospital and nursing care for many people who are not the responsibility of the Government, and who are perfectly well able to provide for themselves.

When Government begins to provide for the people, then they will, to a great extent, take less and less responsibility to provide for themselves. This we have seen in other countries, and we are fearful of it.

Senator SMATHERS. Let me pursue that point with you just a little further.

As I gather it, while you don't want Government to provide for people who can otherwise provide for themselves, your greatest objection is Federal control, as I gather from what you said here today. You have no particular objection to local government, either municipal or county or State government, assuming responsibility in this area of need. That is the reason you like Kerr-Mills.

Now, if we rewrote, in effect, the King-Anderson bill, and changed its provisions so that any funds which would be collected by social security for the health part of the program were turned over to the State commissioner for health and welfare, and he in turn paid it out to individuals rather than to hospitals, if it were done in that fashion, would that not relieve your fear and objection to this present bill?

Dr. ANNIS. No, the extent that funds were expended for the needy, whom we admit are the responsibility of the local and State governments, there would be Kerr-Mills. But when it goes beyond that to provide for the rich as well as for the poor, then we oppose this as individuals and as citizens.

Senator SMATHERS. I want to come back to the one point and not talk about the rich and poor whom it covers for the minute.

Dr. ANNIS. Our point is, it is not one or the other.

Senator SMATHERS. You mentioned this to me in private and I was interested to hear you say it in the committee. Now that you have said it in the committee, I think it would be helpful if we would try to make the record real clear on that point.

As long as these people are putting up this money, we are having what you might say is an enforced savings program through social security for, as you say, people who might not be in need later on down the road, but you said your principal objection to the King-Anderson bill was that the Federal Government would, in payment of these sums of money to the hospitals, get control of the hospitals and finally in running the hospitals, which is what you fear and that subsequently it would then possibly begin to set doctor's fees and all the rest.

Now, if that is your principal objection, and we put into law a provision which would short circuit the control of the Federal Government and take the sums which had been saved, transfer them, in effect, to the State commissioner and he, in turn, could transfer it to the local commissioner, and these people could then take their own money and that matched by the employers to pay for their health care, would it not eliminate any fear on the part of you and other doctors that the Federal Government would be running their program?

Dr. ANNIS. It might eliminate that one objection, but the fundamental objection is still there.

You see——

Senator SMATHERS. Well, the fundamental objection as I understood it was that you were fearful that the Federal Government would take over and run the program because it would be disbursing the money to the hospitals and patients.

Dr. ANNIS. I said this was our No. 1 fear.

Senator SMATHERS. And then subsequently take over and set the standards of what doctors would practice.

Dr. ANNIS. There are many objections; I merely said this was No. 1.

Senator SMATHERS. Is that the No. 1 objection?

Dr. ANNIS. It is not the only major objection.

Senator GORE. It is the principal objection.

Senator SMATHERS. It is the principal objection.

Dr. ANNIS. It is the big fear and the principal objection.

But Senator Smathers, speaking of an enforced savings program, the late Senator Kerr, before he died, asked the actuaries, how much it would cost today's working taxpayer to pay for the people—there were then 17 million over 65—who had never paid anything for the health care part, and never would as long as they lived. Assuming that they will be in the hospital once in their remaining lifetime, according to the figures given by HEW, he asked how much it would cost today's workers to pay for the people who are already over 65.

The answer given to the Senator was $35 billion?

Now, at the same time——

Senator SMATHERS. May I interrupt you right there to ask you this question, and as you can see we are extending the coverage of the social security program now to the point where it includes practically everybody, it now might even, depending upon how the committee votes and the Senate votes, include doctors, so there would be very few people left uncovered by social security now.

You continue to talk about the 18 million of elderly people who had never contributed a nickel to the social security program who will get a benefit from it.

Can you not envision the day in the overall not too distant future, where those 18 million will have passed on because of reasons of old age, or other reasons, and that everybody who lives in the United States will, in point of fact, be under some coverage of the social security system, so that particular problem will, in the future, not be a valid complaint because everybody will have contributed to the social security system——

Dr. ANNIS. Mr. Smathers——

Senator SMATHERS (continuing). And therefore be under medical care?

Dr. ANNIS. May I continue with what I started?

Senator SMATHERS. Sure.

Dr. ANNIS. The answer given to the Senator was $35 billion. At the same time, the administration estimated that the initial cost of this program would be in the neighborhood of a billion and a half dollars.

That would mean that just to provide for the people already over the age of 65, it would have taken a total of 20 consecutive years of taxpayers' moneys, just to provide for those who were now included.

I am merely pointing out when we talk about enforced savings, we are not really talking about prepayment. What we are saying is that for the next 20 years at least everything paid in by the worker and his employer would be used to provide for those who were blanketed in by virtue of a birthday, with not a nickel put aside in prepayment for themselves or enforced savings for themselves. I was merely pointing out and requoting the figures that the Senator himself pointed out—that it is wrong to put this in the same category as insurance or prepayment like Blue Cross.

In effect, what we are talking about is a new tax program to provide a type of benefit that the Government will have to purchase.

Senator SMATHERS. As an ethical or moral question, do you see anything more wrong with that than you do, for example, under the Kerr-Mills law where some people who have been paying 90 percent of their income into the general revenue, some people who have been paying 70, and most of whom are paying 20 percent, when they actually provide their money in order to pay the health care bill of some person who has at no time made any contribution whatever.

Dr. ANNIS. This is correct. But these are the needy.

Senator SMATHERS. Now, as a moral problem and which is right or wrong ethically, do you see any difference?

Dr. ANNIS. Oh, yes; as a nation, from the time we were a very small nation and families got together to take care of the bereaved widow, we have always taken care of people who needed help in the communities, but as we have grown larger we do it through the mechanism of government.

Kerr-Mills provides for people who need help. This is quite different from levying a tax on workers to provide for someone who has had a birthday, even though he may be a millionaire.

Senator SMATHERS. Well, now, suppose that you had a fellow who goes to work and he has lost about 15 different jobs and never be able to do much. Every time he got a little money ahead why he blew it in at the bar or somewhere else and, therefore, when the time came he reached 65 years old, he didn't have a thing, and made no contribution. Yet you believe that he ought to be cared for when he finally ends up at 67 years old with cirrhosis of the liver and about to die. He is going to be taken care of right out of taxpayers' funds of people who have worked hard and made a big contribution and paid taxes.

Senator GORE. Until he is 95.

Senator SMATHERS. So he gets taken care of until he is 95. Now, I don't really see how we can put it on the basis of an ethical or moral problem.

Dr. ANNIS. Senator, every day we take care of people in jails who violate the law, too. We provide for them, as we would for this derelict. But I am sure that you will agree this does not characterize the great majority of our senior citizens.

Senator SMATHERS. I would agree.

Wouldn't you think it would be better, and I am still on the side of Kerr-Mills, if we somehow required people somewhere to look for that rainy day down the road and begin to make some provision for themselves while they are active and while they are working so that they could properly contribute to their own health needs when they retire?

Dr. ANNIS. Of course, that is what we are doing with our educational programs today.

Now, the question is, Are we going to do this by compulsion—is the Government going to make us do this, that, or the other thing—or are we going to do it because we voluntarily wish to?

Three-quarters of the people in this country today buy their own insurance.

We are convinced that the great masses of the American people are independent and this is why they use the great health insurance mechanism to provide for themselves. There is education, and I don't think it should be replaced by compulsion. Even though some people will not provide for themselves, and will ultimately become wards of the state is no reason why we should compel all the people to participate in a Government manufactured and tailored program.

People differ so, just as our areas and locales, and we feel very strongly that the responsibility of Government should be limited to provide for those unable to provide for themselves. It should be expanded if the program is not as good as it should be. I am less concerned about the derelict than I would be about his wife or dependent children; we feel these are our responsibility.

But when we go beyond that, and say, because some people fail to live as upright citizens and be self-reliant and put aside, we are going to make it compulsory for all, it is not wise on a moral basis.

Senator SMATHERS. All right, Doctor.

Senator GORE. I have one more question.

Senator SMATHERS. Senator Gore.

Senator GORE. I gather from what you have said that if we provided for King-Anderson benefits to be paid out of the general fund rather than from social security taxes, that this would considerably lessen your opposition.

Dr. ANNIS. No, sir.

Inherent in the bill——

Senator GORE. I thought that was one of your major objections—that it was the cost that would be raised by taxes, social security taxes.

Dr. ANNIS. Everything, all costs are met by taxes. It is the only source of Government income.

Senator GORE. The objection you raised to this was that it was a new tax, it was a tax on payrolls.

Dr. ANNIS. Correct.

Senator GORE. And I am now asking you, If we provide that the costs come from the general fund would this lessen your opposition?

Dr. ANNIS. No matter where the dollars come from, it is still wrong, in our opinion, to tax workers to pay for people well able to provide for themselves, no matter what the source of income.

Senator GORE. The same question I will put to you again. Would it lessen your opposition if we did not tax payrolls but rather charged it to the general fund?

Dr. ANNIS. No; the bill is still fundamentally wrong, in my opinion.

Senator GORE. Would it be less fundamentally wrong——

Dr. ANNIS. This is like asking which would you rather lose, your right or your left arm.

Senator GORE. Well, if you didn't——

Dr. ANNIS. You don't want to lose either one of them. You want freedom to use them both.

Senator GORE. I know, but you have made these payments—I am not being facetious with you. You have made a great point out of how wrong it is to tax payrolls to provide the funds necessary to pay the costs of medical care, hospitalization.

Dr. ANNIS. I was merely calling attention, Senator Gore, to workers, for example, that they would be taxed——

Senator GORE. I know what you were calling attention to.

Dr. ANNIS. Yes, but they would be taxed to pay for everyone at the age of 65, but income from stocks, and oil and other resources of income would not be taxed.

I am merely calling attention to the inequity that is there.

Senator GORE. I understood you, I understand you now. But what I am trying to elicit from you is an answer to the question, If, instead of providing for a tax on payrolls, we merely charged the expense of this program to the general fund, would your objection to the program be lessened? Would it be less fundamentally wrong?

Dr. ANNIS. Senator, you are trying to get me into the argument like the fellow who has got as many children as I do. They get around the breakfast table and argue as to whether to buy a Chevrolet or a Ford, when the real thing is he shouldn't buy anything at all.

Senator GORE. You are not saying we shouldn't have a health program?

Dr. ANNIS. On the contrary, I have consistently stated, and medicine has consistently taken the position, that Government has the responsibility to provide for those in need, but it does not have a responsibility, because some people need help, of providing for all or for all over a certain birthday.

Now, no matter which method you used, this we would still oppose.

Senator GORE. Well, you have made a great point here, and you have referred to it at least 8 or 10 times, I think—at least many times. You made a great point that King-Anderson, the benefits from the King-Anderson bill, would be paid for by a tax on the payroll of workers.

Dr. ANNIS. This is correct.

Senator GORE. I am just asking you the simple question: If, instead of providing for this added tax, we charge it to the general fund or to the public debt, would this lessen your objection? Or, to use your own words, would it be less fundamentally wrong?

It is a simple question.

Dr. ANNIS. Well, it is simple in its statement but not in its intent.

Senator GORE. I didn't—I don't think your intent is exactly simple, either.

Dr. ANNIS. I would like very much to have you submit such a bill and let us evaluate it, Senator. No such bill has ever been proposed.

The reason for calling this to the attention of the American people who are interested in this is that Senator Smathers has raised a moral

question, Is it right to tax a workingman's wages to pay the hospital bills for some well able to pay for themselves?

Now, we think this is wrong no matter how you raise the money.

Senator GORE. I thought you rather than Senator Smathers, raised that question.

Dr. ANNIS. No; he just reminded me of it.

Senator SMATHERS. I raised the question, he stated that answer.

Senator GORE. You know, Doctor, a judge can direct a witness to answer a question. We have no such procedure here. So if you wish not to answer the question you don't even have to take the fifth amendment.

Dr. ANNIS. I would never do it, Senator. [Laughter.]

If you submit a bill we will be happy to give you our opinion on it.

Senator SMATHERS. Isn't that what Kerr-Mills does?

Dr. ANNIS. For the needy; oh, yes. This I don't deny.

Senator SMATHERS. So, then——

Dr. ANNIS. For the needy. But our fundamental objection, and it would not be erased by putting it on general revenue as opposed to social security, is that it is not the responsibility of Government to provide for everyone because some people need help.

Wherever this exists in other lands, where the government's responsibility is to provide for all, the quality of medicine has deteriorated. We thing this is a wrong use of government power.

Senator GORE. Do you think that a man who is 68, who is down on his back with arthritis, whose wife is 64 and under the constant care of doctors, with a drug bill of $50 a month, whose total income is $159.50 a month, is not in needy circumstances?

Dr. ANNIS. I know that the King-Anderson bill wouldn't provide for them. But Kerr-Mill can, and should.

Senator GORE. I am not sure that King-Anderson wouldn't. But you are saying that Kerr-Mills will and can.

Dr. ANNIS. That is correct.

Senator GORE. It has not and does not.

Dr. ANNIS. Well, Senator, if you follow this letter up I will be very happy to handle it for you if you would like.

Senator GORE. Yes, I guess you would be happy if I would give the name of this person——

Dr. ANNIS. No, on the contrary.

Senator GORE (continuing). To you and then he would be embarrassed by somebody coming out and offering to give him charitable care. This is an American citizen who feels that this society is such that we can have a sound financial program to provide medical care, levy a tax with which to pay it, pay the costs. But you object to levying a tax to pay these costs, and you are even refusing to say whether it would be improved if we didn't levy the tax.

Dr. ANNIS. Senator, if you write to the patient's doctor, I am sure he will handle it without embarrassment to the patient.

Senator GORE. Well, I shall not subject any constituent of mine who writes me a letter to that kind of treatment.

Dr. ANNIS. You might deprive them of the very help and assistance for which they have written. It is often available but they don't know it is available. This is just the point.

Senator GORE. Well, it is not available in this circumstance.

Dr. ANNIS. It may be and they are not aware of it.

Senator GORE. Well, this man is more aware than you may realize.

Senator SMATHERS. Well, thank you very much, Doctor.

We have kept you a very long time only because you are articulate and persuasive and obviously very well informed, and present the position of the medical association idea as well as, in fact better than anybody else I know could present it.

I want to thank you, Dr. Welch, for your statement. I apologize for keeping both of you so long.

(The statement of the American Medical Association previously referred to follows:)

STATEMENT OF THE AMERICAN MEDICAL ASSOCIATION BEFORE THE COMMITTEE ON FINANCE, U.S. SENATE, ON MEDICAL CARE FOR THE AGING—PROPOSED AMENDMENTS TO H.R. 11865, 88TH CONGRESS

STATEMENT OF THE AMERICAN MEDICAL ASSOCIATION PRESENTED TO THE COMMITTEE ON FINANCE, U.S. SENATE, ON AUGUST 13, 1964, BY NORMAN A. WELCH, M.D., AND EDWARD R. ANNIS, M.D.

Dr. Welch, president of the American Medical Association, is a graduate of Tufts College Medical School. From 1943 to 1957, he was clinical professor of medicine at Tufts Medical School and physician in chief at Carney Hospital, Boston, Mass. He serves as a consultant to five Massachusetts hospitals, was president of the Massachusetts Medical Service (Blue Shield) from 1950 to 1963 and is now a member of of its board of directors. Dr. Welch lives in Boston with his wife and five children.

Dr. Annis is the immediate past president of the American Medical Association and is currently president of the World Medical Association. He is a graduate of the University of Detroit and earned his M.D. degree from Marquette University School of Medicine. Dr. Annis has served as chief of the department of general surgery at Mercy Hospital, Miami, Fla., and as a director of the Family Service and Senior Citizens Division of the Welfare Planning Council of Miami. In 1958, he was awarded the Brotherhood Medal of the National Conference of Christians and Jews. He resides in Miami, Fla., with his wife, and eight children.

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SYNOPSIS

The American Medical Association opposes any legislation which proposes use of title II of the Social Security Act as a mechanism for financing a Federal program of health care of the aged. Our objections are manifold. We disagree with the basic philosophy. We oppose the method. We are deeply concerned over the effects Government intervention would have on the Nation's unsurpassed standards of health care.

From the beginning, the question of financial need has lain at the heart of this controversy. There is no justification for the use of tax funds collected from workers at the low end of the income scale to pay health care expenses for the entire elderly population, including the wealthy and the well to do.

No one disputes the fact that some elderly people require help in meeting their medical expenses. But the means already exist for taking care of the needy and the near needy through the Kerr-Mills law. Since its enactment less than 4 years ago, remarkable progress has been made by the States in Kerr-Mills implementation. It fits the established pattern of other assistance programs—Federal financial contributions but State control and State determination of what is required to discharge Government responsibilities to its citizens.

Available information on the finances and health of the aged further explodes the argument of need for this program. As a group, over-65 Americans are self-reliant and independent. They are in control of their economic destinies. Generally, they enjoy good health. Most of them have protected themselves through insurance from the cost of illness.

Presented herewith are detailed facts and figures in these vital areas.

ECONOMIC CONDITION OF THE AGED

Proponents of a centralized program of health care for the elderly, financed by higher payroll taxes, support their case by claiming that Americans over 65 are universally sick and impoverished and only a gigantic Federal aid program can provide them with the health care they need. Statistics, most of them from the Government's own files, refute these allegations.

Most of the older people are in reasonably good health, and really poor health is concentrated among a relatively few. While the aged are more susceptible to chronic conditions than the population as a whole, they are less likely to suffer acute illness or accident or to require surgery.

The difference in physician visits between older and younger patients is 1.8 visits per year, hardly a significant margin. The average stay in the hospital for the aged is about twice as long as for the population as a whole—15 days against 8.4 days. But the average for elderly patients is pushed up by a minority which remains hospitalized for extremely long periods. The U.S. Public Health Service reports that 10 percent of the aged accounts for 39 percent of the total days of hospitalization; that the same 10 percent also account for 38 percent of the expenditures.

The theme of the near-hopeless financial plight of the aged is played unceasingly. Among the claims: more than 50 percent have incomes below $1,000 a year, and the incomes of aged families are only half as much as for younger families.

These are deceptive statistics. Included among those with incomes of less than $1,000 are wives who have zero income even though the family income may be $5,000 or $10,000 per year. It would be just as accurate to say that almost 60 percent of all persons under 65 have incomes of less than $1,000, too. For there are millions of younger people, as well as older, who are unemployed and unemployable, such as infants, schoolchildren, wives, and the sick and disabled.

Equally fallacious is the comparison of gross incomes of older and younger families, ignoring factors which favor the elderly. The question really is how much is available for support per family member after taxes and other demands such as debts and expenditures for education of children?

A survey by the University of Michigan Survey Research Center has disclosed that the liquid assets of the elderly are twice as high on the average as those of younger families. They have fewer family obligations, less debt, own more homes mortgage free, and enjoy special tax advantage allowing them to spend more of their income for their personal needs.

The President's Council on Aging has reported that the total income of older people rose 130 percent in the decade between 1950 and 1961 while their number increased about 40 percent. This compares with an increase in the same period of 80 percent in the total personal income of their entire population.

We do not argue that none of the aged has any serious financial worries. We do say that the overall health and economic problems of older Americans has been grossly exaggerated in the campaign to secure enactment of this program.

KERR-MILLS

The Kerr-Mills law, enacted by Congress in 1960 to provide medical care for the needy and near-needy aged, has had a remarkable record of acceptance by the States in the brief time it has been on the statute books.

Medical aid for the aged programs (to help those who are ordinarily self-supporting but who cannot meet the cost of serious or prolonged illness) have now been authorized in 43 States and 4 other jurisdictions.

Kerr-Mills also provides means for improving health care under existing old-age assistance programs (this is, those on public welfare rolls). Vendor payment medical programs for OAA recipients are now in effect in all 50 States and the 4 other non-State governments, including the District of Columbia. Nine States and two jurisdictions which had no vendor payment programs prior to Kerr-Mills have since begun them; 29 States and the other two jurisdictions have increased coverage, or benefits, or both. Many of the remaining 12 States already had sufficiently broad programs to meet their needs.

During the fiscal year ended June 30, 1962, according to the Department of HEW, $350.7 million in OAA funds and $194.8 million in MAA funds—over a half a billion dollars—were spent in vendor payments for health care. By September 1962, with the oldest MAA programs in effect only 2 years, 1 out of 50 aged persons in the United States had received MAA help. The number has continued to increase in the past year. Monthly caseload and expenditure figures

from the Department of HEW indicate that over a million aged will have received MAA help by the end of the program's first 4 years. In 1964, nearly 2½ million aged persons, 1 out of every 8, are on State OAA rolls. Thus, they are assured of medical care benefits under this section of Kerr-Mills as the need arises.

Attacks on Kerr-Mills invariably follow three lines:

1. Little new aid is being given; the States have merely shifted the cost of their old programs to the Federal Treasury.

This is demonstrably false. Monthly vendor payments for health care under OAA and MAA have increased by $47 million per month since enactment of Kerr-Mills, almost triple the pre-Kerr-Mills expenditure.

2. Three, four or five States are receiving the bulk of Federal funds for MAA, therefore, little is actually being accomplished in the other States.

It happens that these are the most populous States; a large proportion of the aged dwell in them; they also have had long experience with medical aid programs and required less time to get new programs into high gear. Moreover, the percentage of funds going to these States is decreasing as new MAA programs begin and older ones gain experience.

3. The means test is degrading and discourages older people from applying for help.

The steadily mounting numbers of old people being aided by Kerr-Mills destroys this argument. A means test is an established procedure in this country for protecting tax funds from waste and abuse. At least 10 Federal programs, besides Kerr-Mills, require a specific means test. Many labor unions deny strike benefits to their members unless need can be shown. Those who object to this requirement do not speak of the loss of dignity involved when one person takes from another that which he could provide himself.

The AMA is on record as favoring liberalization of the means test. Some States have already done so. Others are considering such action. We believe this pattern will continue.

The record of Kerr-Mills speaks for itself. True help for the truly needy is here now. This program has answered the argument of those who would throw the blanket of public welfare over everyone in an age group, regardless of need, on the ground that this is the only way an unfortunate minority can be reached.

VOLUNTARY EFFORTS

About 10 million elderly Americans today are protected from the cost of illness or accident by voluntary health insurance and prepayment plans. This is well over half the over-65 population which has prepared to meet its individual responsibilities without recourse to a gigantic Federal aid program. The fact that private enterprise has succeeded in finding the means to enable these citizens to stand on their own, and take care of their needs, is the major reason why the proposed Federal program is both unnecessary and undesirable.

Health insurance has made phenomenal advances in this country in recent years, and the coverage of the elderly is making the most spectacular growth. In 1952, probably no more than 26 percent of the aged had health insurance. By 1957, it was estimated that 43 percent had this protection, and by May 1962, 55 percent had some form of private health insurance. It is estimated that the figure has now reached 60 percent.

Voluntary health insurance is currently available to persons over 65 in the United States, regardless of whether they are healthy or sick, and without a physical examination. Insurance companies are pooling their resources to offer comprehensive benefits to older persons at reasonable rates. All 70 Blue Shield plans have made available nongroup, first-time enrollment programs for persons over 65. The result: The elderly are joining Blue Shield at a rate four times faster than all other age groups combined.

Under "paid up" policies now available, coverage continues but premium payments stop at a specified age. An increasing number of workers are being guaranteed the right to retain their group health insurance, or to convert it to individual policies after retirement. Eighty percent of the workers covered by company group plans issued during 1962 were guaranteed this privilege.

Major hospital and medical expense protection has been one of the fastest growing of all types of coverage. Progress continues to be made, too, in expanding basic health insurance to include nursing home and other out-of-hospital services.

And the end is not in sight. By 1970, it has been estimated that 80 percent or more of the aged who need and want health insurance will have it. This

assumes, of course, that the Government does not move in with a social security hospitalization-type program and undermine the efforts and achievements of the private insurance industry over the last decade.

We have long had a tradition in this country of helping our own needy in our own communities through religious, fraternal, civic, and philanthropic groups. In recent years, there has been a notable increase in the number and scope of these projects designed to help the aging in a variety of ways.

The Nation's total nursing home capacity has been doubled, largely under private auspices, and special housing developments for the aging are being offered on an increasing scale. Literally, thousands of voluntary groups in communities across the country have instituted rehabilitation programs to assist older people toward productive and enjoyable lives.

Other programs include recreation activities for older persons, nursing care in their homes, homemaker services, hot meals supplied in their homes for those unable to cook, and even the simple, humanitarian gesture of "friendly visitors" to break the loneliness of the confined.

The range of private efforts is tremendous, ranging from a contribution to a local community chest program to multimillion-dollar subscriptions for construction of vast new medical centers.

Passage of the health care for aging legislation before you today will tend, psycholigically and practically, to discourage these voluntary programs by placing the Federal Government in a dominating role. It will diminish the motivation for charitable contributions and will cause many Americans to feel there is less need for them to give of their talent and time to help the needy. If the incentive toward voluntary private efforts is curbed, the loss to our older persons will be incalculable.

Together, private health insurance, other voluntary efforts, and the Kerr-Mills law have demolished the argument of the need for additional Federal intervention in financing health care for the entire over-65 population. The self-supporting are caring for themselves; the needy are being helped by joint efforts. As more and more workers move into their retirement years, covered by private pension plans and health insurance which they can retain, their ability to meet their health-care costs will advance at an accelerated pace. A permanent welfare program is being proposed here to solve a transitional, diminishing problem.

OBJECTIONS TO THE PROPOSALS TO TACK ON HEALTH CARE FOR THE AGING

Until the added use of the Nation's health care facilities under a program of "free" Government benefits is learned from experience, the ultimate cost of the program cannot be determined. Meanwhile, wage earners have no way of measuring the probable impact of the various proposals on their income through the higher taxes they would be required to pay.

We do know that Government cost estimates in the past during consideration of these programs have been shown to be unrealistically low. The Department of HEW's Actuarial Study No. 57 acknowledged only last year that the King-Anderson program, then under active consideration, would require periodic increases to remain solvent more than 3 years in a rising economy.

The insurance industry estimates of the size of the burden on the Treasury that would result from a Federal attempt to provide hospitalization for the entire elderly population are substantially greater than the estimates by the Government experts. Now a new element has been added in the form of pending legislation to raise social security taxes to pay increased cash benefits to 20 million Americans. A tax to support hospitalization for the elderly would be figured on top of the new social security rates.

This development should alert the Nation to the approach of the day when the average worker will pay more taxes to social security to support Federal welfare programs than he will to support all the rest of the Government activities, including the Defense Establishment. Workers who do not make enough to pay an income tax (about one-fifth of the Nation's families) would share in the increasing social security taxes which begin on their first dollar of earnings.

Uncertainties about the costs of Federal health care proposals underscore another point of fundamental importance to the American people. Naturally, in any measure, the Government would have to establish controls over the expenditure of public funds. This means Federal officials and employees, untrained in medicine, would be empowered to intervene in the operation of hospitals and nursing homes, and in the practice of medicine in those institutions.

Such controls are not compatible with good medicine. Doctors believe care of the patient must come first, all other considerations must come afterward. But

the Government must keep its eye on the budget, tightening the reins on the services as the costs rise. With quantity thus restricted, quality of care would inevitably decline.

The trusted name of insurance has been appropriated by the proponents to describe these Government programs. The aim, obviously, is to convince workers they would be permitted to pay premiums on hospital insurance, with their money set aside for their future benefit. This simply is not true—a point we are sure we do not have to labor before this committee.

The mechanism for supporting Federal health care efforts compels; it does not permit. People would not contribute; they would pay taxes. They would not pay taxes in their working years for medical care in their later years. They would pay taxes for today's beneficiaries.

MEDICAL PROGRESS AT STAKE

Today, the American system of health care is universally recognized as the finest in the world in all respects.

This progress did not just happen. It was brought about by the constant work and effort of individual physicians and the medical profession, aided by contributions from allied sciences and health professions working together in an environment of freedom.

We have a close primary medical interest in the multitude of questions raised by this legislation. It is a natural outgrowth of our historic concern for the health and medical welfare of all Americans regardless of age.

We know from our knowledge and experience that medical aid is not the central or most urgent interest of our aging population. It is something quite different. It is the feeling of loneliness, of having no individuality, no purpose, of not being wanted. In mose instances the "care" for which older people yearn is tangible evidence that they are still a part of the family, their circle of friends, and the community; that they are respected and cherished as persons, not merely attended as bodies in need of physical care.

We have said that some of our elderly suffer from illness and poverty. We have noted that this group should be, and is being, helped.

But for the great majority of older citizens, passage of a law is no answer to their basic need, and certainly not a law which merely offers to segregate them in institutions for a limited time. Total health of the aging involves far more than hospitals and nursing homes.

Proponents of these measures are insisting on an economic solution for a social problem. They would impose on the Nation a permanent system of tax-supported, Government-regulated health care.

As the system grew, it would lead to a deterioration of the quality of health care by disrupting the voluntary relationship between the patient and his physician, interfering with the free selection of diagnostic and therapeutic choices by the physician, undermining financial incentive, and imposing centralized direction which would frustrate the striving for professional excellence. The inevitable result would be a form of medicine alien to these shores—medicine on an assembly line basis—and a loss of able entrants into the health-care field because of Government controls over the profession.

We believe that the proposed amendments to tack on health care for the aging to H.R. 11865, are unnecessary and dangerous to the basic principles underlying our American system of medical care.

We urge that they be rejected.

SECTION I. INTRODUCTION

Mr. Chairman and members of the committee, the American Medical Association is vigorously opposed to any legislation which proposes use of title II of the Social Security Act as a mechanism for financing a Federal program of health care for the aged.

We recognize that there are areas of health care in which the Federal Government has a responsibility such as to members of the Armed Forces and their dependents, veterans with service-connected disabilities, civil service employees, and wards of the Government as in the case of Indians.

But the various proposals before you, whatever the method they envision to reach the desired objective, would transfer to the Federal Government the responsibility for health care for all persons over 65, regardless of their economic need.

The personal responsibility of the individual and his family would be shifted to the back of the Central Government. The States, the counties, and the com-

munities would similarly be relieved of their responsibility toward those among their citizens who are unable to provide for themselves. The assumption of this new obligation and authority by the Federal Government is not reasonable.

We are opposed to this legislation because we disagree with its basic philosophy. We oppose its method. We are deeply concerned with its effects upon the Nation's standards of health care.

As physicians, we believe we have a responsibility to call to the attention of the public—our patients—any projected development which threatens the quality of medicine in this country.

We cannot stand idly by now as the Nation is urged to embark on what we are convinced is an ill-conceived adventure in Government medicine, from which the patient is certain to be the ultimate sufferer. For make no mistake about it: The medical profession will itself never deprive the people of high quality medical care and the fruits of progress of medical science. That will come as Government interferes with freedom in health care.

Our objections to these plans range from the philosophical to the intensely practical, from the general to the specific. We base our position on the following points:

The program would cover millions of people who are self-supporting and do not need to have the Government finance their hospitalization.

The problem of providing health care for the aged who need help is already being solved through the Kerr-Mills law. No alternative Federal law is necessary.

The program would be unpredictably but extremely expensive, and would impose a new and possibly ruinous burden on the social security system.

It would compel the Nation's younger workers, many of them at the lowest end of the income scale, to pay for these unnecessary benefits through an increased gross payroll tax. These same taxpayers would face the certainty of further increases in the years to come—those already written into the law and those which Government actuaries have acknowledged would be necessary to keep a Federal health care program solvent in a rising economy.

Its enactment would mean the undermining of private health insurance and other prepayment plans through which more than half of the older population is now protected from the cost of illness.

It would lead to the decline, if not the demise, of voluntary efforts at the community level, and must eventually contribute to the erosion of our historic concepts of individual and family responsibility.

A doctrine which holds that eligibility for medical aid can be determined on a basis of age rather than need is fallacious in the extreme. Young people, as well as old, are subject to accident or illness. Helplessness to cope with personal disaster because of a lack of resources is no respecter of birthdays.

Enactment of the program would leave only two steps necessary to bring all Americans under a system of completely nationalized or socialized medicine. First, there would be the drive to lower the age for eligibility; then, moves to extend benefits to cover all medical services. Former Representative Aime J. Forand candidly explained the ultimate goal of this type of legislation in January 1961 in these words:

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

From the beginning, the question of financial need has lain at the heart of this controversy. No one disputes the fact that some elderly people need help in meeting their medical expenses. But we have said that the overall economic and health problems of the aged have been grossly misrepresented to the American people in the campaign to secure passage of this legislation.

Today, we will dwell at some length on facts and figures which we believe demonstrates beyond a doubt that this is so. We will cite numerous studies and surveys of groups of older people across the country which show that the majority of over-65 Americans are self-reliant and independent; that they are in control of their economic destinies, that generally they enjoy good health, and that failure or inability to pay their health care bills is the exception rather than the rule among those in this age group.

Further, we intend to discuss in detail the remarkable effectiveness, now a matter of record, of the Kerr-Mills law in helping the needy and near-needy aged meet their medical expenses. The law is filling a vital need of our soicety; it fits the established pattern of other assistance programs—Federal financial contributions, but State control and State determination of what is required to discharge government responsibility to its citizens. Proof of its success is its acceptance by the States which continues on a steadily widening scale.

Besides help for those who need help which is being provided under Kerr-Mills, there is the often forgotten but important voluntary contribution regularly being made by private citizens at the local level toward solving the problems of the elderly. We believe efforts in this field merit review at this hearing. We have long had a tradition in this country of helping our own needy in our own communities through religious, fraternal, civic, and philanthropic groups. Passage of an impersonal Federal aid program for the aged would discourage local efforts and, more important, it would contribute to the elimination of that sense of responsibility Americans feel for one another as individuals and fellow citizens.

Advocates of Government-controlled health care for the aged have claimed repeatedly through this long debate that private health insurance is inadequate and too costly for the rank and file of the elderly. There is no substance to the argument, a fact demonstrated by the progress recorded by the insurance industry since the last hearings.

Since the end of World War II, as our testimony will show, voluntary health insurance and prepayment plans have continued their rapid expansion of coverage among the elderly. Americans 65 years and older are buying this protection at a rate which exceeds that of the rest of the population. They are preparing to meet their medical expenses without recourse to taxes paid by younger workers.

Many of the policies offer a wider range of benefits than could possibly be provided by a limited Government program. And the fact remains that more than 10 million older citizens have bought policies suitable to their needs.

Also, because we are physicians and because concern for the health care of our patients is deeply ingrained in the fiber of our professional lives we propose to point out what is at stake here—what American medicine has accomplished under a free system, and the dangers to the system and the quality of health care it provides that are both explicit and implied in this legislation.

Presented herewith is the detailed testimony of the American Medical Association in these significant areas.

SECTION II. THE AGED—THEIR ECONOMIC AND PHYSICAL HEALTH

The case in favor of engrafting hospitalization and related benefits for the aged onto the social security system rests on parallel fallacies; namely, that debilitating illness is universal among the population aged 65 and over; that economic deprivation is a general characteristic of the elderly; and that these conditions demand a massive rescue operation by the Federal Government.

The evidence we present in this testimony will, we believe, conclusively demonstrate that the vast majority of the Nation's aged are not ill but in fact enjoy good health, and that the aged as a group do not exist on the brink of financial calamity but in fact are economically self-reliant and independent and, for the most part, are as well off, or better, than younger generations.

We believe we can also show beyond reasonable doubt that the Federal Government should be dissuaded from embarking on this unsound, extravagant, and unnecessary program; that the Federal Government in fact has been given, by action of Congress, an effective instrument in the Kerr-Mills law for discharging whatever obligation it may have for assisting the States to assist the minority of the aged who need help in paying for medical care.

Statistical deception

First, however, we submit that contradictions, conflicts, and statistical half-truths bring into serious question the integrity of the evidence which has been presented in attempts to justify a new Federal program to finance partial health care of the Nation's elderly population through the social security system.

One administration publication, for example, employs a form of statistical deception in an attempt to prove the gratuitous assertion that incomes of the aged are "inadequate for even a modest level of living."[1] The income of a mythical aged couple living in a hypothetical metropolitan city is measured against the Labor Department's level of adequacy and found to be too low to sustain even a minimum standard of living. The income figure used, however, is neither the average nor the median income of aged couples living in metropolitan areas. It is the median income of all aged couples in the Nation. It is the median income of all aged couples in the Nation, including those in rural areas where

[1] "The Older American," May 14, 1963, first annual report of the President's Council on Aging.

living costs are substantially less than in large cities. Ignored in this fictionalized situation are U.S. Department of Labor reports showing that the income of the aged who live in metropolitan areas is significantly higher than the national median.[2]

The American people have been assailed by such statements as the income of the great majority of the aged is little more than a monthly social security check. Yet, only a third of the more than $35 billion annual income of persons over 65 comes from social security payments.

While advocates of a Federal program have argued that medical care costs have risen faster than the ability of aged Americans to pay, the President's Council on Aging has said that income of the aged has risen faster than the cost of medical care and faster than the income of the population as a whole.[3]

Economic fallacies

The aged are portrayed on the one hand as a group too impoverished to pay for medical care, but a Government agency on the other hand reports that $3.8 billion of the medical care expenditures of persons over 65 in 1961—nearly three-fourths of total expenditures—was paid from private sources.[4]

The fallacies which have characterized the campaign to force this type of legislation on the American people are easy to detect but not so easy to demolish. Our position is best described by a cogent observation attributed to a French philosopher-statesman, Frederick Bastiat: "Economic fallacies can be stated plausibly in a single sentence; the answer may require a textbook."

Although it is not true that the aged as a group exist in a tragic state of economic privation, the proponents of Federal hospital care for the aging have persistently tried to sell this picture of the elderly with such statements as "the average aged couple has only about $50 a week to live on" or "more than half the aged have incomes of less than $1,000 a year." [5]

Or they have sought to perpetuate a false portrait of the aged as universally frail and feeble, constantly ill, and doddering from one visit to the doctor to the next by declaring that they visit doctors 36 percent more often than younger people or that four out of five have one or more chronic illnesses.[6]

Anyone who explores the facts in depth will soon discover that there is more to these statistics than appears on the surface. He will also discover that this credulity has been assaulted by an artful kind of word weaponry, designed to persuade him to accept the biggest fallacy of all—the plight of the elderly is so desperate that a centralized, multibillion dollar Federal project is imperative.

Chronic illness

The word "chronic" in the context in which it is being used, for example, conveys the impression that most of the elderly suffer a multiplicity of serious afflictions which substantially increase their need for medical care to the extent that it becomes an intolerable financial burden. The 36 percent more visits to the doctor is a statistic with a similar misleading effect.

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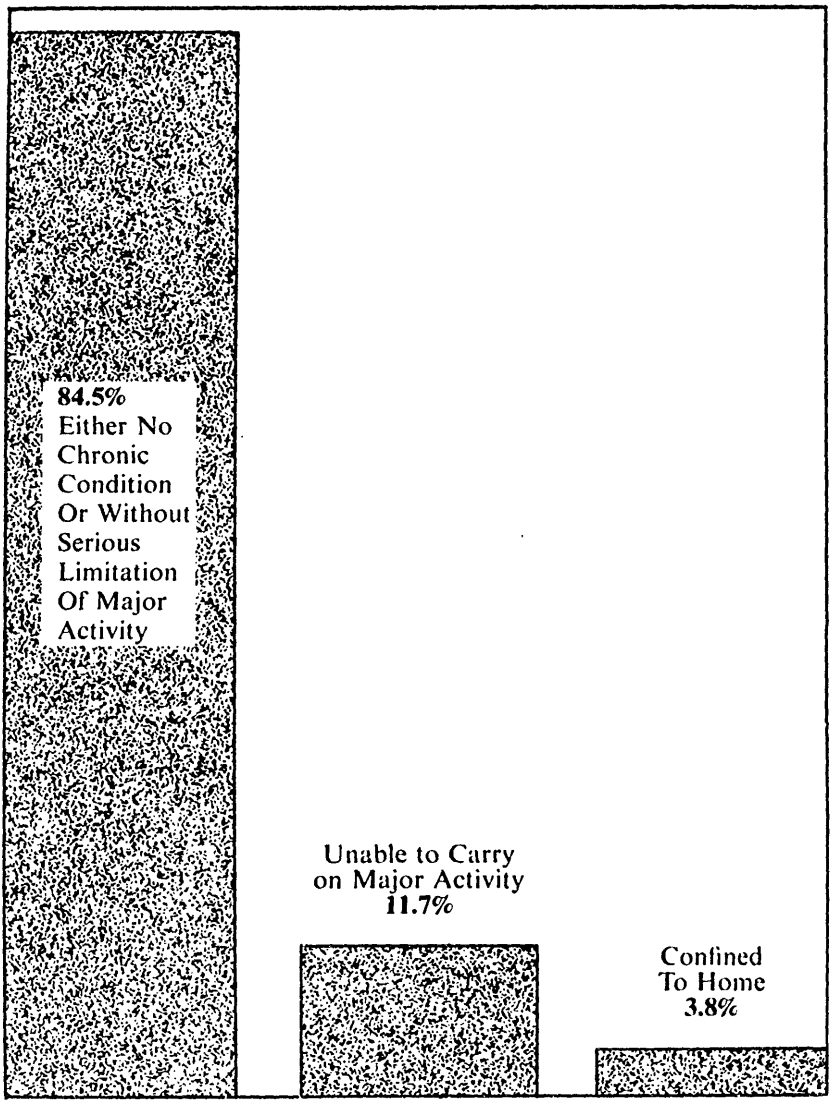
[2] "Survey of Consumer Expenditures, Advance Reports," "Consumer Expenditures and Income, 1960–61," study of 21 cities, Bureau of Labor Statistics, U.S. Department of Labor.
[3] "The Older American," p. 7.
[4] "Facts on Aging," No. 6, April 1963, Office of Aging, U.S. Department of Health, Education, and Welfare, table 1.
[5] "The Older American," p. 9.
[6] "State Action To Implement Medical Programs for the Aged," a staff report to the Special Committee on Aging of the U.S. Senate, June 8, 1961.

FIGURE 1.—*Extent and effect of chronic conditions on over 65 population*



SOURCE:

Health Statistics, Series B–No. 36, From the U.S. National Health Survey, "Chronic Conditions Causing Limitation of Activities," United States, July 1959–June 1961, U.S. Department of Health, Education, and Welfare, Table 10, page 19

But "chronic" defines duration and not severity, and includes such nondisabling afflictions as hay fever and varicose veins. While evidence indicates that about four out of five elderly persons (78.7 percent) do have one or more chronic conditions, it also indicates that only about 15 percent of the noninstiutionalized aged are unable to carry on major activity (fig. 1). Less than 4 percent of the aged have such limiting chronic conditions as to be confined to the house.[7]

Physician visits

When the statement is made that the aged visit doctors 36 percent more often than younger people, the 36 percent translates into only 1.8 additional visits per year, or an average of 5 visits per year for the total population compared with an average of 6.8 visits per year for those over 65.[8] A statistic of doubtful economic significance to the average aged person is thus ballooned into an impressive figure.

The number of times the aged visit doctors, moreover, is not necessarily a test of good or bad health. The fact is that the vast majority of the elderly enjoy reasonably good health, and really poor health is concentrated among a relatively few. The Health Information Foundation survey found that 46 percent of the noninstitutionalized aged consider themselves to be in good health and 44 percent reported some disability but not sufficient to interfere with their physical functioning. Only 10 percent were classified as very sick.[9]

While the aged are more susceptible to chronic conditions than the population as a whole, they are less likely to suffer acute illness or to require surgery. Among the aged who are discharged from hospitals each year, less than 40 percent are hospitalized for surgery. In contrast, among all ages discharged, nearly 60 percent undergo surgery.[10] And the population as a whole has a 244-percent greater incidence of infectious and parasitic diseases than the population over 65—a rate of 25.8 for every 100 persons of all ages compared with 7.5 per 100 for the aged (table 1). Persons over 65 also experience a lower incidence of respiratory ailments than younger people. Furthermore, contrary to a general belief, the aged are less likely to suffer accidental injuries than any other age group. The annual accidental injury rate of 19 per 100 aged persons is significantly less than the rate of 25.5 per 100 for the population under 65 (table 2).

TABLE 1.—*Annual incidence of acute conditions per 100 persons (1958–59)*

Condition	All ages	45 to 64	65 and over
Infectious and parasitic diseases	25.8	9.1	7.5
Upper respiratory	83.1	55.6	54.9
Other respiratory	42.6	28.9	26.7
Digestive system	11.9	8.7	5.8
Fractures, dislocations, sprains, and strains	8.3	9.1	9.0
Open wounds and lacerations	7.3	4.4	2.4
All acute conditions	214.8	142.7	133.9

Source: U.S. National Health Survey, "Acute Conditions, Incidence, and Associated Disability, United States, July 1958–June 1959," U.S. Public Health Service, Washington, D.C., 1960, p. 11, table 3.

TABLE 2.—*Annual accidental injury[1] rate per 100 persons (1959–61)*

Type of accident	All ages	45 to 64	65 and over
Moving motor vehicle	1.6	1.9	1.4
All other accidents	23.9	20.0	17.6
All accidental injuries	25.5	21.8	19.0

[1] Includes only persons with injuries involving 1 or more days of restricted activity or medical attention.

Source: Health Statistics, U.S. National Health Survey, Department of Health, Education, and Welfare, Series B—No. 37, table 2, p. 13 (item II–94).

[7] Health Statistics, U.S. National Health Survey, "Chronic Conditions Causing Limitation of Activities," July 1959–June 1961, series B—No. 36, table 11, p. 20.
[8] Health Statistics, series B—No. 19, "Volume of Physician Visits, United States, July 1957–June 1959," U.S. Department of Health, Education, and Welfare, table 20, p. 29.
[9] "Medical Care Among Those Age 65 and Over," Ethel Shanans, Ph. D., Health Insurance Foundation, Research Series 16, 1960.
[10] Health Statistics, "Hospital Discharges and Length of Stay: Short-Stay Hospitals, United States, 1958–60," U.S. Department of Health, Education, and Welfare.

Hospitalization of aged

The aged who enter hospitals will stay, on the average, about twice as long as younger people, about 15 days against 8.4 days for the population as a whole. The average for the aged, however, is pushed up by the minority who remained hospitalized for long periods, some of whom would be as well care for in nursing homes. The U.S. Public Health Service has reported, for example, that 10 percent of the aged account for 39 percent of the total days of hospitalization for this age group.[11] The 10 percent remain hospitalized for 31 days or longer, while the other 90 percent, who account for 62 percent of hospital days, stay considerably less than that. The 10 percent who are long-stay patients also account for about 38 percent of expenditures.

Health Information Foundation studies suggest that factors, only dimly comprehended, may significantly affect the health and economic well-being of the aged. Doctors know that illness can be induced by loneliness and a feeling of rejection. But how much does anyone know of education (or lack of education) as a factor in illness as well as economic status, or even living in a rural rather than an urban atmosphere?

A diligent, honest, objective search for the facts about the economic and physical health of the aged would serve the national interest a great deal more than the unceasing quest for political exploitation of the elderly which has been going on for too many years.

Fiction, fallacy, prejudice

Those who so avidly desire to reshape the social security system to accommodate a program of politically controlled, federally-operated tax-paid hospitalization for the aged regardless of need stubbornly argue their case from a catalog of fiction and fallacy and prejudice.

Thus, we hear over and over again that the aged are virtually destitute, that half have incomes of less than $1,000 a year, that the average aged couple lives on about $50 a week, that incomes of the aged families are only half as much as younger families.[12] Proponents of this legislation, however, offer no evaluation of this "evidence." Indeed, they dare not because their case collapses on analysis of their statistics.

Income figures examined

Included among those with incomes of less than $1,000 a year, for example, are wage-earners' wives who have no income at all even though the family-income may be $5,000 or $10,000 or $20,000 or more a year. Others included are persons over 65 with small incomes, or perhaps no incomes of their own, who live with children or relatives and receive the basic requirements of food, clothing, shelter, and medical care from those with whom they live. Three out of four persons over 65 are members of families, and thousands of families both old and young have only one breadwinner.[13] More than 200,000 persons over 65, for example, have incomes in excess of $20,000 a year, according to the President's Council on Aging.[14] Few of the wives in such high-income families are likely to contribute anything to the income. Consequently, this statistic obviously is weak support for the argument that the aged as a group are practically impoverished. On the strength of this kind of statistic standing alone, it could be said that all the citizens of America, the richest country in the world, are really almost destitute since nearly two-thirds of the entire population has an annual income of less than $1,000 per person.

The implication that most of the aged are economically prostrate because the average couple has an income of about $50 a week is also deceiving. The statistic applies only to two-member families and thus fails to account for the fact that of the nearly 13 million persons over 65 who live in families, about 42 percent are members of families with three or more individuals.[15] It also ignores the fact that larger families among the aged generally have larger incomes than two-member families. Census reports for 1960, for example, show a $4,122 median

[11] "Hospital Discharges and Length of Stay: Short-Stay Hospitals," United States 1958–60, National Health Survey, U.S. Public Health Service, 1962.
[12] "The Older American."
[13] Current Population Reports, Consumer Income, series p–60, No. 37, "Income of Families and Persons in United States: 1960," table G, p. 11 and table 23, p. 40.
[14] "The Older American."
[15] "Income in 1960 of Families With Head 65 Years and Over, by Selected Characteristics for the United States," U.S. Department of Commerce, Bureau of the Census.

income for three-member aged families, $6,100 for four-member families and $5,727 for families with five or more members.[16]

Demands on income of aged

The emphasis on income as the sole measure of the economic well-being of the aged ignores other important consideration. Income alone is not a valid index of dependency or independency. Fewer family obligations, tax-free income, other tax advantages, less indebtedness, and lower financial requirements all add to the relative prosperity of aged families.

Many of the aged have retired and thus escape transportation, lunches, clothing, and other expenses necessary to employment. Most of them no longer have children to educate, an increasingly costly drain on the budget of younger families. Housing costs are substantially less for the elderly. A recent survey by the University of Michigan Survey Research Center disclosed that 83 percent of aged families who own their homes have paid off their mortgages and of those still paying on mortgages, only 4 percent owe $5,000 or more. In contrast, only 34 percent of younger homeowners were free of mortgage debt, and of the 66 percent with mortgage debt, 43 percent owe $5,000 or more.[17]

Federal income tax laws, as well as those in a number of States, favor the aged, allowing double personal exemptions, credits for retirement income, tax-free income from social security, the railroad retirement program and veterans' pensions and more liberal allowances for medical expenses. It is possible for a couple, both over 65, to have an income in excess of $6,000 without paying any Federal income tax, depending on the source of the income.[18] A younger couple would normally pay nearly $850 on that income. The President's Council on Aging has estimated that these special tax advantages saved older Americans about $775 million in 1963.[19]

Proponents of the legislation adhere to gross income alone in making economic comparisons between aged and younger families. They repetitively recite such figures as the median income of younger families in 1960 was about $5,900 compared with about $2,900 for aged families, and they often follow with such statements as: "The aged are a low-income group and it is high time to stop juggling figures in an attempt to prove otherwise." [20]

However, it is not necessary to juggle figures to demonstrate otherwise. Some simple calculations will do, using these figures as a place to start rather than a place to end. It would appear to be elemental that a family's financial well being would be effected by the number of people to be taken care of as well as the amount of inescapable obligations. In other words, how much is available to these families per family member? Need the point be labored that more money is required to provide for a family of four than a family of two?

Per member income

Federal taxes will not reduce the older family's income in the vast majority of cases, but will reduce the younger family's spendable income. The average older family is composed of 2.34 members, the average younger family 3.97 members. Thus, the after-tax income of the older family in 1960 was $1,240 for each member, only $60 less than the $1,300 after tax, per member income of the younger family (table 3).

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[16] Current Population Reports, Consumer Income, "Income of Families and Persons in the United States: 1960," series P–60, table D, p. 36.

[17] "Survey of Consumer Finances," University of Michigan Survey Research Center, 1960.

[18] "Tax Provisions Favoring Older Persons," appendix F, "Developments in Aging, 1959 to 1963," report of the Special Committee on Aging, U.S. Senate, pp. 221–224, taken from a 1962 report to the President by the Federal Council on Aging.

[19] "The Older American."

[20] From "Income Problems of the Aged," a speech by Dorothy McCamman, a member of the staff of the Special Committee on Aging of the U.S. Senate, excerpts as Appendix D of the Committee's 1963 report, "Developments in Aging, 1959 to 1963."

TABLE 3.—*Median family incomes, before and after taxes, per family and per family member, by age of family head, 1960*

	Age of family head	
	64 or less	65 or over
Family income:		
Before taxes	[1] $5,905	[1] $2,897
After taxes [2]	5,170	2,897
Per family member:		
Before taxes	1,490	1,240
After taxes	1,300	1,240
Size of median income family	3.97	2.34

[1] Given in P-60, No. 37. Other figures based on calculations by the Department of Economic Research, American Medical Association.

[2] Federal income tax and social security tax were only taxes considered. Federal income tax was estimated by subtracting $600 deduction for each dependent ($1,200 for aged head) and standard 10-percent deduction from the median before tax income and applying the appropriate tax rate from Internal Revenue form 1040 to the remaining taxable income.

Sources: Bureau of the Census, current population Reports: Consumer Income, series P-60, No. 37; Bureau of Internal Revenue, form 1040 (item III, 112, table 2).

Advance reports for 21 major cities included in the Department of Labor's 1960–61 "Survey of Consumer Expenditures" offer further evidence that the aged as a group do not live in a financial straitjacket. These reports suggest that people over 65 living in major metropolitan areas may be as well off or better off economically than anyone else living in these sections of the Nation. The average income per person living in households headed by persons 65–74, $2,223, was greater than the average per capita income of all persons, $1,974. The average income per person living in households with head 75 and over was $1,723 which is not much lower than that for all households (table 4).

TABLE 4.—*Average money income after taxes, per household and per household member by age of head, 1960, urban (21 cities)*

Age of head	Average money income after taxes	Average size of household	Average incomes per household member
All ages	$6,120	3.1	$1,974
65 to 74	4,201	1.9	2,223
75 and over	2,964	1.7	1,723

Source: Combination of all observations included in advance reports in 21 cities sampled in 1960 as part of the 1960–61 Consumer Expenditure Survey, Bureau of Labor Statistics. BLS Reports, Nos. 237–1 through 237–21.

We are not suggesting for a moment that none of the aged has any serious financial worries. The fact that more than 2 million of the aged are on old-age assistance rolls and more than 180,000 a month are receiving medical assistance through the Kerr-Mills program is proof enough that a significant number of the population 65 and over do need financial help from some source. Nevertheless, the data currently available strongly contradict the thesis that the vast majority of the aged exists in economic misery without hope of improvement.

President's Council on Aging

Even the President's Council on Aging was able to delineate a remarkable record of economic improvement among the aged in its May 14, 1963, report, "The Older American," and forecast continued improvement in the future.

The Council, since it is a creature of the administration, understandably maintained a steady bias in favor of direct Federal interjacence in the health care field. Consequently, its documentation of the brightening economic profile of the aged is particularly noteworthy.

For example, while offering the opinion that incomes of the aged are "inadequate for even a modest level of living," the Council, at the same time, pointed out that in 1950 there were 12.3 million Americans over 65 with a total income of $15 billion, but by 1961, with the number of aged at 17 million, their income had jumped to $35 billion.[21]

"Thus," said the Council, "while the number of older people increased about 40 percent in the past decade, their total income rose by more than 130 percent. This compares, for the same period, with an increase of 80 percent in the total personal income of the entire population of the country."

The Council also noted that during this period, the consumer price index rose only 26 percent, the cost of all medical care, 56 percent, and hospitalization, 125 percent.

Members of the Council sought to discount the benefits of this remarkable rise in the economic status of the aged in these words:

"This is not entirely a plus, however. For one thing, the purchasing power of the dollar in 1961 was 20 percent less than in 1950. For another, more of the Nation's older people now live in urban areas where costs are high.

"Then, too, a substantial part of this total [income] goes to a relatively small group. Over 200,000 older Americans—1 out of 85—had incomes of $20,000 or more, and over 50,000 had incomes of $50,000 or more in 1961."

A number of observations are appropriate. If the dollar was less valuable to the aged, it was also less valuable to the rest of the population whose wealth increased at a slower pace. More of the aged may now live in urban areas, but, on the other hand, more of everybody live in urban areas. Furthermore, as we pointed out earlier from Department of Labor studies, the income per person among aged families in metropolitan areas was higher than in the rest of the country and even higher than younger families in or out of the metropolitan areas.

There well may be 200,000 Americans over 65 with incomes of $20,000 or higher and 50,000 with incomes of $50,000 and up. If so, there must be tens of thousands of others with incomes of $10,000 to $20,000.

Yet, those who endorse the proposed Federal program, including members of the President's Council, are urging that a payroll tax increase be forced on younger families, whose median income before taxes is less than $6,000, so that hospitalization and other health benefits can be provided at taxpayers' expense to everyone over 65, including these tens of thousands with incomes of $10,000, $20,000, $50,000, and more.

Brighter future for aged

The Council forecasts a brighter future for the aged, since—

Practically everyone will be eligible for social security payments.

Social security checks will be bigger because they will be based on higher average earnings than in the past.

Private pensions will add more and more to the income of the aged.[22]

Older people who retire in the next 10 years are likely to have greater personal assets and savings and equity in property.

Even more astounding than all this is the fact, noted by the Council, that in the 1963 fiscal year, $17 billion was spent or administered by the Federal Government alone on programs for the aged.[23] This, we do not need to emphasize, amounts to an average of about $1,000 per person aged 65 or over.

"General tax money will supplement these social insurance payments," the Council said. "It will be used to provide public assistance payments to the

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[21] "The Older American."

[22] It is estimated that by 1970, there will be nearly 40 million workers enrolled in private and government retirement programs. This estimate was made in Miss Sylvia Porter's column, "A Report on Pension Funds," Chicago Daily News, June 17, 1963. Miss Porter's article was based on the 43d Annual Report of the National Bureau of Economic Research and the study "Economic Aspects of Pensions" under the direction of Roger F. Murray, professor of economics, Graduate School of Business, Columbia University.

[23] "The Older American," May 14, 1963, first annual report, President's Council on Aging.

very needy; it will provide money for medical care for many with very low incomes; it will assist in making adequate housing possible; it will support needed social services for the aged and will make possible special programs for education, rehabilitation, and increasing employment opportunities." [24]

The Council appropriately observed that all this adds up to "astonishing improvements for older people in the past 10 years."

Indeed it does.

And it prompts the question how the Council could compile this record of "astonishing improvements" in the economic fortunes of the aged over the past decade and at the same time offer the opinion that problems of the older American have come "dangerously close to making him a second-class citizen." [25]

Facts on aged finances

Still other evidence persuasively attests to the fact that the economic condition of the aged is not as bleak as has been painted. Surveys have shown that the aged in general have more assets and fewer debts than other Americans. Such surveys conducted by the University of Michigan Survey Research Center, for example, have disclosed:

1. Median total assets held by aged spending units were nearly twice as high as younger spending units, $8,080 compared with $4,630. (Spending units as used by the center include single persons and are therefore different from the Census Bureau's family classifications which include no fewer than two persons.) (Table 5.)

TABLE 5.—*Comparison of assets of older and younger people, 1960*

Value of assets owned	Total assets		Home equity	
	Under age 65	65 or older	Under age 65	65 or older
	Percent	*Percent*	*Percent*	*Percent*
$25,000 or over	9	18	2	5
$10,000 to $25,000	18	23	18	26
$5,000 to $10,000	20	22	17	18
$1,000 to $5,000	36	22	14	14
Less than $1,000			2	1
Not ascertained	2	2		
None	15	13	47	36
Totals	100	100	100	100
Medians [1]	$4,630	$8,080	$1,280	$4,560

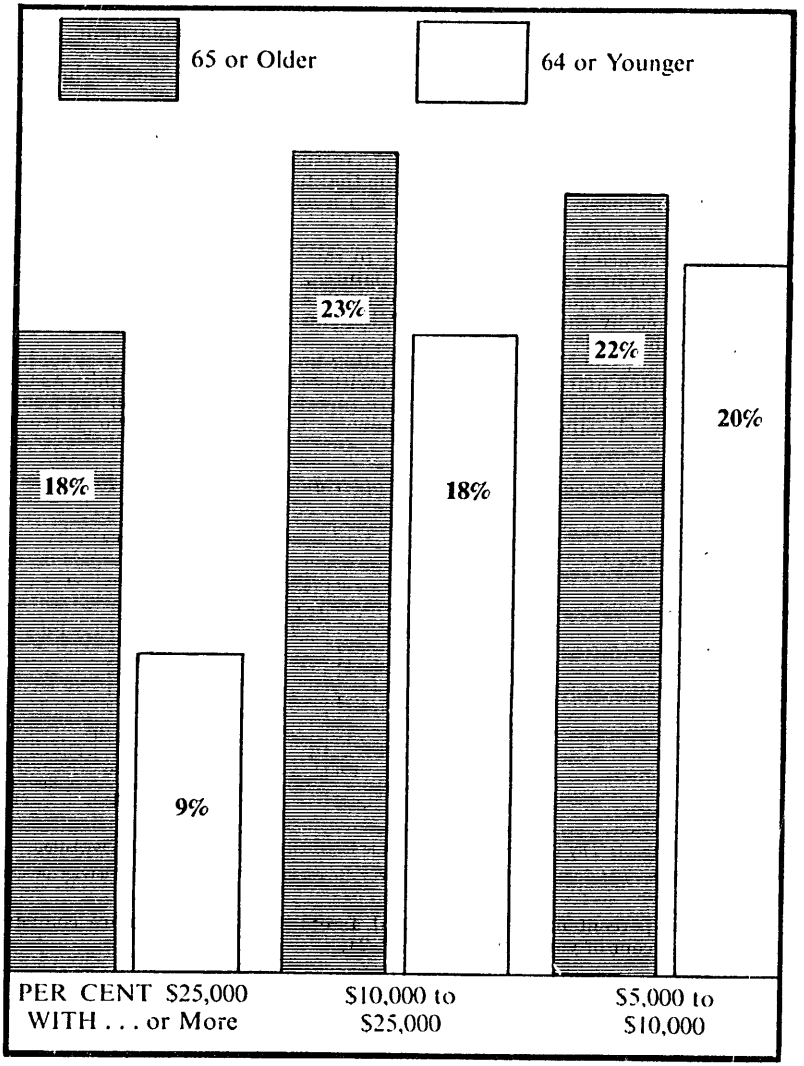
[1] Calculated from the data by Department of Economic Research, American Medical Association.

Sources: "1960 Survey of Consumer Finances," Survey Research Center, economic behavior program, Ann Arbor, Mich.

2. Forty-one percent of older units had assets of $10,000 or more compared with only 27 percent of younger groups (fig. 2).

[24] "The Older American."
[25] "The Older American."

FIGURE 2.—*Comparison of assets of older and younger people 1960*



SOURCE:

1960 *Survey of Consumer Finances,* Survey Research Center, University of Michigan. Percentage refers to "spending units," with specified age of head.

3. Eighteen percent of the elderly had net worth above $25,000 compared with 9 percent of the younger units (fig. 2).

4. Median assets of the lower income group—income under $3,000—was 10 times as much as the comparable younger units, $5,680 against $500 (table 6).

TABLE 6.—*Assets held by younger and older spending units according to incomes, 1959–60*

[In percent]

Total asset classes	Income classes						All incomes	
	Under $3,000		$3,000 to $4,999		$5,000 or over		64 or less	65 or over
	64 or less	65 or over	64 or less	65 or over	64 or less	65 or over		
Substantial: $10,000 or over	3	18	4	12	22	12	29	42
Moderate: $5,000 to $9,999	2	18	4	3	14	1	20	22
Limited or none: Less than $5,000	17	32	15	3	18	1	51	36
All asset classes:								
64 or less	22		23		54		100	
65 or over		68		18		14		100

Source: Survey Research Center, University of Michigan. "1961 Survey of Consumer Finances," (master copy: Study 638, 1960, table LA–111; number of cases: 64 or less, 2,537; 65 or over, 425).

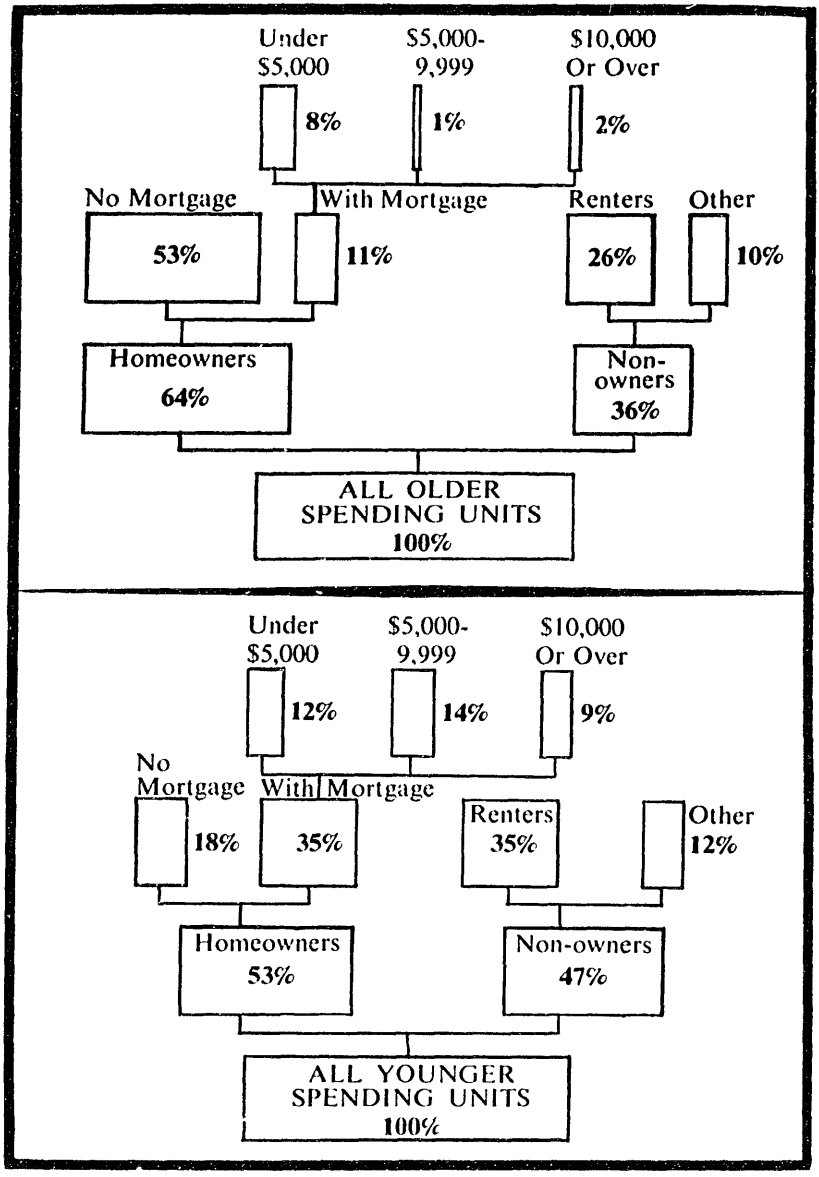
5. The median equity in a home was $4,560 for the aged groups, nearly four times the $1,280 for the younger (table 5).

6. In the income category above $5,000, the survey showed 82 percent of the aged with assets in excess of $10,000, compared with 38 percent of the younger units (table 6).

7. Sixty-four percent of the aged were homeowners, compared with 53 percent of the younger groups (fig. 3).

8. Fifty-three percent of the aged owned their homes free of mortgage, and only 11 percent had any mortgage debt at all. In contrast, only 18 percent of the younger units owned homes clear of mortgage and 35 percent had mortgage indebtedness (fig. 3).

FIGURE 8.—*Housing status and mortgage debt spending units with head 64 or less and 65 or over*



SOURCE:

1960 *Survey of Consumer Finances*, University of Michigan, Survey Research Center

9. Only 4 percent of aged homeowners owed mortgages of $5,000 or more, but 43 percent of younger homeowners owed $5,000 or more (fig. 3).

10. Among the aged, 74 percent had no personal debt and 86 percent had no installment debt. In contrast, among younger units, only 34 percent had no personal debts and 48 percent no installment debts (fig. 4).

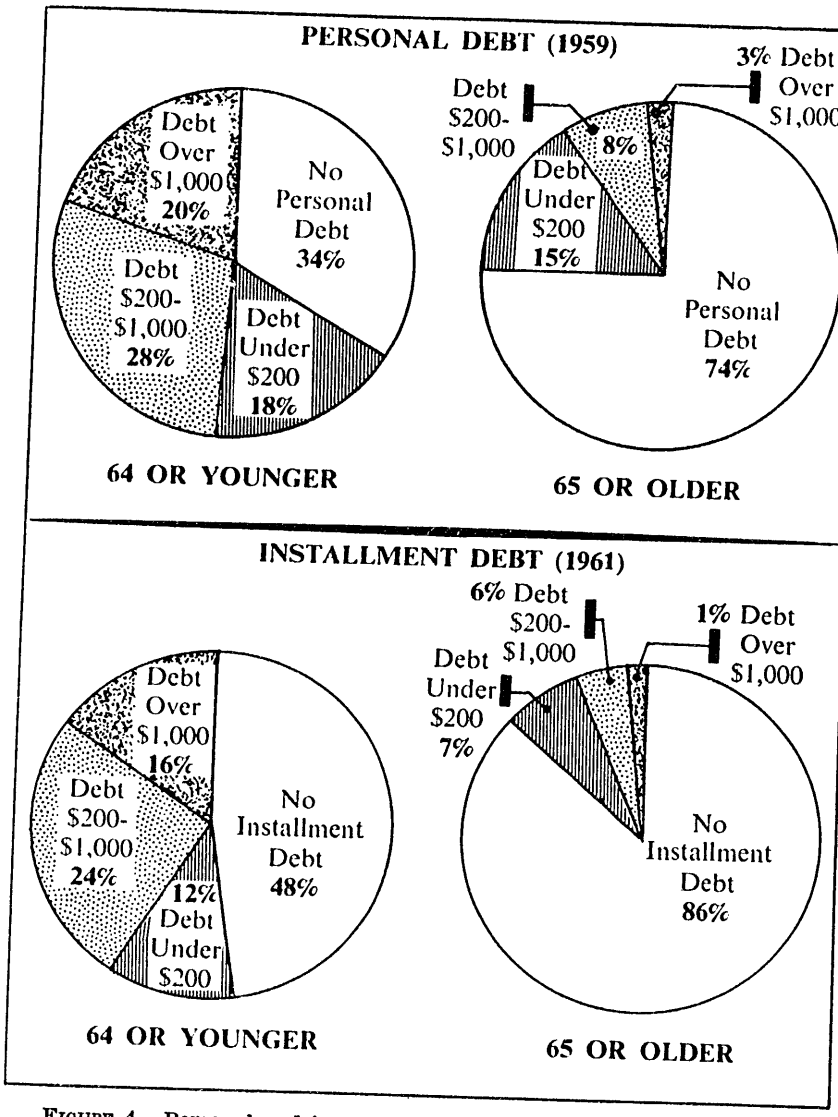


FIGURE 4.—Personal and installment debt of older and younger people.

SOURCE:

1959 and 1961 *Surveys of Consumer Finances*, Survey Research Center, University of Michigan, data refer to age of head of household

11. Only 11 percent of the aged owed more than $200 of personal debt and only 7 percent owed more than $200 of installment bills. But 48 percent of the younger units had more than $200 of personal debt and 40 percent owed more than $200 of installment debts (fig. 4).

12. Fifty-seven percent of the aged had savings of more than $500, compared with 45 percent of the younger groups. And among the aged, 68 percent held their savings or added more during the survey year.[26]

13. In the 2 years, 1959–61, the median income of spending units with a head who had retired increased 10 percent, while median income of semiskilled labor declined by 6 percent, skilled labor by 1 percent, unskilled labor by 2 percent, and clerical and sales personnel by 2 precent.[27]

No medical debt

The Michigan University surveys also found that 96 percent of the aged did not owe anything to a doctor, dentist, or hospital, further refutation of the often-repeated myth that the majority of the aged have no way of paying for medical or hospital care (table 7).

TABLE 7.—*Medical debts of younger and older spending units*

Medical debt status	All incomes	
	64 or less	65 or over
	Percent	*Percent*
Had no debt	90	96
Had debt of—		
Less than $100	4	2
$100 to $499	5	1
$500 or over	1	1
Not ascertained		
With debt	10	4
Total	100	100

Source: Survey Research Center, University of Michigan, "1961 Survey of Consumer Finances," p. 67, table 4-2.

Other facts are worthy of this committee's attention.

It is well established that the higher the education, the higher the income. In the future, education will be an increasingly important factor in the rising financial expectations of the elderly.

The median years of schooling for male wage earners over 65 was 8.3 in 1961. The median income of those with an elementary grade education was $1,621, according to the Census Bureau. Those with high school training had a median income of $2,382 and those with college training $3,509. In 1961, the median schooling of those between ages 45 and 54 was 11.1 years and for those 35 to 44 it was 12.2 years.[28] Consequently, in the next 20 years, school training will increase between 3 and 4 years at the median for those reaching 65. All other things being equal, this should contribute to a 50-percent increase in the income of the aged.

Further evidence that incomes of the aged continue to increase faster than the rest of the population can be found in a report issued by HEW from Census Bureau statistics which stated that in 1961, median income of families headed by a person 65 and over rose 4.5 percent. Median income of all families in the Nation in 1961 increased only 2.1 percent.[29]

Fewer of the aged today must rely on the old-age assistance program for their basic necessities. In the past dozen years, although the aged have increased in numbers the percentage on OAA rolls has declined from more than 23 percent to slightly more than 12 percent. Economists predict that by 1970 only about 8 percent will still be on OAA.

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[26] "1960 Survey of Consumer Finances," Survey Research Center, University of Michigan, (Study No. 678, "Patterns of Family Change," table 7633).

[27] "1962 Survey of Consumer Finances," Survey Research Center, University of Michigan, p. 14.

[28] "Current Population Reports: Consumer Income," U.S. Department of Commerce, Bureau of Census, series P–60, No. 39, Feb. 28, 1963.

[29] "Income of Aged Improved in 1961," based on advance release of Census Bureau statistics and published in October 1962, Health, Education, and Welfare.

Aged pay bills

Administration spokesmen imply that the average person over 65 has insufficient income to be able to pay the increasingly high cost of hospitalization, although they can't seem to agree what average cost to the individual elderly patient is. Last year, the President's Council on Aging said the cost was about $525 to those who are hospitalized. But figures as high as $700 and $900 have been cited on different occasions by others supporting this type of legislation.

The question, of course, arises: How do the aged compare with younger persons in paying their hospital bills? A number of independent surveys have been conducted. These include:

Iowa: A 1960 survey by the Iowa Commission for Senior Citizens reported that half the aged said they could afford a $1,000 emergency hospital, doctor, or general medical bill.

Delaware: A study in Wilmington among the aged showed that 66 percent of those interviewed said they could meet hospital or other medical expenses through insurance, and a survey of hosiptals in Delaware disclosed the 86.2 percent of the aged paid their charges in full.

Indiana: A survey by the Commission on Aging of the Indiana State Medical Association showed that 98 percent of the aged were able to pay or make arrangements for payment of hospital bills.

Missouri: A study of Greene County hosiptals reported in the May 1962, issue of New Medical Material magazine, revealed that patients over 65 were responsible for only 9 percent of unpaid doctor bills, and that of 857 elderly patients treated in a 100-bed hospital over a period of 11 months, only 15 failed to pay.

Montana: At Deaconess Hospital, Billings, 95 percent of the bills of aged patients were paid within 6 months.

Ohio: Among 2, 596 over-65 patients in 60 hospitals in the State, 83 percent had health insurance or other resources to pay their bills.

Oklahoma: 61 percent of 1,300 elderly patients in 44 Oklahoma hospitals had health insurance or other private means to pay the costs; the other 39 percent were receiving help through Kerr-Mills.

Texas: In 480 hospitals, 71 percent of 5,701 aged patients had health insurance coverage.

West Virginia: At Staats Hospital in Charleston, only 1.5 percent of 296 aged treated during a 1-year survey period failed to pay their bills.

Arizona: A study of 1,960 patients over 65 at Tucson Medical Center showed that less than 1 percent of their bills were unpaid.

Vermont: More than 80 percent of the aged in a 1961 survey by the Vermont State Medical Society's committee on aging reported they could pay medical bills with insurance, current income or savings.

St. Louis, Cleveland, Buffalo: Studies by the Conference of Catholic Charities in three lower middle income parishes in these three cities showed that between 80 and 90 percent of the aged had hospital insurance, savings or potential help from children in case of illness.

Arkansas: A study of 720 patients over 65 admitted to Warner Brown Hospital in Union County during 1960 showed that only 6.6 percent had not paid their bill in full by May 1961, and that less than 1 percent had paid nothing on their bill. Seventy-one percent paid their bills from private sources, including insurance, and almost 29 percent from government programs. The average bill was $212, and of the 720 patients, only 25 (about 3.5 percent) had a bill of $700 or more. Of these, only two were not paid in full by May 1961.

Pennsylvania: Seven Allegheny County hospitals reported admission of 15,846 patients over 65 during 1962. More than 97½ percent paid their bills, about 77 percent from private sources, including insurance, and approximately 21 percent were beneficiaries of the Kerr-Mills program. Only 2.4 percent of the bills were unpaid at the time of the survey.

We sumbit, Mr. Chairman, that the available evidence gathered from many sources refutes in every particular the financial argument on which proponents of this measure have built their case. Americans do not become ill and destitute at the instant they become 65 years of age. Yet, this, in effect, is the claim of those who insist that social security hospitalization is the only answer to the health care problems of all the aged, treated as a single impecunious mass of citizens.

SECTION III. KERR-MILLS

The medical profession is delighted to have this opportunity to reaffirm it. faith in the Kerr-Mills law as an instrument for taking care of the medical need: of those aged who can provide for their daily necessities but who cannot with stand an unusual medical expense without undue financial hardship. Since it. adoption by the 86th Congress, this law has compiled an astonishing record o progress and achievement.

And this record has been made despite attempts by some supporters of fed eralized hospital care for the aged to downgrade the Kerr-Mills law in the eyes of the public. The Kerr-Mills program has never been liked and probably never will be by those who want the Federal Government to assume complete charge of all medical care.

In view of the effort sometimes exerted to undermine the law and discourag its acceptance by the States, it might be supposed that the measure would prove a dismal failure. But the contrary is true, and some of the voices that have been the loudest in their criticism in the past are now acknowledging that th law should be kept on the books and strengthened. We submit that this constitutes a conspicuous tribute to the law's proven effectiveness in the brief time it has been in existence.

AMA support

The American Medical Association, along with State and county medical socities, has supported the Kerr-Mills program from the outset, testifying for it when the legislation was being considered by Congress and working for its implementation by the States following its enactment in 1960 into a law with two purposes:

1. Improvement of existing State health care programs for the needy elderly on public assistance, and establishment of such programs in States that did not have them then, the medical part of the old-age assistance program (OAA); and
2. Establishment of new health programs for the near-needy aged who are not on public assistance and are ordinarily self-supporting but who cannot meet the costs of a serious or prolonged illness—medical assistance for the aged (MAA).

If one considers the wide scope of this law, its implementation in the 4 years since it was enacted is truly remarkable. And the progress in its implementation has at times been made in the face of concerted opposition at the National and State level. Critics proclaimed it a failure before most State legislatures even had an opportunity to act on it. Opponents emphasized the usual initial weaknesses inherent in a new program and ignored its successes. State legislators were told that if they would wait, Washington would take care of the matter by getting through Congress a social security medicare bill.

Implementation progress

Despite such formidable opposition 43 States and four other jurisdictions have put Kerr-Mills MAA programs in operation or enacted authorization legislation. In operation are programs in Alabama, Arkansas, California, Colorado, Connecticut, Florida, Hawaii, Idaho, Illinois, Iowa, Kansas, Kentucky, Louisiana, Maine, Maryland, Massachusetts, Michigan, Minnesota Nebraska New Hampshire, New Jersey, New York, North Carolina, North Dakota, Oklahoma, Oregon, Pennsylvania, South Carolina, South Dakota, Tennessee, Utah, Vermant, Virginia, Washington, West Virginia, Wisconsin, Wyoming, Guam, Puerto Rico, the Virgin Islands, and the District of Columbia.

Mississippi enacted a program in June, to take effect this year; Delaware enacted one in July, which is expected to be in operation by November. Indiana and Rhode Island have enacted programs, to begin next January. Texas has a referendum scheduled for November, to make amendments to the State constitution necessary to put MAA into effect. MAA has been authorized and is awaiting funding in Georgia and New Mexico. And, at last report, Alaska had enabling legislation under consideration in the State legislature.

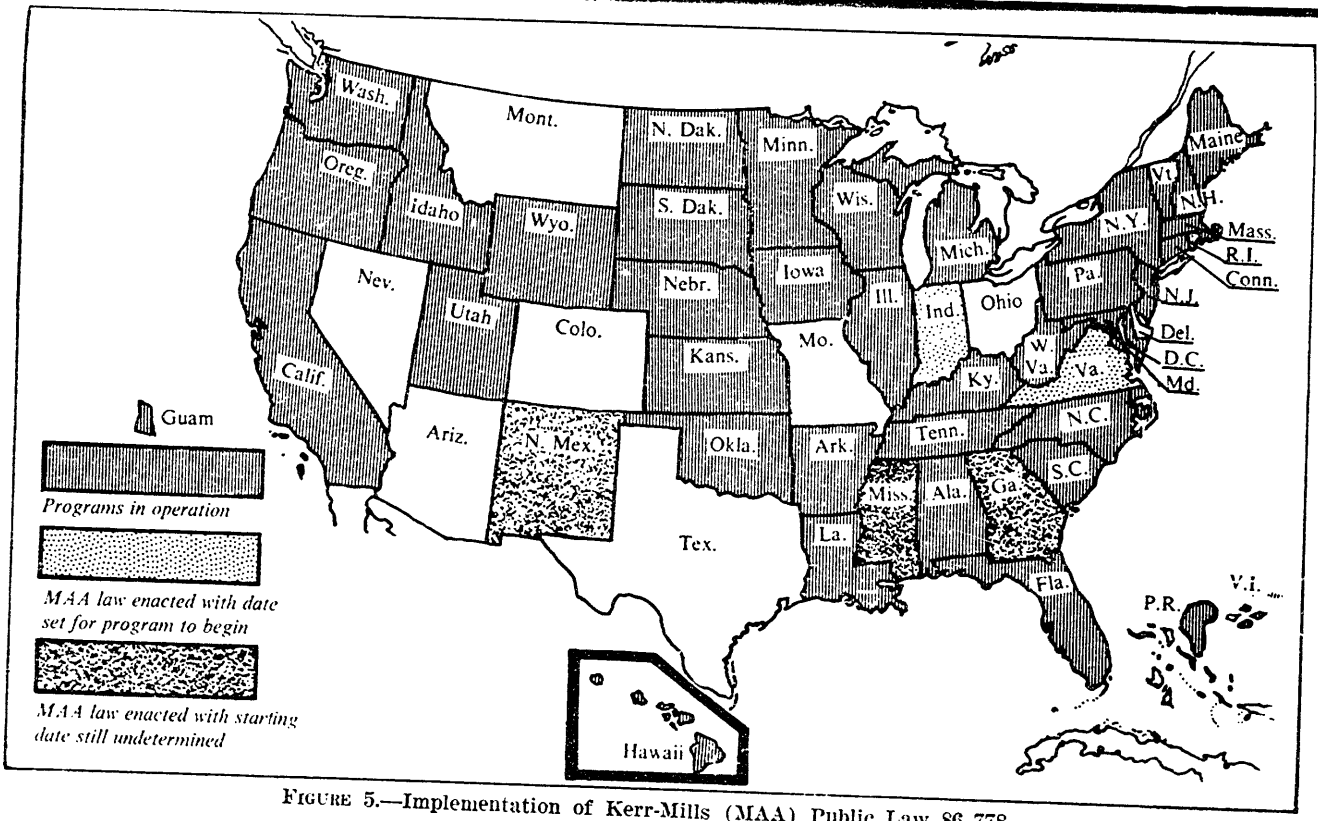

FIGURE 5.—Implementation of Kerr-Mills (MAA) Public Law 86-778.

OAA programs

All 50 States and the 4 jurisdictions now have in effect OAA vendor payme medical programs.

Nine States, Guam and Puerto Rico have initiated OAA vendor payme medical programs since enactment of Kerr-Mills. These States are Alabam Alaska, Arizona, Delaware, Georgia, Kentucky, Mississippi, South Dakota, a Texas.

Twenty-nine States, the District of Columbia and the Virgin Islands ha utilized Kerr-Mills to increase coverage and benefits under OAA medical pr grams they already were operating. They are Arkansas, California, Connectic Florida, Hawaii, Idaho, Indiana, Iowa, Louisiana, Maine, Maryland, Michiga Missouri, Nebraska, Nevada, New Jersey, New Mexico, North Carolina, Ohi Oklahoma, Pennsylvania, South Carolina, Tennessee, Utah, Vermont, Virgini Washington, West Virginia, and Wisconsin.

Twelve States have made no changes in their medical programs for persons old-age assistance rolls following enactment of the Kerr-Mills law, many of the having had sufficiently broad programs that changes were not considered nece sary. In addition, 11 of these States have enacted MAA programs.

In view of this record of implementation, no fairminded person could say th the Kerr-Mills program has been a failure. This is a record of great progres

Number helped

Thousands of needy and near-needy older persons across the Nation are recei ing medical, hospital, and nursing home care every day under Kerr-Mill programs.

With the oldest MAA programs in effect only 2 years, 1 out of 50 aged person in the United States had received MAA help by September 1962.[30] And the num ber of aged helped by MAA has increased steadily. According to figures of th Department of Health, Education, and Welfare, 172,736 older persons receive MAA benefits costing $34.7 million, an average of $201 an individual, in Marc 1964.[31] This represented increases of some 70,000 MAA beneficiaries and $11. million in benefit costs in comparison with May 1962.[32]

In the first 2 years of the program, almost 350,000 cases had been approved fo MAA. Later cumulative totals have not been released, but monthly caseload have increased consistently; by March 1964, they were over 1½ times the loa in September 1962. By September 1962, roughly $323 million had been spen to aid MAA recipients; from October 1962 to March 1964, the next 18 months about $497 million was spent.[33]

From these figures, there appears every indication that twice as many of th aged will be helped during MAA's second 2 years and that, by the end of Septem ber, over 1 million of the Nation's aged will have received help through MA since its inception.

In March 1964, nearly 2.2 million aged persons, one out of every eight, were eligible for medical care benefits provided through State old-age assistance programs (Kerr-Mills OAA).[34] Almost $38 million a month is being spent to purchase medical services for those OAA recipients in need of such care.[35]

Benefits provided

During the fiscal year ended June 30, 1962, according to the Department of Health, Education, and Welfare, $350.7 million in OAA funds and $194.8 million in MAA funds—over half a billion dollars—were spent in vendor payments for health care.[36]

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[30] Table: "Medical assistance for the aged—Number of cases approved and number transferred from other programs, from inception of MAA program through September 1962, by State." Supplied by Division of Medical Care Standards, Bureau of Family Services, Welfare Administration, Health, Education, and Welfare, per Feb. 28, 1963, letter from Thomas B. McKneely, M.D., Chief, to Mr. James H. Fleming.

[31] Welfare in Review, June 1964, Health, Education, and Welfare, Welfare Administration.

[32] Social Security Bulletin, August 1963.

[33] AMA computation from monthly totals of expenditures in Social Security Bulletins, 1963–64, and from Welfare in Review, June 1964. Data for first 2 years, table, footnote 30.

[34] Welfare in Review, June 1964, Health, Education, and Welfare; Welfare Administration.

[35] Welfare in Review, June 1964, Health, Education, and Welfare; Welfare Administration.

[36] "Public Assistance: Vendor Payments for Medical Care by Type of Service, Fiscal Year Ended June 30, 1962." Bureau of Family Services, Division of Program Statistics and Analysis, Jan. 31, 1963.

About $210 million went for inpatient hospital care, $207 million for nursing home care, $49 million for physicians' services, $47 million for prescribed drugs, $6.3 million for dental care, $17 million for other services, and some $4 million was not identified as to type of service.[37]

The predominant services in both programs were hospital and nursing home care—34 percent and 33 percent, respectively, of OAA funds, and 48 percent and 47 percent of MAA funds. Physicians' services and prescribed drugs accounted for approximately equal expenditures, about 12.5 percent each of OAA funds, about 2 percent of MAA funds. Dental care accounted for about 2 percent of OAA expenditures, 0.1 percent of MAA expeditures.[38]

American Medical Association's goal for MAA

Although much progress has been made in implementation of Kerr-Mills MAA, the job is not finished. As far as the American Medical Association is concerned, the ultimate goal is that all States have programs to provide comprehensive medical and hospital services to all aged persons who need financial help.

In 1960, the American Medical Association recommended detailed standards for MAA. Basically, these standards call for all near-needy aged persons receiving all medical services they require, regardless of ability to pay. These recommendations stated:

"Medical assistance for the aged [should] not be limited to the group within some fixed income-and-resources level, but should be based on the individual applicant's medical needs and his ability to pay for care without compromising those resources essential to his retaining self-supporting status after completion of treatment.

"In medical assistance for the aged, any type of treatment or facility medically necessary to the individual's care [should] be included in the possible range of assistance, but that aid [should] be provided in meeting only the costs of those services which are beyond the individual's means rather than all treatment costs for each case" [39]

Kerr-Mills flexibility

The flexibility of Kerr-Mills permits individual States to improve their programs as experience shows changes to be desirable. A vast national program under social security would lack this flexibility.

AMA policy

With the purpose of adding to the flexibility and the effectiveness of the MAA program, the AMA Board of Trustees 18 months ago adopted a policy calling for the following changes in the Kerr-Mills law itself: [40]

1. Remove the requirement that both medical old age assistance (OAA) and medical assistance for the aged (MAA) programs be administered by the same agency;
2. Provide flexibility in the administration of the income limitations proposed under State law so that a person who experiences a major illness may qualify for benefits if the expense of that illness, in effect, reduces his money income below the maximum provided;
3. Include a provision in the law requiring State administering agencies to seek expert advice from physicians or medical advisory committees; and
4. Make "free choice" of hospital and doctor mandatory under State programs.

Improvements in early MAA programs

A survey made by this association a year ago indicated that, of the first 25 States implementing Kerr-Mills MAA, 17 had already instituted improvements. Fifteen had liberalized eligibility requirements and 16 had increased the benefits available. During the past 12 months, additional improvements have taken place. Some States have improved their programs more than once. In only one State, West Virginia, has there been any cutback.

Kentucky is a good example of a State that started with a modest Kerr-Mills MAA program and has improved it on the basis of experience. Prior to MAA, hospitalization was entirely a local responsibility in Kentucky and the State

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[37] Ibid.
[38] Ibid.
[39] "Supplemental Report of the Council on Medical Service on Public Assistance Medical Care," adopted by the house of delegates, Nov. 30, 1960.
[40] Board of Trustees, American Medical Association, adopted Feb. 2, 1963.

government was entering a new field. Kentucky's initial MAA program provide for only 3 days of hospitalization. It was increased to 6 days after a few month and then later to 10 days, with a "reauthorization" provision for still further hospitalization.

Nursing home care up to 120 days was added in Kentucky on January 1, 1963. On April 1, 1963, other benefits were improved and eligibility requirements were liberalized. The drug list expanded. Physicians' home and office visits were broadened from therapeutic only to include diagnostic, preventive, and rehabilitative services. The annual ceiling on dental payments was removed. The annual income ceilings for eligibility were raised from $1,200 to $1,600 for a single person and from $1,800 to $2,400 for a married couple.

Since initiating an MAA program, Tennessee has raised its income ceiling for eligibility, has increased hospitalization from 10 to 20 days, has added up to 90 days of nursing home care and expanded the list of authorized drugs. New Hampshire has increased physician's visits (home or office) from 6 to 18 a year, added hospital visits by physicians, increased hospitalization from 7 to 12 days with a provision for extension, and added drugs.

In a July 8, 1963, editorial, "Oregon's Kerr-Mills Experiment," the (Portland) Oregon Journal commented on improvements in that State's MAA program after 2 years of experience:

[From the Oregon Journal]

"OREGON'S KERR-MILLS EXPERIMENT

"Oregon's 2-year experiment with the Kerr-Mills medicare law has produced two results: It has provided care for about 5,000 financial distressed elderly sick individuals, and it also proved that there had been a great overcalculation of the number of persons in Oregon unable to pay all or part of their medical care. When the legislators 2 years ago voted to go in partnership with the Federal Government in the Kerr-Mills law, it was estimated 55,000 might qualify.

"The middle grounders in the bitter debate over what type of Federal medicare program should be enacted have grounds for satisfaction—5,000 Oregon men and women in straitened circumstances have been substantially helped. Those who scoffed that any need existed have been proved wrong. Those who demanded an all-or-nothing approach have been largely silenced.

"Based on the successful Kerr-Mills experiment, a new giant step has just been taken at Salem. Governor Hatfield's experienced committee, which drew up the 1961 regulations, proposed that the 1963 legislators liberalize the rules, since there are obviously fewer to share the benefits than forecast. This was done by the legislature and now the State welfare commission has announced the larger and longer payments. Also, property qualifications have been significantly lowered. More persons will be benefited. But the spigot has been opened in a fiscally sound manner.

"Meantime, Congress seems to be getting nowhere with the King-Anderson bill, the so-called administration measure. How wise it was for Oregon to experiment, along with many other States, with the moderate Kerr-Mills law. It is obvious that, when the final Federal medicare statute is written, there will be much solid evidence obtained from experiments in Oregon and sister States on which to base proper legislation. Billions, too, will be saved in taxes and expenditures.

"After all, medicare is not a political question as some would have it. Medicare is a medical, a social, a moral problem which should be decided by nonpartisan lawmakers, based on the need and on the financial resources of the country. It must be remembered, too, that the first impact of costs will be on the backs of young and presently employed persons. The recipients will be the elderly, who never contributed to the fund. By progressive stages, fair alike to the young and paying group and to the old and nonpaying group, transition can be made to any type Federal medicare program that is wanted and can be financed."

Lack of administration leadership in MAA implementation

The progress in implementation of Kerr-Mill also must be viewed in the light of the absence of vigorous leadership by the administration which has been noted by various State officials and several members of Congress. Early in 1963, the Department of Health, Education, and Welfare published a 16-page report on its programs for older persons in 1962. The report brushed off the Kerr-Mills program with one short paragraph, prompting an editorial in the Washington Evening Star which said:

[From the Evening Star, Jan. 9, 1963]

"S-S-S-SH!

"If participation in the Kerr-Mills program of old age medical assistance had dropped last year, or even stood still, we can't help wondering what the Department of Health, Education, and Welfare would have had to say about that in its roundup progress report on Government help for the aged.

"As it turned out, the 16-page HEW report devoted a single brief paragraph to Kerr-Mills, concentrating almost entirely on the point that average payments declined under the program. It avoided entirely the facts that the actual number of Kerr-Mills benficiaries during the year ending last June more than doubled, from 46,247 to 101,634, and that monthly payments around the country in that period increased from $9,311,027 to $17,415,814.

"Why? Well, according to Miss Ruth Lauder, a spokesman for the HEW staff, the omission of any reference to gains in the program 'was not deliberate.' For one thing, she said, the report concentrated on 'newer' and 'more dramatic' programs—including, presumably, the President's bill for medical care for the aged through social security, which the report called the 'most important legislative proposal of 1962.' And anyways, Miss Lauder added, the Kerr-Mills program is really 'an income maintenance program,' which doesn't have anything to do with the health of old people, 'except indirectly.'

"This must be a surprise to those Members of Congress who passed the Kerr-Mills program, who think it has not been given a fair shake, and who believe it is at least a partial answer to the administration bill. One who is not surprised, however, is Representative Byrnes of Wisconsin, the ranking Republican member of the House Ways and Means Committee. Mr. Byrnes says the HEW has deliberately kept the program in a vocuum, that it 'has not only been dragging its feet on encouraging State participation in Kerr-Mills but has actually put stumbling blocks in the way of its success.'

"Whether that statement is accurate or not it is certainly true that the public at large has only the fuzziest idea about the Kerr-Mills program and how it is working. And from this viewpoint alone, the congressional investigation of the matter which Mr. Byrnes has advocated is clearly merited."

Kerr-Mills implementation undoubtedly would have been given greater impetus if HEW had taken positive leadership. Because this leadership has been lacking, it has fallen to the lot of AMA's constituent State societies to work with their legislatures for improvements experience has shown to be desirable.

Transfer to MAA

We have spoken already of the remarkable progress in implementing Kerr-Mills, of the 265,000 new MAA cases aided in its first 2 years,[41] and of OAA medical expenditures of $36 million a month.[42] This should be evidence enough that Kerr-Mills is bringing new help to the aging.

But, even as these developments were being recorded, some opponents of Kerr-Mills who should know better have claimed that little new aid is being given, that the States in implementing Kerr-Mills have merely shifted part of the cost of old programs to the Federal Treasury.

The facts refute such claims. In September 1960, the month before Kerr-Mills took effect, according to figures of the Department of Health, Education, and Welfare, the States made vendor payments through their old-age assistance programs of $25¼ million;[43] in May 1963, old-age assistance vendor payments were up $12 million—to $37¼ million—and medical assistance for the aged payments totaled nearly $29 million.[44] That is, vendor payments for medical care to the needy and medically indigent aged had increased, in 32 months, by $41 million per month.

In March 1964, old-age assistance vendor payments were $37.8 million and medical assistance for the aged payments totaled $34.7 million. In the 3½ years since Kerr-Mills began, medical vendor payments for the aged went from $25¼

[41] Table, "Medical Assistance for the Aged: Number of Cases Approved and Number Transferred From Other Programs, From Inception of MAA Program Through September 1962, by State," supplied by Division of Medical Care Standards, Bureau of Family Services, Welfare Administration, HEW, per Feb. 28, 1963, letter from Thomas B. McKneely, M.D., Chief, to Mr. James H. Fleming.
[42] "Social Security Bulletin," August 1963.
[43] "Social Security Bulletin," December 1960.
[44] "Social Security Bulletin," September 1963.

million per month to $72.5 million per month—an increase of almost 200 percent.[45]

In light of such figures, it is difficult to see how an Assistant Secretary of HEW could tell a House subcommittee that most of the States with Kerr-Mills programs "have been involved in no net increase in payments to either hospitals or to the individuals, for medical care." [46]

In June 1961, a staff report of the Special Committee on Aging of the Senate, "State Action To Implement Medical Programs for the Aged," made the statement that, while reports from the six States and two territories with MAA programs at the time were "somewhat inconclusive and tentative," they did show "one definite pattern: a heavy transfer of cases from OAA to MAA." The tabulation which accompanied this statement showed, for six States, Puerto Rico, and the Virgin Islands, only three with any transfers, including Washington State, which had transferred five OAA recipients. In Michigan, one-third of the approved applications were transfers, and only Massachusetts, at this early stage, had an MAA load comprising more than half OAA transfers.[47]

Transfer pattern not established

We feel it is pertinent to question the validity of a staff report that can find a definite pattern of heavy transfer in two jurisdictions out of eight. However, more important is the question: Has there actually been such a pattern in later MAA developments?

Although some States had a strong financial incentive in that they would get more Federal matching funds if they put nursing home patients on MAA, less than one-fourth of MAA patients have been transfers. In the first 2 years of MAA, according to HEW figures, 265,424 new cases were taken care of and 81,423 were transferred from other programs, primarily OAA. Twelve States transferred no OAA recipients, 5 transferred less than 100, 4 transferred between 100 and 508, and 7 transferred 1,000 or more.[48]

This record of transfers hardly constitutes a "pattern." A large majority of MAA cases are new ones. Indications are that the percentage of transfer cases will decrease as the State MAA programs continue because in the States where transferring was the heaviest it was an administrative action at the start of their programs.

For example, during the first month of the MAA program in New York, there were 16,438 transfers. The number dropped to 2,651 the second month, 1,049 the third month, and 593 the fourth month.[49]

One possible indication of the validity of this criticism is the lack of any cumulative figures on transfers later than September 1962. It is our belief that such figures, if released, would show today a far smaller proportion of total MAA recipients are transferred from other programs.

Largest States—Largest allotments

Another criticism of the Kerr-Mills MAA program has been that three, four, or five States have been getting too large a share of the Federal aid under it. HEW Assistant Secretary Wilbur J. Cohen has charged that four States—California, Massachusetts, Michigan, and New York—"receive about 88 percent of the money spent" under MAA programs.[50]

Our first comment on this statement is that this is an outdated percentage, becoming more outdated monthly. But it is not surprising that a few large States have been getting a large part of Federal MAA matching funds.

From the start of the program until June 1961—9 months—Massachusetts, Michigan, and New York were by far the largest States involved. The three States had comprehensive medical programs in effect for the needy aged. They

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[45] "Welfare in Review," June 1964.

[46] HEW Assistant Secretary Wilbur J. Cohen, at House Appropriations Subcommittee hearings, Feb. 18, 1963.

[47] Staff report to the Special Committee on Aging, U.S. Senate, 87th Cong., 1st sess., "State Action To Implement Medical Programs for the Aged," June 8, 1961, p. 45.

[48] Table, "Medical Assistance for the Aged: Number of Cases Approved and Number Transferred From Other Programs, From Inception of MAA Program Through September 1962, by State." Supplied by Division of Medical Care Standards, Bureau of Family Services, Welfare Administration, HEW, per Feb. 28, 1963, letter from Thomas B. McKneely, M.D., Chief, to Mr. James H. Fleming.

[49] Table 3, "Medical Assistance for the Aged: Applications, Cases Opened and Closed, Persons Aided, and Costs, by Month, New York State, April–December 1961," from Research Brief No. 1, 1963, title, "Medical Assistance for the Aged in New York State, April 1961 to December 1962." Bureau of Research and Statistics, New York State Department of Social Welfare, Mar. 9, 1963.

[50] House Appropriations Subcommittee hearing, Feb. 18, 1963.

already had the experience, the staff, and the caseload to operate large-scale medical programs. It was not the least surprising that, in the early stages of MAA, about 90 percent of the expended funds were expended in these three States.

Beginning with June 1961, the percentage in the three States began declining, but, in December 1961, California began its program for long-term care which is a high-cost-per-case program. Then it became four States instead of three States that were using the major share of MAA Federal funds.

In May 1963, the President's Council on Aging added Pennsylvania and had five States accounting for 88 percent of total MAA expenditures in the calendar year 1962.[51]

But other States have implemented MAA since then. States with no previous experience with vendor payments have gained experience. The aging in other States have learned of the existence of the program. Consequently, the percentage of funds going to a few States has been less nearly every month.

However, it is true that the five States cited—California, Massachusetts, Michigan, New York, and Pennsylvania—will receive a considerable amount of MAA funds even after all the other States have good programs going. In fact, in March 1964, with 45 MAA programs in operation, these 5 States accounted for 76 percent of MAA expenditures.[52]

Why? Simply because they have large numbers of older people as residents, and hospital and medical costs are higher in these States. The association last year made a statistical study of these points, comparing the 5 States cited with the other 20 States which had MAA programs in effect by the end of 1962.

They contained about 5.9 million, or 57 percent of the 10.5 million over-65 residents in this 25-State sample.[53] The average hospital stay was longer in the 5 States than in the remaining 20 (8.1 days to 7.1 days, voluntary short-term general hospitals); the average per diem cost of hospital care was higher ($41.69 to $37.51).[54] In fact, if every over-65 person in the 25 MAA States as of the beginning of last year had a hospital stay of the average length and cost for his State, more than 62 percent of the cost would have been incurred in these five States.

These then are the major factors accounting for the high percentage of MAA funds in these five States: early implementation, organized medical programs before MAA, a large aged population, and higher costs.

The means test

The means test, which has been attacked unjustifiably as a weakness in the Kerr-Mills law, is a reasonable and usual method for determining that Government tax revenues go where they are needed. Other than Kerr-Mills, 10 Federal assistance programs require a specific means test.[55] If a test of need is a proper safeguard against waste in the expenditure of public funds in these instances, it is equally prudent in financing a health care program.

For private charities, including those administered through churches, a means test is an established procedure. Some labor unions deny strike benefits to their members unless need is shown. Is it more reasonable to protect private money or union funds from waste than it it public money?

Determination of the applicant's need for help is not in itself degrading or humiliating. The constantly increasing use of the Kerr-Mills program by Americans over 65 should demolish for all time the patently emotional argument of King-Anderson proponents that Kerr-Mills won't work because the elderly will not submit to a means test. Following is an editorial from the June 25, 1962,

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[51] "The Older American."

[52] "Welfare in Review," June 1964.

[53] Data on population calculated from State tally of persons over 65, Congressional Record, May 17, 1962, p. 1018.

[54] Data on hospital stay calculated from data in "Hospitals 1963 Guide Issue" for voluntary short-term general hospitals in 1962. Stay is based on average daily hospital census, times 365, divided by hospital admissions, for 5-State and 20-State groups. Per diem cost calculated on the basis of total expenses reported for 5-State and 20-State groups, divided by total patient-days reported for each group.

[55] Old-age assistance; aid and service to needy families with dependent children; aid to the blind; aid to the permanently and totally disabled; aid to the aged, blind, or disabled, and medical assistance for the aged; low-rent public housing, rural housing loans; school lunch program; veterans' pensions; veterans' hospital, domiciliary, and medical care programs.

Christian Science Monitor which we cite as putting the means test in a true perspective:

"WHAT'S SO BAD ABOUT IT?

"Naturally, for its purpose, the staff report of the Senate Committee on Aging makes as bad a showing as it can for the operation of the Kerr-Mills Act, adopted by Congress in 1960 to assist States in providing medical care for the elderly.

"The main function of the committee and its staff since its inception has been to provide arguments in favor of the Forand bill and now the King-Anderson bill for hospital care through the social security system.

"The chief indictment hurled is that, in each of the 24 States thus far cooperating, the State giving Kerr-Mills aid requires the applicant to undergo a means test, an investigation of income and assets, before receiving assistance.

"What is so wrong about this? The social security system applies means tests. Up to $4,800 a year, it collects its payroll tax according to what an employee earns and what an employer pays. If a beneficiary under 72 earns more than $1,800 a year he forfeits his payments.

"Labor unions employ a kind of means test when they argue that because a certain company makes large profits it can pay a higher wage. Would they want a wage level established at which every firm in an industry could be assured a profit, with no questions asked about its management?

"The proponents of hospital care on social security are asking the United States to set up a large and expensive bureaucratic system to assure benefits to every covered person, indigent or affluent, 'as a matter of right.' This could prove to be a luxury purchased at the cost of many sacrifices made as a result of the payroll deductions.

"Particular exception is taken in the committee staff report to the fact that nine States 'have recovery programs extending to the homes of people receiving help and collectible after death.' Also, to the fact that 12 States apply family responsibility provisions under which children, if able to do so, are expected to contribute to their parents' support.

"Actually the relief lien is one of the most practical plans under which people in need but who own their homes can be given assistance while in possession and enjoyment of their homes. They can feel that to this extent they have provided by their own thrift for this need.

"And is any injustice done by enforcing the lien after the recipients of the aid are gone? If they have no immediate heirs, no one is deprived. If children or other near relatives have been spared a serious expense, should the State pass along intact an inheritance to them while it waives its own claim?

"These practices are not nearly so black as they have been painted. They are methods which may be ill-administered on occasion; but so may a more massive 'insurance' program. They are processes which have the imprint of commonsense and by which American society has done extremely well for those who depend upon it.

"Has that society come so far from concepts of individual and family responsibility that it prefers to rely on a supposedly impersonal, but potentially political, Federal mechanism to do on an indiscriminate scale what State and local agencies can do with more precision and flexibility?"

Helping the most needy

Which is the better method to spend money available for financing health care for the aged—whatever the amount: to give a limited amount of aid to all those 65 years and older, or to give as much help as the available money will provide to those who need help? This is a self-answering question. We do not need to go into details as to which is the more efficient method—the method best suited to really help.

Yet the "means test" has been used as a bad term by Kerr-Mills opponents and King-Anderson supporters. They have claimed that MAA "pauperizes" the applicant.

This is nonsense. Of 37 State programs in effect today, eligibility data for 36 show 20 set a "ceiling" on income, with those having income above this level ineligible. The remaining 16 either exempt a set amount of income as necessary for ordinary living expenses or set an income "ceiling" for eligibility; those with incomes above these levels become eligible when their "excess" income has been applied to medical expenses.

The most common income ceiling for a single individual is $1,500 with only five programs below this level, and eight ranging above it. In the more flexible

programs, the dividing line most commonly falls at $1,800, with only three falling below the $1,500 level.

Income is not all the individual can retain. In all States, the recipient can retain his home, and only seven set any limit on its value. Varying with the State, he also can retain certain amounts of life insurance, personal property, savings, and even an automobile. And the State is prohibited by Federal law from collecting any of the vendor payments from the individual or his spouse during their lifetimes. These certainly are not "pauperizing" standards. However, the American Medical Association still favors liberalization of the means standards. Since 1960, we are on record as opposing any flat ceiling on income as a condition of eligibility, and one of the four Kerr-Mills amendments we have proposed calls for a more flexible financial eligibility standard.[56]

Even without the stimulus of an amendment to the Kerr-Mills law, some States already have liberalized their eligibility standards and others are considering such action. For example, Pennsylvania has increased the annual income ceiling for an individual from $1,500 to $2,400 and from $2,400 to $3,840 for a married couple. New Hampshire increased the eligibility income ceiling from $1,200 to $1,800 for an individual and from $1,800 to $3,000 for a couple. In Oklahoma, the increase was from $1,500 to $2,000 for a single person and from $2,000 to $3,000 for a couple.

We submit that such liberalization of eligibility requirements, based on experience, makes sense. MAA has set out to help the neediest first. When this group is found to be smaller than predicted, the States have expanded their programs to care for those less in need. We believe this pattern will continue.

Responsibility of relatives

We must consider the question of contributions by relatives, particularly children, to the care of the aged. Some attack Kerr-Mills on the ground that it "pauperizes" the children as well as the parents. In our opinion, the impact of "relative responsibility" has been exaggerated.

The American Medical Association believes that health care is, first, an individual responsibility, and then that of the family. We do not believe a person's sons and daughters should cede to Government their responsibilities to their parents. But we do believe that those unable to contribute to the support of their parents should not be forced to do so.

Administration of MAA

The American Medical Association has recommended the elimination of the "single State agency" provisions for OAA–MAA on the belief that in some instances the two programs could be administered more effectively by separate agencies.

We are aware that MAA was originally proposed as a separate title of the Social Security Act, and that among the reasons for its eventual inclusion in title I was the belief that the fact of OAA's being already in existence would facilitate the implementation of MAA. Both programs dealing with the same age group, it was believed that MAA would begin aiding the aged sooner this way than if it were established as a completely new program.

In some States, it worked out this way. A large number of people have already been helped who were not on assistance rolls prior to Kerr-Mills. The existing staffs in many welfare agencies have been able to start the program with a minimum of problems.

But a major problem has been the tendency of staffs, accustomed to dealing with OAA, to consider MAA merely an extension of that program. In some States, staffs have been reluctant to provide any different medical benefits for OAA and MAA recipients.

Yet the two classes of recipients are different. Old-age assistance recipients are long-term needy, dependent on the program for daily living expenses for months or years, while medical assistance for the aged recipients need help only in meeting certain emergency or high-cost medical expenses.

The AMA's policy calls for consolidation of all welfare medical programs, with the same benefits available for all assistance recipients. It calls for elimination of all arbitrary assistance categories based on age or physical disability, with assistance based on a reasonable estimate of need, both financial and medical. While the categories exist, however, we recognize a distinct

[56] P. 38, supra.

difference between the groups aided in OAA and MAA and in the type of aid given. Some welfare agencies recognize this difference; some do not. We believe that the individual States should have the prerogative of deciding whether their purely medical problems should be under a separate agency.

Mr. Chairman, and members of the committee, in summary let me again say that in our opinion Kerr-Mills has made a record of progress and achievement. It is a flexible mechanism, and based upon the experience gained, the financial and medical needs of our elderly citizens will continue to dictate changes and advancements in the States' programs.

SECTION IV. VOLUNTARY EFFORTS

The phenomenal growth of health insurance

The expansion of voluntary health insurance and prepayment protection in the United States, both in the number of persons covered and the extent of the coverage, has been one of the most extraordinary phenomena of this century. In recent years, this expansion has occurred at a faster rate in the over-65 segment of our population than in any other age group.

This voluntary health insurance "explosion" is a comparatively recent and uniquely American phenomenon. The predecessors of our present Blue Cross and Blue Shield programs date back only to the thirties; the programs of private insurance companies a little earlier. In 1940, 9 percent of the population of the United States had any form of health insurance:[57] 10 years later, in 1950, about 50 percent were covered.[58] More than 77 percent of the total civilian population had voluntary health insurance coverage.[59] Over 10 million are 65 years or older and comprise an estimated 60 percent of their age group.[60]

At the end of 1962, 141 million Americans had hospital expense protection; 131 million had surgical expense protection; and 98 million had protection against nonsurgical medical expenses.[61] At the end of 1963, the number with hospital expense protection had grown to 146 million.[62]

These figures have even greater significance when it is recalled that in 1942 only 19.7 million had protection for hospital expenses; only 8.1 million had protection against surgical expenses; and only 3.2 million had protection against regular medical expenses. By 1952, the number of those protected had increased to 91 million, 72.5 million and 35.7 million, respectively.[63]

As of the end of 1962, seven times as many persons were protected against hospital expense as were 20 years ago at the end of 1942; 16 times as many were protected against surgical expense; and 30 times as many against regular medical expenses.[64]

Seventy-seven Blue Cross plans, 70 Blue Shield plans, approximately 840 insurance companies, and nearly 800 independent-type health insurance plans comprise the approximately 1,800 private insuring organizations in the United States that now make voluntary health insurance protection available to the public.[65]

Health insurance benefit payments during 1963 were $7.8 billion[66]—$21.4 million a day—an increase of $700 million over the $7.1 billion paid out in 1962.[67] Insurance companies paid $4.2 billion of the 1963 benefits.[68] This figure was up from the nearly $3.8 billion paid out in 1962 and represented a more than 300-percent increase over the $1.1 billion in benefits paid by insurance companies in

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[57] Anderson and Feldman, "Family Medical Costs and Insurance: A Nationwide Survey" (New York: McGraw-Hill Book Co., Inc., 1956).

[58] Serbein: "Paying for Medical Care in the United States" (New York: Columbia University Press, 1953), table 137, p. 380.

[59] "The Extent of Voluntary Health Insurance Coverage in the United States as of Dec. 31, 1963," Health Insurance Council 18th annual survey.

[60] Statement of Gilbert W. Fitzhugh, president, Metropolitan Life Insurance Co., Chicago Executives' Club, Mar. 22, 1963.

[61] "The 17th Annual Survey of the Health Insurance Council" as reported in "New Gains Toward Meeting Health Care Costs—Voluntary Health Insurance in the United States as of Dec. 31, 1962."

[62] "The Extent of Voluntary Health Insurance Coverage in the United States as of Dec. 31, 1963," Health Insurance Council, 18th annual survey.

[63] "The Extent of Voluntary Health Insurance Coverage in the United States as of Dec. 31, 1962," Health Insurance Council, 17th annual survey.

[64] "Source Book of Health Insurance Data, 1962," Health Insurance Institute.

[65] "Source Book of Health Insurance Data, 1962," Health Insurance Institute.

[66] "The Extent of Voluntary Health Insurance Coverage in the United States as of Dec. 31, 1963," Health Insurance Council, 18th annual survey.

[67] "The Extent of Voluntary Health Insurance Coverage in the United States as of Dec. 31, 1963," Health Insurance Council, 18th annual survey.

[68] The Extent of Voluntary Health Insurance Coverage in the United States as of Dec. 31, 1963."

1952.[69] Blue Cross-Blue Shield and other hospital medical plans accounted for $3.6 billion of the 1963 benefits—also an increase of about 400 percent from a decade ago.[70]

Growth in health insurance coverage of older persons

One of the most rapidly growing phases of health insurance is the growth in the coverage of persons over age 65. Most of this growth has occurred in the past 10 years. A 1952 survey showed that 26 percent of all persons past 65 had some form of health insurance protection.[71] As of May 1962, 55 percent of all noninstitutionalized persons 65 or older had some form of health insurance.[72] It is estimated that the health insurance coverage in this group now has increased to 60 percent—more than 10.3 million older persons.[73]

The extent of such coverage is even more impressive when it is taken into account that an estimated 25 percent of noninstitutionalized older persons are not in the market for health insurance for various reasons. Some are receiving health care under Federal-State OAA or MAA programs. Again based on need, others are cared for by the Veterans' Administration, by general assistance, or by other public and private agencies. Some are retired members of the armed services and eligible for Defense Department medicare. Finally, there are the "self-insured"—those with private incomes and resources large enough to remove any worries about paying hospital and medical bills.

Factors in growth of health insurance coverage of older persons

There are several factors contributing to the acceleration in health insurance protection among persons over 65—factors indicating that coverage among the 65-plus age group will continue to grow at a rate faster than among the population as a whole.

Voluntary health insurance now is available to persons over 65 regardless of whether they are healthy or sick and without physical examination. Insurance companies are pooling their resources to reduce costs of policies for older persons. Many policies now are noncancellable because of age. Under "Paidup" policies now available, coverage continues but premium payments stop at a specified age. An increasing number of workers are being guaranteed the right to retain their group health insurance or convert it to individual policies after retirement.

Growth in over-65-first-time coverage

There has been a dramatic increase in the number of individual and "group" health insurance contracts being made available on first-time basis to persons over 65. Some 170 private companies were offering such protection as of January 1962.[74] This was a 57-percent increase since 1958 in the number of companies issuing such policies.[75] Many of these policies now are available in every State in the Union. They offer a wide range of benefits, including regular "group" hospital-surgical plans, weekly or daily benefit group plans, and catastrophic expense plans available on both individual and group basis. Thus the potential health insurance buyer is daily being presented with a greater and greater variety of plans and policies from which to select the protection that best meets his particular needs. This is an advantage which would automatically be lost in any regimented approach under a purely Federal program.

With an aim of further accelerating this trend toward first-time insurance after 65, the house of delegates of the American Medical Association, in December 1958, adopted a report urging that its constituent and component medical societies, as well as physicians throughout the Nation cooperate in expediting programs for the individuals over 65 with modest resources and low family income. Physicians were asked to agree to accept a level of compensation for medical services rendered to this group that would permit the development of

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[69] "The Extent of Voluntary Health Insurance Coverage in the United States as of Dec. 31, 1963."

[70] "The Extent of Voluntary Health Insurance Coverage in the United States as of Dec. 31, 1963."

[71] Falk and Brewster, "Hospitalization and Insurance Among Aged Persons," Bureau Report No. 18, Social Security Administration, April 1953.

[72] "Private Health Insurance Protection for the Aged," by Joseph F. Follman, Jr., director of information and research, Health Insurance Association of America. Paper was delivered before the medical care section of the American Public Health Association meeting, Oct. 18, 1962.

[73] Testimony of H. Lewis Rietz, representing the Health Insurance Association of America, etc., before the House Ways and Means Committee, Nov. 22, 1963.

[74] "Source Book of Health Insurance Data, 1962," Health Insurance Institute, p. 55.

[75] "Source Book of Health Insurance Data, 1962," Health Insurance Institute, p. 55.

such insurance and prepayment plans at a reduced rate. The affirmative respon was immediate and effective.

At the time the report was adopted there were only a few Blue Shield pla that were offering first-time, nongroup coverage to persons over 65. Today, 7 70[76] Blue Shield plans have made available nongroup, first-time enrollment persons over 65 and are working with Blue Cross plans to provide comprehensi coverage. The effectiveness of this concerted effort is illustrated by the fa that persons over 65 are joining Blue Shield at a rate four times faster than a other age groups combined.

This has been made possible through the cooperation and support of t medical profession. In the majority of instances, doctors are accepting reduce levels of compensation for treatment of older persons with low incomes.

Pool plans

The flexibility of modern programs in meeting the needs of older people illustrated, too, by the pioneering major medical expense programs, such as tho developed in Connecticut, New York, and Massachusetts, where private insuranc companies have pooled resources and risks to offer comprehensive coverag for a wide range of services to anyone over 65 in the State.

Under the Connecticut plan—the first to be undertaken—13 major insuranc companies in the State, by authority of special legislation, pooled their exper ence and underwriting capacities to form a voluntary, unincorporated associatio through which any Connecticut resident 65 or over can purchase basic an major hospital, medical, and surgical expense protection for himself and hi spouse. This plan, and the others like it, are designed to be self-supporting.

The "Connecticut 65" plan had its first open enrollment in September 1961 New York and Massachusetts became the next States to pass enabling legisla tion for such a statewide pooling arrangement. In October 1962, the New York 65 Health Insurance Association, representing 49 insurance companie doing business in the State, held its first enrollment period for a plan operatin much along the lines of the Connecticut program. The "Massachusetts 65" plan jointly offered by 41 companies in the State, also opened for enrollment in October 1962.

Additional pooled-risk plans are now in operation in North Carolina and Vir ginia (a regional pool plan), Texas, and California. Pending the enactment of enabling legislation, the California plan will be expanded to include the States of Arizona, Nevada, New Mexico, Oregon, and Washington in a "Western 65" regional plan.

Increase in health insurance retained after retirement

An increasing number and percentage of older persons are retaining their health insurance, either on an individual or group basis, after retirement.

Before the health insurance movement gathered momentum, most nongroup hospital insurance policies terminated at age 65. But today the trend among insurance carriers is to guarantee policyholders the right to continue their protection when they retire. In 1963, at least 90 policies or programs offered by major insurance companies were guaranteed renewable for life, either on a continued-pay or a paid-up-at-65 basis. Twenty of these plans provided extended benefits, after an initial deductible, for "catastrophic" illness or injury, up to limits of $15,000, or even higher in some coverage.

Another important factor in the increase in health insurance for older persons is the accelerating trend in labor-management contracts to continue coverage of workers after retirement. It is estimated that more than half the workers covered by company group plans now can stay under group coverage or convert it to an individual policy upon retirement. Such a provision is being written into more and more work contracts negotiated by labor unions and management. Eight out of every ten workers covered by such new group policies issued in 1962 could retain their coverage after retirement.[77]

It has long been an important provision in Blue Cross and Blue Shield contracts that subscribers may continue their coverage after leaving groups or after reaching age 65. As of June 1961, there were 3.25 million Blue Shield subscribers over 65, representing over 7 percent of total Blue Shield enrollment.[78]

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[76] In Maine, such coverage is provided through a Blue Shield subsidiary.

[77] "Data Sheet, Survey of Health Economics," Health Insurance Institute, June 26, 1963.

[78] "Meeting the Health Needs of the Aged," by Henry S. Blake, M.D., chairman of the board, National Association of Blue Shield Plans, as presented at the second National Conference of the Joint Council To Improve the Health Care of the Aged, Dec. 15–16, 1961.

There were 5 million Blue Cross subscribers over 65.[79] More recent estimates indicate that the number of Blue Shield subscribers over 65 is now more than 4 million, and that the number of older persons with Blue Cross coverage has grown to 5.3 million—increases of 23 percent and 8 percent, respectively. During the period 1951–61, while total Blue Shield enrollment was increasing by 128 percent, the number of persons over 65 covered by Blue Shield increased by 225 percent.[80]

Improvement in quality of health insurance

The continuing growth in voluntary health insurance for all age groups has been one of quality as well as quantity—a growth not only in numbers covered, but in the scope and variety of programs and plans available.

Statistics indicate that 93 percent of older persons with hospital coverage also have surgical protection, and 50 percent have medical protection.[81]

The U.S. National Health Survey for the years 1958–60 shows that, in cases where health insurance was utilized, more than 60 percent of all persons 65 and over had more than three-fourths of their total hospital bills paid for by insurance. And over 80 percent had more than half their bills paid.[82] Those over 65 who are hospitalized longer than 30 days are supposedly "the catastrophic" group for whom health insurance protection runs out. Yet, even in this group the same high proportion, 8 out of 10, had more than half their hospital bill paid by insurance. It is reasonable to assume that these percentages are even higher today.

Growth of "major medical" plans

Major hospital and medical expense protection has been one of the fastest growing of all types of coverage. These plans provide payment, above a deductible amount, for 75 to 80 percent of virtually all categories of health care expenses incurred as a result of catastrophic illness, up to limits of $5,000, $10,000, $15,000, or even $30,000. Over an 8-year period the number of persons protected under this type of plan increased from 2 million[83] to more than 38 million at the end of 1962—an 1,800-percent increase. A wide variety of such plans are now available.[84]

Progress continues to be made, too, in expanding basic health insurance protection to cover nursing home and other out-of-hospital services. As of September 1963, 78 insurance companies were making available specific coverage for nursing home care, either on a direct individual or group basis, or in conjunction with the other insurance companies participating in the special "65-plus" insurance pooling plans offered to older persons in Connecticut, Massachusetts, or New York. At least 50 of these programs provided coverage on a group basis; and 7 made it available on both a group and individual basis. The programs cover a range of 30 to 200 days of care per illness or per calendar year, and provide benefits of from $5 to $25 per day of care. Nearly all of these programs have come into being since 1959.[85]

As more administrative and cost experience becomes available on home care programs, a further expansion can be expected in such health insurance protection patterned after the successful Blue Cross demonstrations in Detroit and Rochester, N.Y., in providing home care in lieu of hospitalization.

Thus, potential health insurance buyers, particularly those 65 years and older, are daily being presented with a greater and greater variety of plans and policies from which to select the protection that best meets their particular needs.

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[79] "Financing Health Care of the Aged," Blue Cross Association, pt. 1, p. 127.

[80] Computed by AMA staff using three sources: "Meeting the Health Needs of the Aged," Henry S. Blake, M.D., chairman of the board, National Association of Blue Shield Plans, as presented at the second National Conference of the Joint Council To Improve the Health Care of the Aged, Chicago, Dec. 15–16, 1961, p. 68; Statistical Research Bulletin No. SR–62–10, National Association of Blue Shield Plans, Mar. 30, 1962; and "Enrollment Reports, Blue Shield Plans," Dec. 31, 1951, National Association of Blue Shield Plans, table 4, p. 4.

[81] Percentage figures cited are based upon the assumption that the aged have the same coverage pattern as the population as a whole. Reference: "The Extent of Voluntary Health Insurance in the United States as of Dec. 31, 1961," Health Insurance Council, 16th annual survey.

[82] "Proportion of Hospital Bill Paid by Insurance," U.S. National Health Survey, Series B, No. 30.

[83] "Source Book of Health Insurance Data, 1962," Health Insurance Institute.

[84] "The Extent of Voluntary Health Insurance in the United States as of Dec. 31, 1962," Health Insurance Council, 17th annual survey.

[85] "Health Insurance and Nursing Home Care," Health Insurance Association of America, September 1963.

It is clear from the above data that those persons now over 65 who need but do not have health insurance comprise a group which is steadily shrinking. As insurance protection continues to expand among all age groups, as more persons reaching 65 continue their coverage, and as additional numbers now over 65 take advantage of the many individual and special "group" programs available, the number needing but not under such protection in the over-65 age group becomes smaller. It has been estimated that by 1970, 80 percent or more of those over 65 needing and wanting health insurance protection will have it.

Health insurance doing effective job

In discussing the extent to which voluntary health insurance covers total private expenditures for medical care, in whatever age group, it is important to clarify exactly what health insurance should do and what it should not do. Voluntary health insurance does not and should not provide benefits for all health expenditures. Some health expenditures are not of a type that should be insured.

The total private expenditure for health care in this country includes money spent for millions of bottles of aspirin, vitamins, cold "remedies," and various other nonprescription items purchased for self-medication. It also includes such nonmedical items and services as the use of television, radio, telephone, or luxury accommodations in hospitals. In fact, about $2 billion was spent in 1960 for such nonmedically dictated items by persons with health insurance coverage.[86]

Voluntary health insurance does not and should not cover such expenditures, which totaled $2 billion in 1960, any more than automobile insurance should cover oil changes, lubrication, battery replacement, gasoline, and tire repairs or any more than home insurance should cover maid service or the spring painting.

What health insurance should do, and is going effectively, is to provide for all age groups a cushion of protection against the large, individually unpredictable medical expenses.

Other voluntary efforts in behalf of the aging

Consideration of Federal health legislation cannot ignore the contributions being made on a wide and increasing scale by private citizens and groups, at the local level, toward solving the problems of our older citizens.

Voluntary efforts of Americans with a sense of social and community responsibility have long furnished assistance to those elderly persons who need help.

Most often these efforts have been channeled through programs and projects of religious, civic, fraternal, and philanthropic groups. It is inspiring to realize that there has been a great increase in the number and scope of these voluntary projects for the aging in the past few years.

In unselfish programs such as these, the private citizen—working in his immediate surroundings—has had a particularly praiseworthy role. His help is benevolent, yet realistic. He is close to the problem, whatever it may be—in housing, recreation, special services, or health care.

Such projects for the benefit of the elderly range from great geriatric centers to a small social club where older persons may enjoy hours which otherwise might be empty.

This growing tide of voluntary efforts by private citizens and groups should be encouraged, not dampened in any way.

The Federal Government has cooperated ably with State and local groups in some areas of assistance to the aged—housing and recreation, for example. This cooperation, however, must not be permitted to become dominant. If it does, the initiative and imagination for programs started and conducted at the community level will be discouraged.

Peril to voluntarism

Passage of social security hospitalization would endanger these voluntary efforts. It could smother the incentive and altruism which private citizens and groups have displayed in meeting particular problems in their own communities.

Voluntary projects for the aging have increased so greatly in number and scope in the past 2 years that their accomplishments should be outlined.

Housing for the elderly has received much attention, especially from church and civic groups. There are programs of recreation activities for older persons, nursing care in their homes, homemaker services, hot meals supplied in their

[86] "An Evaluation of the Present Extent of Voluntary Health Insurance," by Mr. David Robbins, assistant director of statistical research, Health Insurance Association of America, December 1962.

own homes for those unable to cook, and even the simple, humanitarian gesture of "friendly visitors" to break the loneliness for those up in years who are not able to get about as they used to.

Many new nursing homes have been built and existing ones expanded. Standards have been raised, and our older persons in nursing homes are receiving better care under safer conditions. There are rehabilitation programs, which are returning the disabled older people to productive and enjoyable lives. Geriatric studies and treatment centers are leading the way to healthful later years.

Church projects

The churches of our Nation have been most active in programs to help our elderly, and they have increased their efforts in the past few years.

The American Lutheran Church, for example, has built 32 new homes for the aging and added to 14 existing ones since 1961. The church presently has 100 homes caring for 7,000 older persons, and 33 more are planned or being constructed.

The Roman Catholic Church in the United States, through its Catholic Charities section, has 357 homes for the aging, with 31 new homes added since 1961. About 31,500 elderly persons are residents.

The Lutheran Church, Missouri Synod, announced just over a year ago that 10 Lutheran projects for 748 living units for senior citizens had been constructed since 1961. In addition, Federal mortgage insurance totaling more than $26 million had been approved or was in the process of being approved for 24 more housing projects identified as Lutheran which would provide 2,299 units for the elderly.

The Assemblies of God, with headquarters in Springfield, Mo., cares for more than 2,400 persons in homes for the aging or nursing homes. Eighteen of these have been established since 1960.

The Evangelical United Brethren Church, which cares for 784 persons in homes for the aging or nursing homes, has organized a department of health and welfare to carry out responsibilities in this field. The Unitarian Universalist Association, in addition, has formed a committee of professional persons active in the field of gerontology to investigate the denomination's responsibility in the care of the aging.

A Salvation Army nursing home for the aging at Flushing, N.Y. will care for 300 persons. The United Presbyterian Church in the United States of America maintains five homes of congregate living for older people.

There are only a few of the widespread programs in housing for the elderly which the national church organizations are conducting. Many local congregations or diocesan groups have projects or programs of their own. Housing for the elderly is only facet of the work of the churches in this field, of course. Their efforts in local programs of counseling, recreation, and many other activities are so numerous that an accounting would be hopelessly time consuming.

Specific programs

Your committee will undoubtedly hear from many other organizations about specific voluntary programs and projects. To point up what is happening and is being accomplished, we want to mention only a few of the thousands of such projects across the Nation where civic, religious, or other groups working at the local level have played a major part.

In our newest State, Hawaii, for example, the commission on aging was formed, even before the President's 1961 White House Conference on Aging, and has three programs underway—an independent living project which comes under the State rehabilitation group, a home care project, and a homemakers program.

In Iowa, a pioneer project in Earlham, a town of about 800, provides for "homemakers" to visit elderly persons needing care, cook meals if necessary, do washing and ironing, and go shopping for them. The project also includes nurses who make regular visits to check on the health of the elderly and "handymen" will mow lawns, do house repairs, and other odd jobs where needed.

Just outside of Louisville, there is the home for the elderly operated by the Kentucky Geriatrics Foundation. The foundation was formed with the encouragement of the State government and leases for $1 a year the former Waverly Hills Tuberculosis Hospital which was closed in 1961. There are rooms for 430 persons, healthy as well as sick. Nursing services are provided for those who need them.

In New Hampshire, a newly formed chronic illness and aging program is intended to correlate special programs for the aging with the activities of the private agencies.

In Michigan, the voluntary Michigan Health Council has played a major role in working under a 2-year grant from the McGregor fund. Programs are in operation in 10 communities with coordinated home care paid for by the patient, the family, official and voluntary agencies, major medical insurance policies and prepayment sources, such as Blue Cross.

More local efforts

In an urban setting, there is the Kundig Center, established by the Catholic Charities of Detroit, Mich., which completed a new addition called a terrace unit in April 1963. The Kundig Center was started 8 years ago to give attention to older persons who lived in a roominghouse situation in a congested area. Preparation of meals, recreation, counseling, and some medical services are provided and most persons walk to the church dining facilities for their meals.

The terrace unit provides room with bath accommodations for elderly persons with the average resident being 74 years old. Rooms are rented at a modest rent which includes room, board, and recreational activities. The unit is filled, of course, and there is a waiting list. The success of the Kundig Center terrace unit has led to plans for similar projects.

Pennsylvania's Citizens Council Commission on Aging is unique in that it is the only statewide group of a fully voluntary nature which formally accepted the responsibility for following up recommendations stemming from the White House Conference on Aging. The Pennsylvania Medical Society is a charter member. Mrs. Roy W. Engle, chairman, Commission on Aging, points out that committee members "were fully aware that governmental efforts alone could not possibly move forward the recommendations emanating from the White House Conference on the Aging. A partnership between public and voluntary efforts was needed."

With the help of a Ford Foundation study, the Commission is researching priority needs of older persons and how they are established.

In Philadelphia, additional facilities are being provided in a complex of buildings which serve older persons. The Philadelphia Home for the Jewish Aged is housed in a modern, four-story building built in 1950. Its gerontological research institute was founded in 1961 with facilities in the same building.

In 1960, York House was opened just north of the Home for the Jewish Aged. It is a private, nonsectarian 11-story residential apartment building with 220 units specifically designed with the needs of healthy men and women over 60 in mind. Harry A. Robinson, York House president, explained, "We had not expected to build a second York House. But the number of applications has been so overwhelming that we have decided to add more facilities." The nonprofit corporation decided a second apartment building just south of the present York House was the only answer to the demand.

In Texas, some 30 cities offer some type of home care service—teaching by demonstration, direct patient care, case work, nutrition, and homemaker service.

In the State of Washington, the King County Medical Society's "Over 65 Plan" has the purpose of aiding the older person who has a little too much income or savings to qualify for State welfare medical aid, but who feels that his doctor bills are a hardship. The society encourages these persons to apply to it. The individual requiring consideration is given a card which entitles him to a specific percentage reduction in the doctor's fee. A similar program also has been developed in St. Louis County, Mo.

The Richmond (Va.) Area Community Council cooperates with health, welfare, and recreation agencies on all government levels in its senior citizens information and referral service. Professional counselors are on duty to answer requests, primarily by phone, but often in person, from the elderly. Information is most frequently sought on health facilities, recreation, housing, finance, social security, old-age assistance, family situations, and employment opportunities.

Like many other communities, Lincoln, Nebr., has a recreation program for older persons sponsored by the city recreation department. More than 600 men and women, some in their nineties, belong to "Good Times Clubs" which meet weekly in churches, community centers, and even a fire station.

Many cities have "drop in" centers with recreational and handicraft activities for the elderly. Most are sponsored by United Fund, church, or civic groups. The extent of these craft projects, for example, is shown by the one in Raleigh, N.C. The Raleigh project has a $100,000 business in ceramics alone with the

work done mostly by the elderly under sponsorship of the city recreation department.

In Cincinnati, Ohio, two volunteer bureaus sponsor a program with a direct personal touch. The "Friendly Visitors"—300 of them ranging from stenographers to retired carpenters—have volunteered to be friends with lonely older persons. The older persons are at home, in nursing homes or hospitals, and the friendly visitors do such kind things as write letters, tend plants, take their friends shopping, or in some cases even to a Cincinnati Reds baseball game.

Damper on private initiative

Every one of our 50 States has some projects underway to help older people. Besides those voluntary efforts planned primarily for the elderly, there are many other programs of a voluntary nature, not designed specifically for older persons, from which the elderly benefit greatly.

Most encouraging is the fact that these noteworthy efforts by private citizens and groups are increasing at an accelerating pace. They should be fostered and encouraged.

We believe that passage of a new Federal program, conveying the impression that the parent government is assuming responsibility for older citizens, will tend to discourage many of these voluntary efforts to help these same citizens. It will diminish the motivation for charitable contributions. It will make private citizens less likely to give so generously of their talent and time. It will discourage new approaches to aiding the elderly at the local level.

If the incentive toward voluntary efforts to assist the elderly is curbed, the loss to our older persons and our Nation will be incalculable.

SECTION V. OBJECTIONS TO THE PROPOSALS TO TACK ON HEALTH CARE FOR THE AGING

In the years of debate and public discussion over the proposal to federalize hospital care of the aging, it has been impossible to pin down reliable estimates of the cost of the program.

Individuals and organizations most directly concerned by these proposals are confronted by constantly shifting figures as to costs, tax increases, and murky projections of probable demands of older people for use of the medical facilities.

In the final analysis, all cost estimates must be based on the degree to which the covered benefits will be used. And we submit that on the basis of the limited data available, it is well nigh impossible for anyone, and this includes Government actuaries, to make an accurate prediction of use, hence provide the Nation with a true picture of the financial burden such a program would entail.

Yet, until we can capture these elusive pieces of information—and fit them together—no wage earner and no employer can possibly know what he faces in the way of reduced income because of the program.

That is the problem. Now, let us consider the record which shows that the costs of these programs—and the individual tax increases they would require—have been consistently underestimated over the years by the responsible Government officials and agencies.

Actuarial study No. 57

As recently as last year, the Social Security Administration acknowledged that a proposal then under active consideration would be doomed to insolvency in a dynamic economy unless Congress would rescue it by keeping pace with increases in the amount of wages subject to the social security tax. This candid document was actuarial study No. 57 entitled "Actuarial Cost Estimates for Hospital Insurance Bill."

The document clearly stated that a one-half of 1 percent payroll tax on a $5,200 base to support the King-Anderson program would keep it afloat for no more than 3 years; that thereafter Congress would have to increase the tax, or the amount of wages subject to the tax, to keep the program from going bankrupt in a rising economy.

Of a striking significance was the fact that the admissions in actuarial study No. 57 were in direct conflict with official claims and pronouncements which had previously been made by proponents and agency officials regarding the soundness of the measure's financing provisions. Repeatedly, they had insisted that the $1.5 billion in increased taxes the legislation would have extracted from the pockets of wage earners and employers would be sufficient to pay full benefits

to the aged. According to the statistical analysis in the study, this very obviously was not the case.

Increasing estimates

Nor was this the end of it. During congressional committee hearings, it agreed that if the wage base was not increased, and if wages and hospital costs continued to rise as they have in the past, the program would require a 1 percent tax on a $5,200 base—half on employee and half on employer; a rate double that which had been widely advertised before the Nation as sufficient to underwrite the cost of the program.

No wonder the American people are confused over the cost of a Federal hospitalization program. The sole cost estimate offered by the proponents in earlier stages of this debate, as we have noted, was $1.5 billion. Late last year, the Department of HEW produced altogether new cost estimates—$1.6 billion by 1966, rising to $2.5 billion by 1990. Actually, no one really tries very hard any more to conceal the fact that it would be necessary to take from the pay envelopes of the Nation's wage earners periodic increasing amounts in order to cover the benefit costs.

The insurance industry has predicted a cost of $2.7 billion to start and an increase to $6.8 billion by 1990. Further, insurance actuaries have warned that a King-Anderson type of program would require a tax rate of 1½ to 2 percent on a wage base of $5,200, depending on how high wages and hospital costs rise in the future. This would be three to four times the rate which has been proposed in previous versions of this legislation.

To reemphasize the point, we suggest there can be no accurate cost figure until the probable use factor is known. And the added use of the Nation's health facilities under a program of "free" Government benefits can only be determined by experience. Meanwhile, the financing provisions for any Federal health care proposal represent pure conjecture—an administrative numbers game in which taxpayers are required to play blindfolded.

Substantial tax burden

Nevertheless, proponents of the legislation continue to dwell on what they term its "infinitesimal" cost in terms of taxes. Far from it. We are dealing with a tax increase of major proportions.

Earlier versions of this type of legislation called for a raise in the tax base from $4,800 to $5,200 together with a rate increase to finance the projected benefits. At a minimum, this would have been a 16-percent increase in tax for everyone making $100 a week or more.

Before you is legislation to finance higher social security cash payments for 20 million beneficiaries. This measure would raise the base to $5,400 and increase the rate from its present 3.625 percent to 3.8 percent and 4.8 percent by 1971 without regard to any hospitalization or health care program.

It follows that the payroll tax to finance a Federal health plan out of social security would be on top of this increase, adding a further burden to employees and employers to finance benefits for millions of Americans who are able and willing to take care of their own personal needs.

This fact underscores a matter which should be of intimate concern to every American wage earner. That is the approach of the day when the average worker will pay more taxes to social security to support Federal welfare programs than he will to support all the rest of the Government activities, including the Defense Establishment.

Approximately one-fifth of today's American families do not pay income taxes because their incomes are too low. But many of them pay social security taxes which begin at the first dollar of earnings. For them, underwriting hospital care and related benefits for the entire elderly population would mean a deeper cut in an already small paycheck.

In this connection, we should like to remind the committee that Assistant Secretary Wilbur Cohen of HEW has advocated an eventual social security tax of 20 percent and a virtual doubling of the present base. When Mr. Cohen appeared before the Senate Finance Committee on March 23, 1961, Senator Curtis of Nebraska described a hypothetical case of a man making $9,000 a year with income taxes of $1,174 and, under the witness' proposal, being forced to pay social security taxes of $1,350. Then the following colloquy took place:

"Senator CURTIS. Do you feel that as much of that man's earnings of $9,000 as a Federal tax source should be devoted to this one single program of social security as is available to help finance all other activities—the functions of Government, the paying of the national debt, and defense of our country?"

"Secretary COHEN. Yes, I do, Senator." [87]

Rising social security taxes

We are aware that the social security system has been suffering for years from a mounting excess of outgo over income from payroll taxes, merely to keep abreast of the current payments to the retired and disabled. As we know, the present state of the funds was a factor in the decision to seek enactment of the pending social security tax increase.

We wonder if the American people are aware of the heavy tax burden social security will impose on then in the future. Five years from now, even if Congress does not make a single change in the present law, the American people will be paying more than twice as much in social security taxes as they paid in 1962.

In that year, workers and employers paid $13.1 billion in social security taxes. With no further amendments to the law, these taxes will soar to $26.7 billion in 1968, according to our projections. The maximum tax on the individual worker has increased more than 220 percent since 1952. By 1968, with no further changes in the law, it will have increased by more than 310 percent over 1952. Nevertheless, the system has been running a deficit in recent years. Benefits paid have exceeded taxes collected in 4 of the last 5 years, for a net loss of $3,722 million, despite the fact that the tax has been increased three times during the 5 years.

Objective reappraisal needed

There is an enormous disparity of opinion about the soundness of the financial structure of the social security system. We frankly admit we are in no position to evaluate the system's present condition or future prospects. We submit, however, that when wide differences exist on the actuarial soundness of the system, an objective reappraisal is in order before any further consideration in given to schemes of such uncertain financial consequences as those calling for blanket Federal health care for everyone over 65 regardless of financial need.

Lasting effects on social security

In any case, Mr. Chairman, the facts militate against the argument that the proposal is so well intentioned and so inconsequential in cost that no one in good conscience could possibly object to it.

As we have suggested, any raise in the wage base and tax rate, for whatever purpose, must have a profound and lasting effect on the future fiscal aspects of social security and the tax bills paid by workers and their employers to support the system. An increase in the base will apply to all future rate increases—those already in the law as well as those Congress may be called upon to approve in the years ahead.

Government medicine for all

Further on the subject of future developments, we have said before and we repeat: A Government health program, if enacted, would not stop at limited hospital and nursing home care for those over 65.

If such a measure became law, the pressure would go on for lowering the age limits on eligibility for tax-supported care, and increasing the types of benefits beyond the limits now proposed. There could be only one eventual outcome: The entire population would be engulfed in an alien system of medicine, controlled by the Government and financed by an increasing tax burden on the Nation's work force.

Parenthetically, we should like to point out that whereas the minimum age under social security is now 62, the minimum age for health care at Government expense, mentioned up to now, is 65. Does anyone seriously suggest that one of the first proposals after enactment of a bill would not be to reduce the age for health care to 62 as a starter?

Approximately 2 million more Americans between the ages of 62 and 65 would become eligible for benefits from the Federal Treasury toward which they had paid little or nothing in taxes. Cost of the program would go up; taxes would have to go up.

Either that, or the amount of health care available to older Americans would have to be drastically revised downward through the control authority invariably built into legislation dealing with the expenditure of public funds. The American people should have no doubts on this score. There will be controls in any program enacted, controls enabling Government employees, untrained in

[87] Printed proceedings, "Hearings Before the Committee on Finance, U.S. Senate," 87th Cong., 1st sess., Mar. 22 and 23, 1961, p. 125.

medicine, to make medical decisions and venture in the administration of medical institutions.

Controlling costs

This, then, is a basic conflict of purpose in plans for Government-financed health care for any segment of the population. The Nation's doctors believe every individual is entitled only to the best and most conscientious care, beyond all other considerations. But the Government cannot escape a responsibility to hold its programs, including those dealing with health care, to the limits imposed by tax receipts and budgets.

Thus, the availability of medical services to the aged would be contingent upon the availability of tax money and not, primarily, upon the medical needs of these citizens. With quantity thus restricted, quality would inevitably suffer.

The basis for all good medical care is the intimate relationship between a doctor and his patient. It is on the basis of his particular knowledge of his patient's illness and requirements that a physician selects a course of treatment to fit the individual need. The physician is best qualified to judge how ill his patient is, what treatment should be prescribed, whether or not he should be admitted to a hospital, when he is well enough to go home.

We have noted that various proposed programs have included such devices as "utilization review" committees to govern the flow of patients in and out of hospitals and nursing homes. We have pointed out that the reason for such provision is plainly financial, not medical. We have acknowledged that some such method is necessary from the Government's standpoint to enable Federal officials to control the cost of the program.

We have also said many times before and we repeat: Such control is not compatible with good medicine. We doctors believe care of the patient must come first, all other consideration afterward.

But the Government must keep its eye on the budget, tightening the reins on services as costs rise.

Canadian hospital experience

This is not merely supposition on our part: it is fact. For illustration, let us briefly turn to the experience of our neighbor to the north. Since January 1961, every Province in Canada has had a program of compulsory taxation for financing of hospital care. In each Province, money is collected on a compulsory basis from almost all residents, as an annual premium of head tax, or as an increase in general taxes. These moneys, with matching funds from the National Government, are administered and paid directly to hospitals by a government "hospital insurance commission" or "rate board" in each Province.

In the light of proposals which have been made here for creation of a tax-supported Government hospital program in the United States, we believe it is reasonable to ask what effect a similar program has had on hospital administration in Canada. Has there been increased government control over the providers of medical services Have the institutions lost any of their right to handle their own affairs?

There are some answers to these questions in an article in the May 1, 1963, issue of the Journal of the American Hospital Association—"Canadian Dilemma: Hospital Finances and Hospital Autonomy."

Discussing major issue between the hospitals in Canada and the Government—the need for hospitals to expand versus Government control of funds—the article states:

"The hospitals insist on the right to provide the services required by their communities regardless of cost. The Government reserves the right to approve the expansion of any facilities and services supported wholly or partly by Government funds."

Reading further, we find an example of the situation which arises when Government attempts to intervene in the operation of a hospital for fiscal reasons, as distinguished from medical considerations:

"The British Columbia Insurance Service suggested that the Trail-Tadanac Hospital reduce its nursing staff by 17 nurses to live within an annual budget reduced from $1,030,783 to $931,783—a reduction of $99,000 for this 154-bed hospital. The (hospital) board refused and the medical chief of staff, said, 'Don't touch the staff. We are already stretched to the minimum requirements. We're already taking chances.'"

No greater control than financial control

Elsewhere in the article, J. Gilbert Turner, M.D., executive director of the Royal Victorian Hospital of Montreal, sums up the situation confronting his institution under the Canadian Government program. These are his words:

"There is no greater control than financial control. Every single item of our budget is thoroughly scrutinized, and if it cannot be supported, then it is disallowed. Naturally, in the setting up of a new scheme, there were bound to be delays. Only this week (Dec. 5, 1962), did we get our final settlement—which was quite satisfactory—for the year 1961. In regard to 1962, we submitted our preliminary figure at the start of the year, but it has turned out to be quite insufficient, so we have appealed. This appeal met with very little success, so we are presently in the stages of a second appeal, which means resubmission of the budget to be followed by an on-the-spot check by the accountants of the hospital service. This, as a rule, takes 5 to 10 working days, and it is then followed by studies at the hospital service headquarters."

We hold there is a lesson in the experiences of Canadian hospitals with their Government which should not be overlooked by advocates of a system of federalized hospitalization in this country. It is axiomatic that government tends to control what it subsidizes. Surely, this is borne out in the Hospital Journal article.

There can be little question that the autonomy of the local hospital in Canada has been seriously undermined because virtually all hospital care funds have been concentrated in the hands of one paymaster—the Provincial Insurance Authority. A Canadian hospital cannot make any significant departure from the status quo, such as adding more beds, purchasing major equipment, or hiring additional personnel without first securing budgetary approval of the Provincial authorities. The control of the purse strings has shifted the focus of decision-making from the hospital administrators and trustees at local levels to far-removed officials working in Government bureaus and commissions.

It is our contention that the same situation will ultimately prevail in the United States if the legislation before this committee is enacted. And, as physicians, we must point out again that we want to be responsible for our patients to the limit of our competence; we want to take care of their needs first and foremost; we do not believe the highest quality medical care can be attained when Government employees undertake to decide what services should be provided in medical facilities.

Not an insurance program

From the beginning of the drive to impose federalized medicine on the Nation's aged, the foremost supporters of the program have misrepresented it before the American people as "insurance." By the use of this trusted word, these spokesmen seek to deceive workers into believing they would be paying premiums on hospital insurance, with their money set aside for their own future benefit. This is simply not true—a point which we are sure we do not have to labor before this committee.

The system envisioned in proposals with which we are familiar compels: it does not permit. People would not contribute; they would pay taxes. They would not pay taxes during their working years for medical care in their own later years. They would pay taxes today for today's beneficiaries.

Moreover, as the committee knows, the Supreme Court has upheld the arguments of the Justice Department that benefits under social security are for the general welfare and, this being true, the levy to pay them "must be a tax within the meaning of the Constitution."[88] This is a fact of record. Nor, is there any question that the Internal Revenue Service has ruled specifically that money collected for social security is a tax and not an insurance premium.

Through their history, Mr. Chairman, Americans have resisted proposals which would place unrestrained power in the hands of Government. When such advances are made to them in language that is less than candid—when they are asked to approve a course of conduct without knowing exactly where they are going, when they are going to get there, or how much it is going to cost—there is sound reason for their opposition to be justified.

We submit that the proposals before you clearly fall within this category and should be rejected.

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[88] Brief of the Justice Department, *Helvering* v. *Davis*, 301 U.S. 619.

SECTION VI. MEDICAL PROGRESS AT STAKE

Throughout this testimony we have discussed the pending proposal in terms of the economic status of elderly Americans which makes such an expensive and wasteful program unnecessary. We have pointed out the other programs which are available and operating to provide help for the minority of elderly Americans who require assistance in meeting their health care costs. We have stated our belief that Government encroachment on the field of medicine, directly or indirectly, would threaten the quality and the strength of the American health care system as never before.

Our system, despite its imperfections, is universally recognized as the finest in the world in all aspects—research, education, training, and the end result, clinical application of high standards of care for the American people.

Before we embark upon any venture which might undermine that system, it might be wise to consider what we have, how we got it, and what is being done in a constant effort to improve the art and science of medicine, including the care of our growing elderly population.

Therefore, as we conclude today, we should like to present just a few of our credentials.

Medical progress

The progress of medicine in this Nation is one of the most dramatic stories of the century. Here are just a few salient highlights of the story:

Four and one-half million Americans are alive today who would be dead if the mortality rate of 25 years ago still prevailed. These 4½ million people earn an estimated $10½ billion per year to add to the vitality of our economy.[89]

For the first time in our history, average life expectancy for Americans has exceeded the Biblical threescore and 10, and it now stands at 70.2 years.[90] A dramatic illustration of modern medical progress is the fact that of all the people reaching age 65 since the beginning of time, 25 percent of them are alive today.

Eighty percent of the drugs commonly prescribed today were unknown just 10 years ago.[91]

The United States has made more important drug discoveries in the past two decades than all the rest of the world combined, or seven times as many as the next leading country.[92]

Just last year the prescription drug industry set a new record of $282 million in research, an investment triple that of the average industry.[93]

There now is a record number of hospital beds in this country—1,701,839, an increase of more than a quarter million beds since 1948.[94]

In 1963, infant mortality rates declined to the lowest in U.S. history, 25.2 deaths per 1,000 births.[95]

A record number of 7,168 new physicians graduated from U.S. medical schools in 1962, and a record number of 31,078 students were enrolled in medical schools during the academic year.[96]

In 1946, there were 6,125 registered hospitals in the United States. Today, there are 7,138.[97]

A record number of Americans, 145 million, are now covered by voluntary health insurance and prepayment plans.[98]

These and countless other scientific and socioeconomic advances in medicine did not just happen. They were brought about by the constant work and effort of individual physicians and the medical profession, aided by contributions from allied sciences and health professions, nurses, public health workers, legislators, business and industry, and the American people.

Frequently over the years, in and out of the legislative area, the American Medical Association position on some issues has brought formidable opposition

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[89] "A Truth Treatment for Critics of American Medicine," George M. Fister, M.D., Today's Health, February 1963, p. 6.
[90] "A Truth Treatment for Critics of American Medicine," George M. Fister, M.D., Today's Health, February 1963, p. 6.
[91] "A Truth Treatment for Critics of American Medicine," George M. Fister, M.D., Today's Health, February 1963.
[92] Ibid.
[93] Annual survey of the pharmaceutical manufacturers, Aug. 5, 1964.
[94] "Hospitals," Journal of American Hospital Association, Aug. 1, 1964, vol. 2, p. 471.
[95] Provisional report, U.S. Public Health Service, February 1964.
[96] "A Truth Treatment for Critics of American Medicine," George M. Fister, M.D., Today's Health, February 1963.
[97] "Hospitals," Journal of American Hospital Association, Aug. 1, 1964, vol. 2, p. 471.
[98] Health Insurance News, Health Insurance Institute, July 1964.

and great unpopularity in certain quarters. However, if we are to serve the best interests of the American people, we must concern ourselves with principles and facts, not with an expedient search for universal popularity.

AMA leadership

The American Medical Association, which has a membership of 200,000 physicians, represents the medical profession. Since its inception its primary interest has been the welfare of the patient.

The 250 physicians who founded the AMA on May 5, 1847, in Philadelphia, were concerned over the poor quality of medical education in the United States, the brisk traffic in patent medicines and secret remedies, and the lack of a recognized code of ethics to protect the public. The founding physicians felt that a national association was needed to lead a crusade for better medical care—for the patient.

That crusade continues today. Our objectives, now as then, are "to promote the science and art of medicine and the betterment of public health." For the past 116 years the AMA has fought for many things which would help achieve those objectives. Over the same period of time the association has fought against some things which would be detrimental to the quality of medical care and the public welfare.

Medical education

When the AMA was organized, formalized medical education was practically nonexistent. Men boasted they could—and did—buy medical degrees for a little cash. Others hung up shingles with no training at all. Since 1847, AMA has worked to improve the Nation's medical schools. Its activities led to the housecleaning between 1905 and 1920 of medical "diploma mills." Since then, AMA and the Association of American Medical Colleges have periodically inspected all schools to make certain high standards are maintained. All this is in the public interest. It means patients have better physicians.

Since the end of World War II, nine new medical schools have been opened.[99] Commitments have been made for the establishment of 12 additional schools.[100]

The medical profession recognizes the need for more physicians and is doing something about it.

Last year, in 1963, physicians voluntarily contributed approximately $5½ million to medical schools—$4¼ million directly and $1¼ million to the American Medical Association education and research foundation funds for medical schools.

To make sure that able entrants into the medical field are not deterred by lack of funds, the AMA has established a student loan guarantee program through its educational and research foundation. Since its inception 2½ years ago, the program has provided 15,183 loans representing a principal sum of approximately $17½ million.

The medical profession also has an affective nationwide medical careers information program to attract superior students. AMA headquarters receives more than 300 letters a week from students interested in medical careers.

The number of physicians per 1 million population is on the increase—135.7 in 1960; 141.7 today.[101]

This means more and better trained physicians for the patients of America.

War on quacks

Carrying out one of the original purposes of AMA is the department of investigation which, since 1906, has carried on a relentless fight against quacks and charlatans and their nostrums and gadgets. At one time medical quackery and traffic in patent medicines ran rampant.

Today, AMA's Department of Investigation has the largest files existent on medical quackery. It has been most effective in revealing facts concerning unethical and fradulent practices and in providing regulatory bodies with evidence leading to conviction.

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[99] UCLA, University of Florida, University of Miami, Seton Hall University, Albert Einstein Medical School, University of Puerto Rico, Southwestern Medical School of the University of Texas, University of Washington, and the University of Kentucky.

[100] Source: "Datagrams," Association of American Medical Colleges, vol. 6, No. 2, August 1964.

[101] Physician population 251,577 in 1960. U.S. population 185,369,000. Physician population 275,142 in 1963. U.S. population 194,117,000. Source: AMA Directory Report Service. Figures include non-Federal physicians in the 50 States and District of Columbia, Puerto Rico, and other U.S. outlying areas and Federal physicians regardless of location. Bureau of Census, current population reports, population estimates. Includes all U.S. citizens, regardless of location, except U.S. citizens working at civilian jobs abroad, studying in foreign universities, or residing abroad for other reasons.

This program to reduce quackery in this country also is in the interest of the patient.

Medical ethics

One of the paramount reasons for founding the AMA was to develop a code of ethical conduct for physicians. The principles of medical ethics are guides to correct conduct with specific advice on how to maintain ethical relations with patients. They have been set down primarily for the good of the public, but they also serve as an inspiration to the physician to remain true to his oath.

Serving the patient

Scores of organized medicine's programs are designed specifically for the patient.

Emergency call systems are established and maintained so patients can get a doctor in a hurry when an emergency strikes.

Grievance committees, or mediation committees, have been established to hear patients who have grievances against a physician.

County medical societies across the Nation have developed publicity and advertising programs to tell the people of their respective communities that physicians guarantee their services to all regardless of ability to pay.

Serving the public

In addition, the medical profession serves the public, in a thousand different ways:

By studying the usefulness, limitations, and health problems of cosmetic preparations.

By evaluating foods, special food products, drugs, and chemicals to assure safety and proper use.

By helping to place physicians in small communities and rural areas through its placement services.

By answering thousands of personal letters on health subjects each year and by using every medium of communications in its health education program for the public.

By encouraging high standards in advertising and labeling of foods and drugs.

By working closely with schools and educators to help provide for pupils' health needs.

By conducting public educational campaigns on such subjects as traffic safety, use of seat belts, and ways to reduce accidental poisonings.

By working with industry to control health hazards on the job, and to promote rehabilitation of disabled workers.

By alerting the public to the importance of preparing for any emergency resulting from a national disaster.

By helping rural communities improve their health environment.

By developing standards for nursing homes to assure proper care of patients and by promoting home care programs, homemaker services, information and referral centers, and other activities aimed at providing good care at minimum cost.

By publishing Today's Health magazine to inform the public, including schoolchildren, of the latest facts about medicine, health, and disease prevention.

By carrying out a comprehensive health education program through films, radio transcriptions, TV shows, exhibits, pamphlets, and books.

These are only a few examples of continuing, expanding AMA activities. In the legislative area—on National, State, and local levels—the medical profession has fought for many things designed to protect the American public.

For example, it was the AMA that fostered public health facilities throughout the Nation. Ninety years ago, it urged establishment of State boards of health.

As early as 1912, AMA urged establishment of a Department of Health in the President's Cabinet, which later led to the Department of Health, Education, and Welfare.

AMA also recommended creation of the U.S. Public Health Service, and the Federal Food and Drug Administration, and in 1948 participated in the development of the World Medical Association.

In 1882, the AMA urged State legislatures to introduce hygiene as one of the branches to be taught in the schools. Today, through a long and mutually profitable joint committee with the National Education Association, it edits a standard textbook on the teaching of health in the schools.

Within the past 3 years, as our activities expand and multiply at an ever faster rate, the AMA has sponsored or cosponsored such events as the First National

Congress on Mental Illness and Health, the First National Farm Safety Congress, the First and Second National Congresses on Medical Quackery, in cooperation with the Food and Drug Administration, and the Third National Congress on Voluntary Health Insurance. A Second National Congress on Mental Illness and Health will be held in November.

Reflecting the profession's growing concern over the modern hazards to public health caused by water and air pollution and other problems which man has created by his own scientific advances, the AMA 3 months ago sponsored the First National Congress on Environmental Health Problems.

The association has also established a new Central Registry of Adverse Reactions to Drugs and Chemicals, and participated in the formation of a Joint Commission on Medicine and Pharmacy. Establishment of a new Institute for Biomedical Research has been announced and work is progressing on the $3½ million building in which it will be housed. Just recently, the World Medical Association adopted the emergency medical identification symbol of the AMA as the "universal emergency medical information symbol."

As Members of Congress, you gentlemen naturally have a particular interest in the field of Federal legislation. During the past 12 years, the American Medical Association has taken a position on more than 4,000 bills of a medical nature. In the great majority of cases over the years, the AMA has supported the principles and objectives of health legislation. In a minority of cases over the years, we have opposed bills which we believed would be detrimental to the quality of medical care and the welfare of the American people.

Health care for the aging

In the particular area which concerns us here today—health care for the aging—we have a close, primary medical interest. It is a natural outgrowth of, and an integral part of, our interest in the health and welfare of all Americans, regardless of age.

We were interested in this subject and in the changing patterns in health and disease long before they became legislative issues. After all, as physicians supplying medical care—in our offices, in the patients' homes, in hospitals, in nursing homes, and wherever needed—we believe that we are rather close to the subject.

On the organizational level, the American Medical Association became active in this total field shortly after World War II when it helped to found the Commission on Chronic Illness, which conducted a comprehensive study of chronic diseases from 1949 to 1956. As a result of that work, several large volumes pertaining to chronic diseases and aging were published and widely distributed.

Increasing interest, both by individual physicians and organized medicine, led to the creation of an AMA Committee on Geriatrics in 1955. After considerable study and communication with other authorities in the field, that committee decided at its very first meeting that it had been misnamed. Subsequently, it was renamed the committee on aging.

The reasons for that name change are germane to the issue at hand here today. The fact is that no diseases or ailments are specifically and entirely the result of old age or the passage of time. The health problems of older people are simply extensions or variations of conditions which can begin developing, or which can occur, at any age.

Furthermore, objective study of elderly people shows that health and health care compromise only one facet of the total picture. Equally important, if not more so, in any long-range view of the subject, are such factors as housing, employment, recreation, economic status, cultural activities, and the need to be a continuing part of family and community life. These people want to be citizens, not senior citizens; patients, not geriatric patients; voters, not a political bloc; workers, not old workers.

People over age 65 should not be regarded as a group with uniform characteristics and problems. Rather, they should be viewed as millions of individuals, with countless variations and combinations—physical, mental, emotional, social, and financial.

The only special, distinguishing problems confronting the aging, and which are not shared by all other age groups, are those imposed by the outmoded concept of compulsory retirement and the narrow view that people over 65 have suddenly become a separate, segregated group in our national life.

AMA programs for aging

With the foregoing ideas as a foundation, the AMA Committee on Aging for the past 8 years has been developing a comprehensive, well-rounded program on

aging. The association has promoted that program through nine regional conferences, establishment of State medical society committees on aging, sponsorship of the Joint Council To Improve Health Care for the Aged, participation in the White House Conference on Aging, distribution of informational materials to the Nation's libraries, and continuing cooperation with numerous governmental and private agencies interested in the subject.

In 1958 the AMA House of Delegates adopted an official policy urging all physicians to adjust their fees in order to expedite the development of an effective voluntary health insurance and prepayment program for people over 65 with low income and limited family resources. As has been stated previously in our testimony, that policy has helped greatly in stimulating the growth and development of specially tailored coverage for elderly people.

In 1960 the association strongly supported the Kerr-Mills bill to provide medical assistance to the needy and near-needy aging—the people who really need help. In another section of our testimony, we have presented evidence demonstrating the great progress and potential in implementation of the Kerr-Mills law.

As pointed out earlier, the AMA during recent months has suggested four amendments which we believe will help to strengthen and improve the Kerr-Mills program. We also have suggested certain amendments to the Internal Revenue Code, designed to assist all taxpayers involved in financing hospital and medical expenses of the aging.[102]

The American Medical Association has also been in the forefront of a nationwide drive to promote high standards of care in nursing homes. With the American Nursing Home Association, the AMA formed the National Council for Accreditation of Nursing Homes. Since February of this year, the council has approved 370 homes after careful investigation.

Some basic principles

To sum it up, these are problems of individuals, transitional in nature and calling for full use and development of the flexible mechanisms already at hand.

Unfortunately, there are many today who choose to ignore the temporary, transitional nature of the individual economic problems involved. As we have seen and heard over the last several years, they claim that the only solution lies in imposing a permanent pattern of tax-paid, Government-regulated health care—a pattern inherently subject to inevitable expansion of both benefits and eligibility.

Would be dangerous law

This makes it necessary to consider some of the factors which, added together, clearly point to a deterioration of the quality of health care under any program of Government-controlled medicine for any segment of the population.

1. The basis for high quality medical care is the voluntary relationship between the patient and his physician. This would begin to disappear as the Government supplanted the individual as the purchaser of health care services.

Whatever the form a new Federal welfare program might take, a grant of unprecedented power to Government employees to meddle with the administration and medical practice in participating hospitals is inescapable. It makes no substantial difference whether the measure provides for a direct service type of program or for an indirect subsidy of care. Any legislation must contain grants of power to enable the Government to carry out its basic responsibility toward the expenditure of tax funds.

The result would be third-party political interference with the free selection of diagnostic and therapeutic choices by the physician.

2. Then, as the Government fixed prices for services rendered—as indeed it must to protect the public purse—financial incentive would begin to melt away.

3. The incentive of competition with one's peers would also fade, since the striving for professional excellence would be frustrated by centralized direction.

4. As physicans and health facilities became more and more subject to intervention by Government employees, a decline of professionalism would be certain.

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

6. Quality medicine would be dealt a further blow by the loss of able entrants into the health care field because young people, viewing a profession under partial or total Government control, would seek careers in other fields.

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[102] "Eight-Point Program for the Aged," board of trustees, American Medical Association. Adopted Feb. 2, 1963.

The American Medical Association believes this legislation to be not only unnecessary, but also dangerous to the basic principles underlying our American system of medical care.

We urge you to help preserve the vitality, promise and potentiality of that system by rejecting the pending proposals and any similar legislation which would open the way for the Government to fasten a burden of taxes and controls on present and future generations of Americans from which they could never hope to escape.

Senator SMATHERS. Our next witness is Mr. J. M. Wedemeyer, director of State Department of Social Welfare, State of California, appearing in behalf of the American Public Welfare Association.

STATEMENT OF JOHN M. WEDEMEYER, DIRECTOR OF STATE DEPARTMENT OF SOCIAL WELFARE, STATE OF CALIFORNIA, APPEARING IN BEHALF OF THE AMERICAN PUBLIC WELFARE ASSOCIATION

Mr. WEDEMEYER. Mr. Chairman and members of the committee, my name is John M. Wedemeyer. I am appearing as a representative of the American Public Welfare Association in my capacity as a member of the executive committee of the National Council of State Public Welfare Administrators, which is a constituent body within the association. I am the director of the California State Department of Social Welfare. For the past 30 years I have held administrative and supervisory positions in both public and voluntary welfare organizations in local as well as State agencies. Before coming to California, I served as the administrator of the State welfare department in Washington, and I also worked in the welfare program in Wyoming. In all of these public welfare agencies, I have carried responsibilities for public assistance and medical care.

The American Public Welfare Association is the national organization of State and local public welfare departments and of individuals engaged in public welfare at all levels of government. Its membership includes Federal, State, and local welfare administrators, welfare workers, and board members from every jurisdiction.

I think it is worth emphasizing that the membership of the association consists mainly of people whose daily work involves welfare programs, including the new and expanded programs of medical assistance made possible by the Kerr-Mills legislation of 1960. These people, whose experience qualifies them to assess the strengths and weaknesses of public assistance, are largely agreed that social insurance—not assistance—should be the first line of defense against not only the loss of work income, but the financial consequences of serious illness in old age.

SOCIAL SECURITY AMENDMENTS

An adjustment in the OASDI benefit level, together with appropriate changes in the tax rate and wage base, is needed at this time to make up for the increase in living costs which has taken place in recent years. The provisions in the House bill, now before your committee, to increase all benefits by 5 percent, would take up some, though perhaps not all, of this lag.

We are in accord with the proposal to extend benefits at a reduced rate to those older persons who have a record of work experience which falls short of the required six quarters. While the number involved

would be relatively small, it includes a high proportion of those who receive public assistance or who are living in marginal circumstances. Moreover, while we are in basic agreement that benefits should be based on contributions to the system, these people have all made some payment for which they would otherwise receive no return. Their numbers will rapidly diminish and will soon be phased out of the system.

We look with special favor upon the provision which would pay for continuation of benefits to age 22 of a child who remains in school. In this era of ever-greater demands for technical skills and professional competence in the labor market it is of the utmost importance that all young people be given every opportunity to obtain an adequate education. Providing these continuing benefits to children in school is consistent with the highest purpose of the social security system and would serve the best interests of the entire Nation as well as of the individuals directly involved.

Similarly, the provision for retroactive application for disability benefits is, for obvious reasons, highly desirable.

HOSPITAL INSURANCE FOR THE AGED

Our primary purpose in appearing before your committee today, however, is to express our support for the establishment of a program of hospital insurance for the aged within the social security system. The American Public Welfare Association has a genuine interest in and knowledge of pubilc medical care programs going back to the inception of the association more than 30 years ago. The position we present to you today is based upon the experience of the men and women in the ranks of public welfare who administer the medical care programs under public assistance and the medical assistance for the aged program under the Kerr-Mills legislation. These persons are keenly aware both of the need of the aged for medical care and the problems of administering medical care programs. There is wide agreement among them that public assistance—valuable and necessary as it is—should not be relied on as the basic public program to cover the high cost of hospital and related care that aged people are not able to meet by themselves.

It is because we have observed so closely and worked so continuously with the administrators of public welfare medical care programs that we feel the association is qualified to conclude that the public assistance approach to meeting the medical care needs of the aged is not the total answer to this question. On the basis of this background of experience and concern, the association by action of its board of directors has taken a position in support of a program for the payment of hospital and related costs of aged persons, to be financed through the OASDI system for covered beneficiaries, and from the general revenue for those who are uninsured.

THE PROBLEM OF FINANCING HEALTH CARE FOR THE AGED

The problem of financing health care for the aged, although easily stated, is one of gigantic proportions. The number of aged persons in the United States is increasing rapidly. Today we have nearly 18 million persons over 65. Tomorrow at this time there will be 1,000 more such persons since that is approximately the daily net increase.

Because of the advances 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 6 is in the eighties, and the women exceed the men by nearly 125 to 100. But this extended lifespan brings with it the diseases of age and senility; diseases which are usually long in duration and which frequently require expensive care in hospitals and other medical institutions.

What is the solution to the problem of payment for medical care for the aged? In the United States we have developed one of the highest standards of medical care in the world. Our physicians, our dentists, our nurses, 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 it is generally agreed 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. The prevention, diagnosis, and treatment of disease are the province of the physician and the allied medical professions. But the economic arrangement under which a person is able to purchase medical care is a problem with which we are all concerned.

There are only a few alternative methods of financing the cost of health care. First, there is the traditional method of paying through the individual's own resources. A casual analysis of the income of the aged will reveal that this is not a practical solution for the rank and file of the aged. You are already aware that more than two-fifths of the total income of the aged comes from income maintenance programs, primarily social security and other public programs. You are aware also that in 1959 almost three-fifths of the married couples with the head or the wife aged 65 or older had incomes under $3,000: among nonmarried persons aged 65 and over, almost three-fourths had incomes under $1,500. And these amounts included all the income available through social security and public assistance. It must be obvious, therefore, that for the bast majority of the aged the payment of medical bills by the individual is out of the question.

A second method of handling the problem would be through philanthropic medical and social welfare agencies. Private hospitals and doctors 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 increased aged population. Many of our hospitals face tremendous deficits because of free service to the aged. I think that the representatives of voluntary organizations would be the first to admit that they are in no position to make substantial increases in the support of programs for the nearly 18 million aged.

A third method would be through an extensive system of public relief or public assistance for those who cannot pay the medical care bill. The persons who administer such programs are the membership of the American Public Welfare Association. They are concerned over the fact that many persons are receiving old-age assistance today almost entirely because of their medical care needs. In other words, were it not for medical care bills, these aged would be self-supporting. I wonder how many Americans feel that it is a 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 with all the variations to be found in such a program. In many States persons without income will not qualify until they have been in residence for 5 years. A variety of other restrictions makes it impractical to think of public assistance as a total answer to the problem.

A variation of public assistance is the Kerr-Mills approach, originally opposed by some of the very people and organizations now supporting it. We have urged the States to take whatever action is necessary to benefit from the provisions of the Kerr-Mills Act which makes available additional Federal financing of medical care in old-age assistance and establishes the new Federal-State program, medical assistance for the aged. However, our members who administer this program are acutely aware of its limitations.

The development of this new program of medical assistance for the aged offers an illustration of the problems that States have encountered. Nearly 4 years after it began, 15 States still have no program in effect. Even the 27 States that provide at least hospitalization, nursing home care, and practitioners' services have significant limitations on the conditions for extent of services, and many States, because of rigid eligibility requirements, are limited in their ability to help large numbers of the aged who have medical needs. Only about 13 States have so far established eligibility requirements which permit the State to consider the individual's income level in relation to his medical expenses in determining whether public funds may reasonably be provided to help him with his medical bills.

In talking with State welfare administrators, we find that these limitations in the new program of medical assistance for the aged are not based on reluctance to help the aged, or on any deficiencies in the Federal law, but on the inability of many States to assume additional major financial burdens. We find, therefore, that although the Kerr-Mills Act was broadly conceived by its authors and by the Congress, it has not been possible for many of the States to implement this intent fully. For example, in April 1964, three States (New York, California, and Massachusetts) made 65 percent of the outlays under medical assistance for the aged, although they had only 22 percent of the aged in the Nation.

A fourth method of caring for the problem would be through voluntary insurance. Voluntary insurance for the aged has made tremendous progress in the United States, but it cannot provide the solution to the total problem of medical care for the aged. 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 their premiums would be very high; the numerous exclusions; and the inability of many voluntary insurance programs to carry persons into their eighties and nineties; these and many other factors limit the use of voluntary insurance. Furthermore, voluntary insurance cannot finance without much higher premiums the many millions already aged and receiving medical care. The experience of Blue Cross and Blue Shield in many States indicates that the aged are a high-cost group which makes serious drains on the total program. Much of the insurance being sold under the "65-plus" type of policy falls short of meeting the expenses it applies to. Ten dollars a day for 30 days of hospital care meets only half of the room and board bill in a $20-a-day room. It pays nothing for stays beyond 30 days, and

severely limits the benefits for ancillary services, often nearly equal in toto to the room and board charges.

The various modifications proposed to these four methods likewise will not fully solve the problem. Public subsidy to voluntary insurance plans, public aid to low-income groups needing medical care but not eligible for public assistance or aid under the Kerr-Mills Act, and many other proposals have been examined. We consider them partial measures which do not offer complete or satisfactory solution.

THE SOCIAL INSURANCE FINANCING MECHANISM

A fifth and, to us, a satisfactory method of financing medical care for the aged would be through the social security mechanism. The association recommends the social insurance financing mechanism for meeting the health needs of the aged not only because we find the public assistance approach does not completely solve this problem, but because we believe strongly that it is not the wish of the American people that substantial numbers of our aged citizens be required to turn to public welfare for help with their medical needs. The association's Federal legislative objectives state: "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; and against health costs of OASDI beneficiaries."

Whereas cash benefits under the OASDI program may be sufficient in many instances for the aged individual's routine maintenance requirements, it is rare that medical costs of an unpredictable or large character can be met unless the aged person has considerable other income and resources. From the special viewpoint and experience of public welfare, we know that many aged individuals go without medical care because they cannot bring themselves to apply for public aid or to ask for private charity. Furthermore, charity or free care is not generally available on any kind of continuing basis. These alternatives, furthermore, are unpalatable to the American people.

Just as employees and the self-employed are now able to contribute, throughout their working lifetime, to their retirement income, so should they be able to prepare for and contribute to the greatly increased health costs they will have in their later years. Voluntary health insurance is essentially "term insurance." Each contract is for a limited period in order to allow for renegotiating rate increases as medical costs and utilization rise. Prefunding of future benefits, such as for retirees, is virtually impossible under such an arrangement. Furthermore, if this high-risk, high-cost group is removed from voluntary health insurance coverage, the voluntary plans will be able to do a much more effective job for the rest of the population.

We strongly urge, therefore, the establishment of a program of hospital benefits for social security beneficiaries as part of the contributory social insurance program so widely accepted and endorsed by the American people.

Private health insurance can be a help, but aged persons often have just enough money to meet the essential costs of daily living, and for this reason (and sometimes simply because they are forgetful) they fail to keep up premium payments. Then there is no health insurance when an expensive illness comes along. Sometimes premiums are paid

faithfully, but policies are canceled when the aged person demonstrates that he is a poor risk, or riders are attached to the policy relieving the insurer of obligation to provide protection against health costs arising from specified conditions. So often children of aged parents have to assume their parents' heavy hospital and medical costs, though the children may have families of their own and may be hard pressed to meet their own bills. Frequently, these hospital and medical costs are continuing, rather than one-time, expenses.

Public assistance programs, especially medical assistance for the aged, can be a big help in dealing with the health costs of the aged. But, as we point out elsewhere in our testimony, we do not believe assistance should be the basic public program for this purpose. It conflicts with the desire of aged persons, and indeed the desire of all of us, to remain independent. Moreover, where assistance is the only Government program, many States are not financially able to pay their share of the costs of adequate benefits.

SPECIFIC RECOMMENDATIONS FOR CONTENT OF A HEALTH INSURANCE PROGRAM

It is our understanding that a number of proposals relating to health insurance for the aged will be submitted to your committee. Each of these reflects thoughtful study of the complexities involved in formulating a schedule of benefits and of providing for sound financing. Among these variations there are no doubt a number of constructive alternatives available. We should like to submit for your consideration our views on certain major aspects of a sound program of health insurance for the aged.

Persons entitled: The association's statement of policy concerning a health insurance program recommends that the health costs of old-age, survivors, and disability insurance beneficiaries should be financed through the OASDI program. We recognize that at this time, however, there is need for a choice, because of financing problems, between the groups of beneficiaries to be covered. It appears reasonable to exclude the younger beneficiaries, dependents, and survivors whose health problems in general are fewer and whose sources of income other than OASDI are more often adequate. We recommend, therefore, that as a minimum persons 65 and over who are entitled to OASDI benefits or railroad retirement benefits, and their aged dependent spouses and survivors, be considered for coverage under a health insurance program.

We also recommend that persons aged 65 who have not been able to qualify for social security cash benefits be included in the health benefits legislation, with the cost of protection for them financed from general revenue. Practically all persons reaching age 65 in the future will qualify for social security benefits (either as retired workers, dependents, or survivors), so this special provision should not be needed on a continuing basis.

Health benefits provided: A minimum scope of services in a health insurance benefit program should include inpatient hospital services, skilled nursing home services, outpatient hospital diagnostic services, and organized home health services. Without any one of the last three items of service there is likely to be unnecessary utilization of inpatient hospital care. This has been demonstrated, we believe, by the exper-

ience in many Blue Cross plans, and by the growing tendency of such plans to add a limited coverage for these services in their benefits.

Obviously, the ideal program would provide the quantity of each of these types of service needed by an individual patient. Practically, however, financing problems and the possibility of overutilization make it necessary to impose certain limits. We recommend that these limits be based on actuarial estimates of the amount of care which can be financed by the tax increase which the Congress finds feasible at this time. Recognizing the limitations made necessary because of cost, we agree that the emphasis should be placed on protection against hospital costs, which generally are the most unpredictable and burdensome of the health costs of aged persons. As I have mentioned, however, we believe it essential to provide less costly alternatives to inpatient hospital care as well, in order to promote efficient use of health facilities.

We believe that, as experience is gained in the program, it should be possible, and will undoubtedly be essential, to make certain modifications in the level of health benefits. At this time it does not appear either feasible or necessary to include physicians' and other practitioners' services as a benefit, except as these are provided to all patients by any of the institutions participating in the program.

We recommend that the effective date for the provision of all these services be the same, since we believe that if any one is omitted, even for a brief period of time, there will be an imbalance in the program which should be avoided.

Deductibles or enrollment fees: We do not agree with proposals for either deductibles or enrollment fees. We recognize that deductibles have been suggested in part for financial reasons and in part to meet the fear of some that there will be overutilization, particularly of hospital care. We believe, however, that it would be unfortunate to create this barrier to early hospitalization in a program which is attempting to overcome some of the problems the aged have had in receiving essential care early in an illness. We point out, further, that this could well result in increased cost of hospitalization when the patient is finally admitted at an advanced state of illness.

We recognize that the undesirable aspects of including deductibles in a health benefits program would be mitigated by a provision permitting beneficiaries to choose various combinations of deductible and duration of covered hospital care, especially if this permits a beneficiary to choose to eliminate the deductible entirely in his case. But we believe it would be preferable not to have any deductibles at all.

If a deductible is found essential for reasons of cost, we urge that the committee give consideration to the possibility of applying this to nursing home care rather than inpatient hospital care. The individual entering a nursing home has his other living expenses either completely eliminated or greatly reduced and he could, therefore, afford to pay a small deductible or cooperative payment on each day of nursing home care. This is not as true for the hospital patient who must maintain his home against the day of his discharge and who also will be faced with sizable physicians' bills. If necessary, this form of deductible might be combined with a deductible applied to the cost of hospital care after the first 21 or 30 days of hospital care. This would act as a deterrent, if the committee believes this is necessary, to un-

necessarily long stays without serving as a barrier to early admission and treatment.

Financing: We have already indicated our strong approval of financing through social insurance. We would add only that we are in agreement with those proposals that include a separate trust fund or account for health insurance benefits. This is a sound approach and will reassure those who sincerely fear a health insurance program might cause "raiding" of the OASI trust fund. We do not concur in this fear but we do think that a separate fund or account will encourage orderly financing of the program. We believe that it is sound policy to provide health benefits for the present aged who are not OASDI beneficiaries and to meet from general revenue the cost of benefits and administration with respect to these persons.

Administration: The proposal for the establishment of an advisory council to assist the Secretary in matters of general policy and in the formulation of regulations for the health insurance program is supported. We support, too, the proposal that in determining conditions of participation by providers of service the Secretary shall also consult with appropriate State agencies and recognized national listing or accrediting bodies. In the determination of whether an institution or agency meets these conditions of participation, and in the establishment of rates of payment, the use of State agencies, under an agreement with the Secretary of the Department of Health, Education, and Welfare, is supported.

Arguments against the proposal: The American Public Welfare Association has examined very carefully the arguments against this proposal. One of the major arguments is that it will lead to socialized medicine. May I remind this committee that the same argument has been used against other proposals which have been enacted into the Social Security Act. The argument has proved to have no validity in connection with the disability freeze or disability insurance and we believe that the use of the social insurance principle to provide economic arrangements under which medical care bills will be paid for the aged has nothing to do with socialized medicine. There is no proposal here for the establishment of Government hospitals or for the employment of doctors by the Government to treat patients. There is nothing here to disturb the traditional patient-physician relationship. As President Kennedy stated in his message to the Congress on February 21, 1963:

> The program I propose would pay the costs of hospital and related services but it would not interfere with the way treatment is provided. It would not hinder in any way the freedom of choice of doctor, hospital, or nurse. It would not specify in any way the kind of medical or health care or treatment to be provided by the doctor.

In connection with the charge that this plan would bring socialized medicine to our country, some have said that Government control would result from the Secretary's authority to establish standards for participation. The Department already has similar authority with respect to hospitals and nursing homes receiving grants under Hill-Burton legislation, but this has not resulted in "Government control." Similarly, the States, in their licensing of practitioners and institutions, establish standards as a protection to the public, and have administered such provisions for many years, without controlling the practice of medicine or the operation of medical institutions.

When workmen's compensation was first introduced into the United States, the same arguments were used against it as are now used against the proposal to use social insurance to provide payment for medical care for the aged. 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. In the four States that provide cash benefits for the temporarily disabled, namely, New York, Rhode Island, New Jersey, and California, the same arguments were used but experience has indicated that such programs have not constituted any threat to the traditional American system of medical practice.

The same argument of socialized medicine was used in fighting the whole idea of Blue Cross and Blue Shield. Even voluntary prepayment plans were opposed by some of the same groups who now support them, and who now, in turn, oppose health insurance for the aged through social security.

Another argument used against the proposal is that social insurance is a financially unsound method of financing medical care for the aged and that the costs are unpredictable. The fact remains that we now know more than we have ever known about medical costs. Blue Cross and Blue Shield, group programs such as HIP in New York, industry and union plans, all provide us with wide experience as to cost.

It has also been said that it would be difficult to administer. I firmly believe that, with the tremendous ability the United States has shown in organizing governmental programs, we can effectively organize a program of medical care for the aged. Furthermore, all of you are aware of the fact that we have developed here in the United States one of the most efficient governmental programs through the Social Security Administration. We are confident that the administrative problems involved in such a program would be well and competently handled by the Social Security Administration.

It is our belief that a rich country such as ours must develop a more satisfactory method for providing medical care to its ever-growing number of aged citizens. In the distant past this was less feasible, 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 would otherwise 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. Your committee now has before it the opportunity to make a contribution to the solution of the financial aspects of these problems through social security. The proposals now before this committee utilize the machinery of social insurance which has proved successful and which has been administered soundly, efficiently, and economically in connection with old-age, survivors, and disability insurance. 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. We firmly believe that such a solution is sound from the standpoint of the medical profession, the patient, and the general community.

Senator SMATHERS. Thank you, Mr. Wedemeyer, for a fine statement. Your supplemental statement will be made a part of the record.

(The supplemental statement follows:)

SUPPLEMENTAL STATEMENT OF J. M. WEDEMEYER, DIRECTOR, STATE DEPARTMENT OF SOCIAL WELFARE, STATE OF CALIFORNIA, ON H.R. 11865

Gentlemen, the statement I have read represents the position and recommendation of the American Public Welfare Association, and local public welfare departments and of individuals engaged in public welfare administration. Its official policy position reflects the thinking of people whose experience qualifies them to assess the strengths and weakensses of the various methods of financing medical care for the aged. Their near-unanimous agreement is that social insurance—not assistance—should be the first line of defense against the financial consequences of serious illness in old age.

As welfare administrator of the most populous State in the Union, I take this opportunity to inform you why enactment of "medical care through social security" is so strongly urged upon you and what its effect would be on California.

As you know, Governor Brown gave strong support to the King-Anderson proposal as introduced and submitted testimony in its behalf at the House Ways and Means hearing on November 21 last year.

California has a traditional concern for its aged residents. Its old-age security program antedates the Social Security Act. It has implemented the medical care amendments to the Social Security Act, passed in 1956 and 1960, to the fullest extent its financial resources permitted.

In 1963 vendor payments for medical care for old-age assistance recipients totaled $39.5 million, and expeditures for medical assistance for the aged reached $66.7 million. This represents an average expenditure of nearly $400,000 each working day of the year.

Our program for old-age assistance recipients is primarily an outpatient care program. The $39.5 million expenditure was composed of $11.6 million to physicians, $11.2 million to pharmacies, $7.7 million to providers of ancillary and miscellaneous services, $4.7 million to dentists, $3 million for eye appliances, and $1.3 million for rehabilitation.

Our MAA program is primarily an inpatient care program to finance long-term care. The $66.7 million expenditure was composed of $30.7 million for care in public and private hospitals and $36 million for care in nursing homes, nearly all of them operated under proprietary auspices.

Although these costly programs place a heavy burden on State and local tax resources they do not afford prompt, continuous, and comprehensive health services for the needy aged. For example, for purely fiscal reasons we have not been able substantially to cover hospital care of less than 30 days' duration yet this accounts for the bulk of hospital care needed by the aged and may, in fact, have a major influence on needs for future prolonged hospitalization. Consequently our present program is estimated to help only 25 percent of the 145,000 Californians over age 65 with an income of less than $2,000 a year who require hospital care each year.

MAA, the 1960 compromise program, is not and can never be the answer to the problem of the aged. The cost of making MAA in California a comprehensive short- and long-term medical care program would bankrupt the State and county governments. If a prosperous, progressive, and conscientious State like California is in this position, it is no wonder that HEW reports continue to reflect little or no substantial improvement in the health care of the aged across the Nation as a result of MAA. Under both MAA and other forms of public assistance medical care there can be little basic assurance of even a common care program available throughout the country. Plans vary widely between States.

What is needed is a fiscally sound system of contributory social insurance through which our people, during the active working years of their lives, build an entitlement to care when needed in old age; a system which will promote self-reliance and respect for human dignity. Such a system available to all through the country would afford a form of common security now lacking and a core of basic care around which States could much more easily plan and develop such supplemental care as is required and within their respective means.

I am fully aware that such an insurance system, even supplemented by pri-

vate insurance resources, must have limits on the duration of benefits. It is after these benefits have expired that the MAA program can play a realistic and useful role in meeting the Nation's needs.

Incorporation of benefits under the social insurance program will disencumber State and local tax commitments to an extent that will enable States like California to build a comprehensive health care program, with the emphasis on preventive medical services which is now lacking in the majority of programs. It may enable the States to assume greater responsibility for the health care of those economically deprived persons who have not yet reached the magic chronologic age of 65.

As welfare administrator, I favor the proposal particularly for the reason that it will be a major component in the Nation's attack on the problem of poverty. There is no doubt that ill health breeds poverty, especially among the elderly, and that the opportunity of early diagnosis, prompt care and rehabilitative measures when indicated, will help break the vicious cycle of illness and poverty which saps our strength as a nation.

I realize that the proposal will cost money and that it must be financed through an increase in payroll taxes. But I am convinced that this is a small price that the working people of this country are willing to pay for basic security against the costs of health care in their retirement years and against having to ask for public aid after a lifetime of personal self-reliance.

With the possible exception of the few who see "socialism" in all human progress, the social insurance program has won overwhelming public support and is an integral part of American life today.

The people know that today three generations of middle-aged and older people have available to them a base of economic security under social security which, if absent, would result in massive personal suffering and economic catastrophe to individuals and the Nation as a whole.

I urge your committee to extend this same protection in the case of paying for health care costs as an act of social justice and respect long overdue for the older citizens of California and the Nation.

Senator SMATHERS. The committee will stand in recess until 3 o'clock this afternoon, when we are going to hear from Mr. H. Lewis Rietz, the Health Insurance Association of America.

(At the request of the chairman, the following are made a part of the record:)

STATEMENT OF JOHN P. MEDELMAN, M.D., PRESIDENT, MINNESOTA STATE MEDICAL ASSOCIATION, ST. PAUL, MINN.

THE MINNESOTA STATE MEDICAL ASSOCIATION'S POSITION ON FINANCING HEALTH CARE, EITHER OPTIONAL OR OTHERWISE, UNDER THE OASI PROGRAM

In 1959, and also in 1961, the physicians of Minnesota had an opportunity to present a statement to the House Ways and Means Committee on the Forand and King-Anderson bills. We appreciate this opportunity to communicate with the Senate Finance Committee in 1963, because conditions which might have appeared to justify such legislation have changed materially in a period of 2 years as more statistics have become available.

Four years ago, in our statement to your colleagues of the House, the Minnesota State Medical Association said: "In summary, the physicians of Minnesota are aware of the problems involved in providing health and medical care for our senior citizens. We are pledged to do everything possible to meet this challenge by implementing existing plans, and we wish to be permitted to carry out this pledge." You have given us the right to implement the "existing plans," and today thousands of persons over 65 years of age are reaping the benefits. Since July, nearly 38 percent of all the aged in Minnesota have come under our new comprehensive health care plan.

On August 4, 1961, Dr. J. Minott Stickney, an actively practicing Mayo Clinic physician, pointed out to the House committee that we in Minnesota had collected many "solid facts about our aging population." After enumerating much new data collected by the Minnesota Department of Public Welfare and other agencies, Dr. Stickney made this statement: "On the basis of the facts uncovered in Minnesota, the question arises as to the need for the King bill in Minnesota. We believe that these facts warrant the conclusion that the bill is not needed."

Since then we have assembled additional pertinent statistics from local hos-

pital studies, as well as from a comprehensive survey completed in late 1963 by the Community Health and Welfare Council of Hennepin County, Inc., the latter being a united fund agency.

We believe that the information contained in the Minnesota Department of Public Welfare study of 1960, augmented by recent studies and events in Minnesota, demonstrates conclusively that there is absolutely no need for any additional type of health care program in our State whether it be optional or otherwise.

Minnesota's aging population receive top care

New health care plans.—According to a survey done in 1960 by Dr. Marvin J. Taves, former professor of sociology at the University of Minnesota, 5 percent of the Minnesota people over age 65 said they had a medical need which was uncared for because it was too expensive.

Since July 1 of this year, no Minnesotan over 65 can make that statement. The legislature in Minnesota has now passed a comprehensive medical care program under the medical assistance to the aged portion of the Kerr-Mills bill which will take care of such needs. The State has had a full benefit old-age assistance program, in addition, for the past 15 years.

The MAA plan will provide the following benefits for 38 percent of all the senior citizens:

1. Inpatient hospital services.
2. Skilled nursing home services.
3. Physician's services.
4. Outpatient hospital or clinic services.
5. Home health care services.
6. Private duty nursing services.
7. Physical therapy and related services.
8. Dental services.
9. Laboratory and X-ray services.
10. The following, if prescribed by a licensed practitioner—drugs, eyeglasses, dentures, and prosthetic devices.
11. Diagnostic, screening, and preventive services.
12. Any other medical care or remedial care recognized under State law.

Over 140,800 of the 370,000 persons over 65 in Minnesota will receive $13,700,000 in additional health benefits each year. Those who qualify will be able to own and keep up to—

1. $15,000 in real property.
2. $1,800 annual income if single and $2,400 if married.
3. $750 liquid assets if single, and $1,000 if married. Not included are personal and household effects, prepaid burial plot, or cash surrender value of each person's life insurance up to $1,000. This latter provision may be waived by the county agency administering the plan.

The above-named benefits are available to the recipient after he has obligated himself to pay the first $200 of his health care bills in the preceding 12-month period. Health insurance premiums are included in the $200 deductible, and the insurance benefits are applied to the health care costs of the individual beneficiary before the remainder of his bill is paid by the administering agency. Again, the agency may waive the $200 deductible if it causes undue hardship on the recipient.

One now asks, How are the other 62 percent of the senior citizens going to pay for their care? We believe that guaranteed renewable private and nonprofit health insurance will take care of their needs.

Minnesota Blue Cross began selling two new health plans tailored exclusively for senior citizens over age 60 in January 1963. The first, known as series 60 plan A, is a $25 deductible program which pays $10 per day for room and board for 30 days every 6 months. The following hospital services are covered in full, less the deductible: operating room service, anesthesia when administered by a salaried employee, X-ray, clinical laboratory service, pathological laboratory service, electrocardiograms, physical therapy, oxygen therapy, dressing and plaster casts, drugs, biologicals, etc. The premium is $96 per year.

Plan B of the 60 series is a 75–25 coinsurance plan entitling the subscribed to 70 days of hospitalization every 6 months. All hospital services enumerated above are covered as well as daily room and board in a 2-or-more-bed room. Outpatient care is covered if the patient is admitted to the hospital within 24 hours after the accident. Nonacute care is covered if the patient enters such a facility within 72 hours after discharge from a confinement of at least 5 days or more in an acute hospital. The premium for this plan is $150 a year.

Minnesota Blue Cross has always provided coverage to all persons through group plans or individual contracts when enrollment occurred before the age of 60. Individual contracts are guaranteed renewable beyond the age of 60. A member of a group plan who reaches retirement age may elect to continue protection under the plan for a period of 3 months. The benefits of this coverage provide up to $15-a-day room rate for hospital care or an 80–20 coinsurance plan, depending on the amount of benefits he had in his group plan. At any time during the 3-month conversion period, the retiree may choose to continue to receive protection by subscribing to a new contract on a 80–20 coinsurance basis.

More than 65,000 Minnesotans are covered by the two 60 series plans, the 80–20 coinsurance plan, and the other conversion programs provided for group contract retirees. There are many more thousands over age 65 who are still working and covered by group contracts.

Other health care plans.—The basic senior citizens contract of Minnesota Blue Shield is in its fourth year of operation. It has had fine acceptance in the State.

Prior to the over-65 plan, Blue Shield subscribers converted their regular Blue Shield contract upon retirement to a nongroup contract. The cost was increased because the plan was of the nongroup type. Now a person who wants a noncancelable physician plan and did not have one before age 65, or a person who wants to convert his group plan upon retirement to a senior citizen contract may do so. Over 9,960 have subscribed to the senior citizen contract.

The doctors in Minnesota who service the Blue Shield's new senior citizen plan will provide physician services at no additional cost to all individuals age 65 and over whose income is $2,400 or less and couples whose income is less than $3,600 annually. An individual's net worth may be $20,000 or less and a couple's $30,000. If a senior citizen has more income or net worth than mentioned above, the physician can charge him over and above the benefits paid under the plan. The plan costs only $35.40 a year.

Blue Shield has a hospital expense rider plan for senior citizens, but few have taken advantage of it. It provides for 90 days of hospital room and board plus 60 days of nursing home care. The aged person may purchase a $10- or $15-a-day room and board plan and the nursing home benefits are $10 a day. The plan will pay for 80 percent of the total ancillary hospital costs. Premiums are $8.85 a month for the $10-a-day plan and $10.51 for the $15 one.

Hence, Blue Shield and its hospital rider plan can provide full-service physician benefits, as well as 90 days of hospital care and 60 days of nursing home care at $15 and $10 per day, respectively, for a premium of $170.40 a year.

Nearly 40,000 Minnesotans over 65 have a nongroup Blue Shield plan and many thousands more are covered by a group contract.

Private health insurance has continued to expand in Minnesota. There are 41 companies now writing guaranteed renewable policies for the aged. Nationally, 3 companies alone write policies for 2 million people over 65. In 1961, 9.3 million of the 17 million Americans over 65 had some form of health coverage.

The Taves senior citizens report noted in 1960 that 60 percent of the persons interviewed had hospital insurance and that in the metropolitan area where hospital costs are much higher, 71 percent had such coverage. Over 50 percent had medical and surgical coverage. It should be noted that this survey was done before the Blue Shield and Blue Cross plans mentioned above were available.

Minnesota's old-age assistance program is one of the best in the Nation. In the fiscal year ending June 30, 1963, $32,656,679 was spent on medical care for Minnesota's old-age assistance recipients. Hospital and physician costs continued to decrease while nursing home costs have increased. The reason for the decreasing hospital costs while nursing home costs went up lies in the fact that more nursing home beds are now available to care for patients who do not need intensive hospital care. Actually, nursing home costs increased by $5.3 million over the previous year, and a major factor was the release of many of the State's institutionalized patients to nursing home care. Often these persons are senile but do not belong in the State mental hospitals where they have been under custodial care for many years.

Old-age assistance recipients in Minnesota receive comprehensive benefits and have free choice of vendor. In 1963, the average monthly caseload was 43,139 persons over age 65 receiving aid under this program. Almost 61 percent receive medical care at some time during the year, and 59.1 percent of the total money spent for old-age assistance will be for health care.

The OAA health care dollar was divided as follows, as of June 30, 1963:

	Cents
Licensed nursing home care	49.3
Acute hospital care	25.3
Drugs and medical supplies	9.8
Physicians' and surgeons' services	6.7
Hospital care for chronic diseases	4.5
Others	4.4
Dental care	.6
Special diet	.9
Health insurance premiums	.7
Optical care	.5
Ambulances	.3
Appliances	.4
Visiting nurse	.2
Others	.8

Hence, in Minnesota, the senior citizen can purchase excellent health care coverage at nominal rates, and those who cannot afford such rates can receive comprehensive care under the old-age assistance or the new Minnesota medical assistance to the aged programs.

The wealth of the Minnesota senior citizen

The 1960 Taves sudy pointed out that over half of the persons interviewed had a net worth of $10,000 or more. Forty-nine percent stated they had enough income to live on comfortably; 35 percent had enough for subsistence only; and 16 percent did not have a living income. Under the Minnesota assistance to the aged plan, 38 percent can receive complete health care.

In a late 1963 population report of the U.S. Department of Commerce, Bureau of Census, it is pointed out that 91.8 percent of the families whose head was 65 or over had an income of over $1,000. In fact 27.7 percent had incomes over $5,000. The median income of these families was $3,382 annually.

The November 1960 Monthly Labor Review stated that an adequate budget for a retired couple in Minneapolis in the autumn of 1959 was $3,135. This would indicate that aged Minnesotans who receive the national median income of $3,382 would have more than enough to live on. Included in the retired couple's budget mentioned above was $315 for health expenses. The Hennepin County Welfare Department figures a minimum budget is $1,854 annually for a couple.

In the Taves report, it was pointed out that 25 percent of the persons interviewed had spent up to $49 that year for health needs, 59 percent less than $200 and only 5 percent paid over $500 for such care. It is interetsing to note that while some persons stated they needed care and that the care was too expensive for them, many did not know that free care was available to them. The survey pointed out that 45 percent of the aged did not know that the public health nurse was available to help them. About 34 percent said that they never, rarely, or seldom used the public health nurse in their communities.

After reviewing these statistics in Minnesota, we can conclude that the average aged citizen does have enough to live on; his health bills are reasonable; he does have health care facilities available for him to use, but he does not know about them. In most cases his home is paid for, his children are grown, and his living costs are about $3,000 a year.

How do Minnesotans pay for hospital bills

A study has been made over the last 4 years of hospitalized patients in a rural Minnesota hospital. This hospital has 41 beds and 10 bassinets. Of the total admissions during the 4 years, 17.3 percent were over 65 years old and of that group, 16.2 percent were admitted for surgical operations and 83.8 percent for medical conditions.

Over three-quarters of the patients over 65 paid their bills from private resources, including insurance payments, and less than one-fourth of the bills were paid by government programs. Each year the number of persons who had all or part of their hospital bill paid by insurance has increased. In 1960, 33 percent of the aged had insurance coverage. By 1961, the percentage increased to 40 percent, in 1962 it was 47 percent and by 1963 over 54 percent had coverage.

During the 4-year period, 88.8 percent of all persons hospitalized over 65 received bills that under under $500 and only 4 percent spent over $1,000.

The most important point in this study, as it relates to financing health care under the social security system, is that by February 15 of each ensuing year year only 2.9 percent or 39 people had not paid their hospital bills in full. Just a little over 1.1 percent or 15 people in the group had not made any payment at all on the account.

Another study was completed in late 1963 in the Minneapolis-St. Paul hospitals. This study showed that the average length of stay in the hospital was 7.9 days, the average bill per stay was $338.71, and the average bill charged per patient day was $42.84. The report noted that age, sex, locality, day of the week, etc., had an effect on the average length of stay.

Persons over 65 showed an average length of stay of 11.2–14 days. This is more than the overall average noted above. It was interesting to see that the longer the stay, the less the per day cost. The person who stays 14 days had an average per day cost of $39.56. The study further noted that "those over 65 are most significantly different in degree (from other age groups), but not so much in kind." The report stated that after age 30, the average bill charge per stay increased with age but at a nearly constantly decreasing rate.

The Twin City hospital study pointed to the fact that older people pay their hospital bills faster than any other age group. The study, which included 11,029 discharges from the 25 short-term general hospitals, was a 5-percent probability sample. "Grandma and grandpa—at whatever age 50 and above you choose—are the lowest nonpayers of their bills in both percentage by number and percentage by amount," the reports stated.

The age group of 20 to 29 accounted for the largest group of persons who did not pay their hospital bills. Over 6.71 percent of old billed charges from this group remained unpaid at least 6 months after discharge. In addition, their average bill is one of the lowest for any age group.

The Hennepin County Community Council's 1963 survey revealed that in a 60-day period, 17 percent of new admissions for all clinic services at the Minneapolis General Hospital were for persons 65 years and over. This would indicate that over 80 percent of the charity and emergency cases in Hennepin County involve younger persons.

All these studies show clearly that senior citizens in Minnesota can and do pay their hospital bills. Two of the studies indicate that younger couples seem to have a more difficult time paying these bills. Yet under the social security method to finance health care, the Government will tax the young couple and provide "free" health service to the aged. It is obvious that most older people do have the means to care for themselves and they want to do so.

Comparing the Minnesota medical assistance law with the King-Anderson bill, one of the suggested methods of financing health care under social security

1. *Who would be covered?*—Under the Minnesota medical assistance to the aged program, 140,800 persons over 65 will receive comprehensive health services. The King-Anderson bill will provide institutional health benefits to 370,000 or nearly all of Minnesota's aged.

2. *What benefits would the people receive?*—We have already noted that benefits under the Minnesota medical assistance to the aged program would be comprehensive. As the committee knows the King-Anderson benefits would constitute partial institutional care, plus some home health services and outpatient diagnostic services.

In other words, after a small deductible. the King-Anderson benefits provide for the first 45, 90, or 180 days of hospital care in a benefit period. What happens to the patient who has an acute condition and uses up the 45, 90, or 180 days? If he doesn't have the money to pay for the health care, he must seek public relief.

The Minnesota medical assistance to the aged plan asks the recipient to pay the first $200 of health care in any 12-month period if he has it and after that, all remaining health care is paid in full. If he does not have the $200, he can still have full health care coverage. This is set up as a "catastrophic" plan, because this is the type of health care insurance the aged need. Unless indigent, most persons over 65 can pay the first $200, but many cannot pay the next $200, $400, or $600 for their care.

The Hennepin County study showed that "Persons over 65 can expect an incidence of illness of 1.6 acute conditions per person per year, as compared with an incidence of 2.2 acute conditions per person per year among people 25 to 44. In the area of chronic or long-term illness, however, only 22 percent of those over 65 are entirely free from chronic health conditions, as compared

with 30 percent of the total population under 65 in the United States." This again points up the need for long-term protection for the aged, not merely 45 days or 90 days of hospital care.

The Hennepin County study also revealed the fact that persons over 65 do not get proper dental care. According to this report, "studies (in Kansas and several other States) show that 15 percent require no treatment, 25 percent are not treatable, and 60 percent are treatable and in need of dental care. Ninety percent of those who are treatable have pyorrhea. One out of three need dentures. A total of 67 percent of those over 75 have no natural teeth."

The King-Anderson bill does not help persons over 65 to secure dental care. On the other hand, the Minnesota medical assistance plan provides complete dental care after the $200 deductible for all health care. Hence we must point out that the Minnesota assistance to the aged bill will do the best job in caring for the health needs of the people over 65.

3. *Is it necessary to provide some health care to all the aged in Minnesota?*—We noted earlier that only 5 percent of the Minnesota aged stated they needed health care and did not have it because they could not pay for it. We also noted that 49 percent of the people said they had enough money on which to live comfortably and over 50 percent had $10,000 net worth or more. The people of Minnesota are already providing complete health care to 38 percent of the aged population. We know that another 21 percent are covered by Blue Cross and Blue Shield, and that more than 50 percent of the aged in Minnesota can afford to buy health insurance because they have done so. The doctors of Minnesota feel that most of Minnesota's aged population can afford to buy insurance or they have already bought insurance and can use it to pay for their health care. It has been pointed out earlier and should be pointed out again, that most senior citizens want to be independent, they want to choose their own doctor, their own hospital, their own nursing home, and they want to pay their own bills.

4. *What Government controls are placed on the doctor under both plans?*—Under the King-Anderson bill, the Secretary of Health, Education, and Welfare or his assistants, sitting in Washington, D.C., or at regional offices, will administer the plan. In many cases they will not know the differences that exist in health care practices from county to county and State to State.

The individual doctor will be in constant jeopardy because the hospital utilization committee can force him to move his patient whether or not he feels it is in the best interest of the patient. If the hospital in which the doctor practices does not sign an agreement with the Government, the doctor cannot take his aged patients to that hospital unless the patient abrogates his right for "free" care in order to choose his own physician. The doctor cannot prescribe a new drug and have it paid for unless it is found in one of the four drug encyclopedias or approved by the local drug committee.

Because of the amount of Government interference, the intimate relationship of doctor and patient could completely disappear.

The Minnesota medical assistance to the aged plan is administered by the county welfare departments. Each patient is free to choose any doctor, hospital, or nursing home. The physicians, through the medical society, have agreed to service the Minnesota plan at Blue Shield plan A rates. Each local medical society has established a committee to review any questionable charges for the local welfare department, and the physicians have agreed to this procedure. The same type of structure has been established for the dentists and pharmacists, but hospitals and nursing homes receive full payment for their services. The doctor is free to treat the patient without Government interference.

5. *Where will we find the personnel to care for all of the people who are sure to take advantage of "free care"?*—One of the problems that would confront this country immediately if 17 million persons over 65 demanded their "right" for "free" health care would involve lack of the personnel to care for them. The Hennepin County study noted that, "A shortage of professionally trained people in the medical and paramedical fields, including social services and research, still remains as bottlenecks for the development of expanding health services in Minnesota and in Hennepin County." The Minnesota Commission on Patient Care, an organization concerned with the lack of qualified professional health personnel, made a survey of the problem in 1960. According to the commission, the results of this study were as follows: "(The number following the listings by fields represents the professional persons that could be immediately employed if qualified and available.) Nurse anesthetists, 40; dietitians, 37; trained medical record librarians, 28; medical technicians, 119 registered and 57 trained laboratory assistants; physical therapists, 55. This shortage of professional

persons in these positions cut down the capacities of respective hospitals and nursing homes in extending care to the aged and the chronically ill." The study did not cover the physician; medical social workers; registered, licensed, practical, and public health nurses.

6. *What are the costs of the two plans?*—In Minnesota we provide complete health care to 140,800 persons over 65. About 43,000 are old age assistance recipients and the rest come under the Minnesota medical assistance to the aged plan. Hence, 98,700 new persons can now receive complete health care over and above those on OAA. The additional cost for providing complete care for 98,700 aged Minnesotans under the MAA plan would be estimated at $13,700,000 a year. Of this amount, Minnesotans will pay about $2 million a year, plus Minnesota's percentage of the $11.7 million which will come from Federal funds. One-fiftieth of $11.7 million is $234,000. We realize that $234,000 is only an estimate, but it is safe to predict that the total cost would be about $2,234,000 a year in new taxes. On the other hand, we know that the people of Minnesota will pay at least $19,180,000 in additional social security taxes each year for the King-Anderson bill. In 1962, 1.4 million people in Minnesota paid social security taxes. The average annual wage on which the social security tax was levied was $2,740. To finance the King-Anderson plan, social security taxes would be raised one-fourth of 1 percent on the employer and one-fourth of 1 percent on the employee or one-half of 1 percent overall. One-half of 1 percent of $2,740 is $13.70, the average tax increase per individual. Multiply this figure by the 1.4 million who pay this average tax increase, and $19,180,000 is what Minnesotans will pay to the Federal Government for partial institutional care for all persons over 65, whether or not they can pay for their own care. It should also be noted that the Federal Government, in so doing, is taking another $19.18 million out of Minnesota's disposable income.

Hence, in Minnesota we can give complete care to 98,700 persons who may need health care for $2,234,000, and continue to provide complete care to OAA recipients which number 43,000 persons, or we can give partial health services to 370,000 people, many of whom can pay for their own health care for $19,180,000 under the King-Anderson plan.

No need.—In view of the factual material presented in this testimony, it is abundantly clear that there is no need for the King-Anderson program in Minnesota. The physicians, with the help of God, have created the problem of care for the aged; and the physicians working with others, but without the help of the King-Anderson-type legislation, will solve the problem. We feel that all persons in Minnesota over 65 have the finest health care available, and they will not need to be impoverished to get such care. The doctors in our State feel that this is the way it should be. Older people should not be made class 1, class 2, or class 3 citizens. They should be able to keep some resources, and yet when they need health care, they should be able to get all of the care they need. All studies point to the fact that those who can afford health insurance are buying it. Nearly everybody wants to be self sufficient. They do not want the Government deciding whether or not they have stayed in the hospital too long. The fact is, our programs are so good in Minnesota that we do not want the Federal Government to come in and take more of our tax dollars to give us less service than we now receive.

Physicians continue to strive for outstanding health care for the aged

We are all proud of the health services available to the aged in Minnesota, but we physicians will nevertheless continue to lend our energies toward making the United States a healthy place for all the aged. We pledge our dedication to the following program:

1. The Minnesota State Medical Association's statewide advisory committee will cooperate fully with the Minnesota Department of Welfare to perfect the MAA plan and to strengthen the State's unlimited medical care program for OAA recipients.

2. The physician members on the Governor's citizens council on aging will continue their work on behalf of the aged. Physicians have been participating in many of the local community councils this past year. They will continue to share in this project as well as to cooperate at State and regional meetings.

3. As noted earlier, many senile patients have been released from State hospitals and returned to nursing homes when new beds were made available. We will help in furthering this project.

4. For years now, our association has been actively engaged in recruiting men for medicine, as well as helping the allied professions find people for their own paramedical fields. The shortage of professional personnel is one of the greatest problems facing those who are responsible for health care of the aged and others

who are ill, as well. Physicians talk regularly to many high school students at career festivals and elsewhere, urging them to consider the health careers. To encourage students who are interested in medicine as a career, we offer scholarships and long- and short-term loans.

5. We have set up a joint labor, management, hospital, and physician committee to try to control the cost of medical care plans. Also we have adopted and published a relative value study which has been made available to insurance companies, as well as the doctors in Minnesota.

6. Physicians who serve on the association's committees such as cancer, diabetes, heart diseases, etc., continue to devote their time and research to helping the aged.

7. We are proud of our record of improving the health facilities in our State. In the last few months, the Hill-Burton advisory committee which is largely staffed by association personnel has approved funds for another metropolitan hospital for Minneapolis. During the past 2 years, we have reached 93 percent of the ideal number of first-rate general hospital beds in our State.

SUMMARY

The truth is, as we have noted before, that we physicians helped to create the problems of the aged, and we feel we can help to eliminate them. Our sole interest lies in helping our aged patients to receive the best possible medical care.

We firmly believe that the numerous controls placed on the physician, the contracts that must be signed by the hospitals, the qualifications that nursing homes have to meet, the limited benefits of the program, and the fact that the King-Anderson-type legislation is not flexible enough for the needs of the aged, will all work to the detriment of our patients, our own mothers and fathers, and our grandparents.

We are confident that we will have no problems in Minnesota. All of our aged are able to pay their health care bills through use of the MAA program, their private resources, or by the private insurance companies. We know that this is the way people want it. Elderly people are not looking for "something for nothing." They have said it time and time again. They want to pay for their care if they can. If they cannot pay, then we in Minnesota feel that complete care must be provided for them, for as long as they need it. No one will ever again be forced into indigency because of health care bills in our State. The State of Minnesota has taken care of this responsibility to our aged population.

When a patient is sick, he sees a doctor. The doctor gives the patient a complete physical examination. Sometimes X-rays are taken, or sometimes he is subjected to special tests. Then the doctor collects the results, analyzes them, and then decides what he should do to help the patient. This is exactly what we have done with respect to the problem of health care for the aging. In the course of the last 4 years, we have analyzed the problem and arrived at a solution.

The doctor does not perform a surgical operation when it is not necessary. We feel that the Government should not pass any type of health care legislation, which is tied to social security, when it is not necessary either.

Two years ago, in our testimony to the House Ways and Means Committee, we pointed out that modern rehabilitation of the disabled and the aged called for self-help and self-discipline programs. These programs were set up to help the disabled or aged person to regain his self confidence, to learn to work again, talk again, and to maintain his own independence and self regard.

The same principles applies to health programs. The aged do not want to be given health care for nothing. If possible, they want to help themselves. Our program in Minnesota does not help the aged person to help himself. We feel that this type of program must be fostered and that the King-Anderson approach is unnecessary. We continue to be unalterably opposed to any method of financing health care which is tied to the social security program, and we will use all of our resources to develop our Minnesota plan for giving full assistance to those who need help, and for helping all other to help themselves.

TESTIMONY ON THE KING-ANDERSON BILL FOR THE SENATE FINANCE COMMITTEE BY THE MEDICAL SOCIETY OF VIRGINIA

The Medical Society of Virginia, with 3,200 members, is the largest and most representative medical society in the State. It is one of the oldest medical

societies in the Nation—having been founded in 1820. While it has grown with Virginia and the Nation, its purposes have remained unchanged over the years; namely, the promotion of the science and art of medicine, protection of public health, and the betterment of the medical profession.

While the Medical Society of Virginia is essentially a physicians' organization, it has established a long and enviable record of public service. It has made its voice heard in the areas of medical service, voluntary health insurance for all age groups, public health and welfare, medical education, mental health, and so on down the line.

As far as services to its members are concerned, it has provided active leadership in matters pertaining to postgraduate education, State and national legislation, public relations, mediation, professional liability and other insurance programs, ethics, etc.

Concern for the health care of our aging population is certainly nothing new for the Medical Society of Virginia. As a matter of fact, the society played a leading role in obtaining the enactment of legislation which established Virginia's State-local hospitalization program in 1946. This program is still unique in that it assists the State's medically indigent to obtain hospital and medical care without turning to the Federal Government. The program is a cooperative one—stressing and placing responsibility where it truly belongs—at the local and State levels. The program assists the needy sick of all ages—not just those over 65. Virginia, and the Medical Society of Virginia concurs, believes that the needy young must be helped just as much as the needy aged. Illness and adversity know no special targets. Regardless of the fact that our State-local hospitalization program has operated with little, if any, fanfare or publicity, its splendid record is available for all to see.

The Medical Society of Virginia took a strong stand in support of the Kerr-Mills law in 1960 and feels that its faith in that legislation has been more than justified. Virginia has participated in the old-age assistance (OAA) portion of the law since its inception, and implemented the medical assistance to the aged (MAA) portion on January 1, 1964. The delay in implementing the MAA portion of Kerr-Mills can readily be explained by the fact that Virginia's General Assembly meets every 2 years and it was not possible to enact enabling legislation until the 1962 session. It is to the credit of Virginia's lawmakers that, even in a period of unusually heavy budgetary demands and problems, they made available those State funds necessary for a first-rate program. The State appropriation is based upon an estimated need of $3½ million per year.

In 1959, The House of Delegates of the Medical Society of Virginia called upon Virginia physicians to continue their policy of providing medical service regardless of ability to pay, and, especially in the aged group, to recognize the importance of providing services at the lowest possible cost. The House also asked all carriers to develop and bring forth new plans designed especially for those over 65. Members were requested to accept reduced fees under any such special plans offered by Blue Cross-Blue Shield and the commercial companies.

As the result of that request, the Virginia Hospital Service Association (Blue Cross) and Virginia Medical Service Association (Blue Shield) developed special senior citizen contracts. These contracts, now available at any time during the year to our older citizens, have been found most attractive—over 1,000 already issued. It is also good to note that commercial insurance companies are writing special contracts for the older age group, and an industrywide "over 65" plan is now a reality. The plan is similar to those developed in Connecticut and elsewhere.

One of the society's most active committees has been that concerned with the aging and chronically ill. It was through this committee that the society, in 1960, took the lead in organizing the Virginia Joint Council to Improve the Health Care of the Aged. This council welds the Medical Society of Virginia, Virginia Dental Association, Virginia Hospital Association, and Virginia Nursing Home Association into a coordinated unit—working to find the answers to mutual problems.

Virginia physicians are greatly concerned over the conflicting estimates of what a health care program financed through the social security mechanism would cost. The administration has placed first year cost at $1.1 billion. This figure, according to insurance actuaries, is much too low. There are many who predict that the cost would be at least twice that much. They also say that by 1983, the cost will be $5.4 billion—an increase of more than 500 percent.

Should these dire predictions be true, then it would appear that our social security system is in serious danger of being completely swamped.

It is difficult to say just how Virginia's already overburdened taxpayers would stand up under such increased loads. Should King-Anderson legislation be enacted, an additional 15 to 17 million social security tax dollars would be taken from our Virginia taxpayers and mandatorily assigned to a specific area of governmental activity.

In summation then, the Medical Society of Virginia is unalterably opposed to the King-Anderson bill, and clings strongly to the principle that the finest health care available should be provided those who need help, but no bureaucratic program of unpredictable cost should be established for those who are perfectly able and willing to take care of their needs.

[From the Virginia Council on Health and Medical Care—Special Report No. 8, October 1963]

THE STATE-LOCAL HOSPITALIZATION PROGRAM

What it is.
When it developed.
Why it developed.
What it does—Who is helped.
Who participates in it.
Administrative problems.
Why it needs expanding.
Some facts and figures.
Why it is important to all Virginians.

What is the SLH program?

The State-local hospitalization program is a statewide plan to provide inpatient hospital care and treatment for medically indigent residents of Virginia. Funds appropriated by the general assembly are made available to match local money on a 50–50 basis, as long as funds appropriated by the State last.

The SLH program is administered locally under limited State supervision. It is based on a law which permits counties and cities to decide the extent of their participation. It is a local option law. All counties except two, Amelia and Powhatan, and all cities except one, Hopewell, participate in the SLH program. Almost all counties and cities have participated in the program since it started.

Each locality determines who is eligible for hospitalization at public expense on the basis of its own definition of "indigency" and "medical indigency."

Local responsibility for operating the SLH program rests with governing body which can designate any person or agency to administer it as their authorizing agent.

The choice of hospitals to be used by a locality is left up to the locality. It negotiates an agreement with hospitals for care on the basis of an all-inclusive per diem rate. The law requires that the State department of welfare and institutions give its final approval to these agreements.

No Federal funds are involved in the SLH program.

When was the SLH program developed?

The general assembly established the State-local hospitalization program in 1946. This came following a study made by a commission set up by Joint Resolution No. 8 at the special session of the general assembly in 1945. The commission was created "* * * to make a thorough study of the facilities now offered by the State of Virginia for the hospitalization of indigent people. It shall give careful consideration to the amounts now being appropriated to the hospitals of the University of Virginia and the Medical College of Virginia for the care of indigent patients, and determine if more efficient service could be rendered by making available to the political subdivisions of the State a sum sufficient to care for their indigent citizens."

Why did the SLH program develop?

Some findings of the legislative commission:

1. There was no coordinated plan in the Commonwealth for the hospitalization of medically indigent persons.

2. With rising hospital costs, persons of modest means were either being denied needed hospitalization or hospitals which accepted these persons as patients were facing serious financial losses with the possibility of their closing.

3. A large number of people needed hospitalization but were financially unable to provide it for themselves.
4. Providing adequate hospital care for medically indigent persons is the joint responsibility of the State and localities.
5. Hospital facilities which were available were not evenly distributed or equally accessible to all counties and cities.
6. No State agency was charged with the responsibility or had the authority to provide hospitalization for the indigent.
7. Eligibility and admission requirements to hospitals were not uniform. It was found difficult to have an indigent person admitted to a hospital, "* * * and frequently patients are sent a long distance to a hospital only to find that they cannot be admitted."
8. There was a great difference in the ability and willingness of local governing bodies to provide hospitalization for those unable to do so for themselves.
9. There was no uniform rate paid to hospitals by localities for their medically indigent.

These and other facts pointed clearly to the need for a uniform law for the hospitalization of medically indigent persons, a law which would be made available, on a local option basis, to all counties and cities.

What does the SLH program do—who is helped?

The State-local hospitalization program makes hospital care possible to those of limited income who otherwise might not be able to obtain it. Persons who are certified as eligible to have their hospitalization paid for from public funds are admitted as ward patients. Whatever medical or surgical care is needed for SLH patients is provided without charge by physicians and surgeons who are members of the medical staff of the hospital.

By reimbursing hospitals for care of the indigent, the SLH program is helping hospitals meet the staggering financial burden of caring for these persons, so that the cost of this care is not passed on to the private patients.

The SLH program is helping to protect and maintain the health of the citizens of the Commonwealth by encouraging and assisting counties and cities to take care of those of their citizens who require hospitalization, but are not able to assume this responsibility themselves. It is also helping to provide financial stability for Virginia hospitals.

The SLH program is a factor in keeping people off welfare rolls by making hospitalization available to them for corrective procedures. This restores many workers to gainful employment as taxpaying citizens.

Who participates in the SLH program?

Over 130 general hospitals in Virginia and bordering States participate in the State-local hospitalization program. Counties and cities may negotiate contracts with any general hospital that is willing to accept medically indigent patients in accordance with the provisions of the law. These agreements are negotiated between localities and hospitals on the basis of a flat, all-inclusive, per diem cost.

Of the 97 counties, 95 participate in the SLH program. Of the 32 cities, 31 participate.

As of July 1, 1963, a maximum per diem rate of $27.32, excluding depreciation, was established to reimburse hospitals. In most instances this is "acceptable" to hospitals, but in many cases it does not cover the hospitals' operating expenses which averaged $29.36 per patient-day in 1962.

Administrative problems in the SLH program

The law under which the State-local hospitalization program was established is one of the most progressive pieces of legislation of its kind anywhere. However, there are some problems which handicap the program, and which hinder it from functioning as effectively as it should. The following are some of the problems.

1. A lack of local matching money provided by some areas.
2. Insufficient State matching money.
3. Poor communicating between authorizing agents and hospitals.
4. Local policies which exclude certain types of cases.
5. A lack of uniformity in interpreting the SLH law.
6. A lack of uniform criteria for eligibility.
7. Difficulty in verifying eligibility—socioeconomic information.
8. Unwillingness on the part of some local governing bodies to recognize their responsibilities as they relate to their indigent residents and the SLH program.

Why must the SLH program be expanded?

There is still a wide gap between the cost of care borne by the hospitals and the amount they receive as reimbursement. During 1962 it is estimated that Virginia hospitals lost a total of $10 million taking care of indigent persons for which they were not paid.

When State or local funds are exhausted before the end of a fiscal period, hospitals frequently must admit emergency patients for which they will not be paid. This leaves hospitals no recourse but to pass some of this cost along to private patients.

Before the close of the fiscal period ending June 30, 1963, 42 counties and 23 cities used all or had exceeded their 50-50 matching money.

During the fiscal year which ended June 30, 1963, the State was only able to match $966,000 of its 50-percent share of $1,226,450. In other words, the State appropriation should have been $260,450 more to have fully matched the eligible local expenditures.

A growing population requires that the SLH program be expanded through the appropriation of more State and local matching money in order to keep pace with the growth and development of Virginia.

If Virginia is to meet the needs of its medically indigent persons, and help keep its general hospitals from financial disaster, more matching money, both from State and local sources, must be made available.

Some facts and figures on SLH

During the 17 years of the SLH program, over 170,000 medically indigent Virginia citizens have been provided with care and treatment in over 200 general hospitals throughout the Commonwealth and bordering States at a total cost of $27 million. Of this amount the State has appropriated $11,700,000 and localities $15,300,000.

Physicians have given of their time, knowledge, and skills to perform 55,000 surgical operations, have cared for 90,000 medical, 16,000 obstetrical, and 9,000 diagnostic cases. It is estimated that the collective value of these services donated by physicians totals at least $17 million.

During the fiscal year ended June 30, 1963, 10,923 persons were hospitalized under the SLH program costing a total of $2,699,661. During the same period Virginia hospitals lost approximately $10 million absorbing the cost of caring for the medically indigent for which they were not paid.

Why the SLH program is important to all Virginians

Adequate payments for indigent hospitalization are essential to guarantee high standards and good quality of care for all citizens in hospitals throughout Virginia. The SLH program is important to the survival of general hospitals in every part of the State. Without the SLH program the cost of hospitalizing the medically indigent could place hospital care beyond the reach of the average citizen.

If Virginia fails to meet its obligation to its indigent citizens through a sound, locally administered program which has the enthusiastic support of the Medical Society of Virginia, the State department of welfare and institutions, the Virginia Council on Health and Medical Care, the Virginia Hospital Association, and many other groups, then Virginia leaves the door open for a flood of federally financed, federally administered, and federally controlled programs, foreign to its own philosophy of States rights and free enterprise.

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STATEMENT OF THE ILLINOIS STATE MEDICAL SOCIETY REGARDING THE ADMINISTRATION'S PROPOSAL INVOLVING MEDICAL-HOSPITAL CARE FOR THE ELDERLY

The Illinois State Medical Society, founded more than 125 years ago, is comprised of over 10,000 physician members. Its main purposes are to promote the science and art of medicine; to elevate the standards of medical education; and to protect the public health. In its effort to maintain the highest standards and quality of medical care this country has ever known, the Illinois State Medical Society opposes medical care coverage under social security now being discussed before your committee.

Such legislation would result in poorer and less satisfactory health care. Specifically, it represents the beginning of socialized medicine; it would provide medical care to an entire segment of the population regardless of need; its compulsory features would augment the coercive power and influence of the Government over private citizens; it violates the basic concept of OASI by providing services rather than cash benefits; and regulations affecting the quantity and quality of service rendered would be determined in Washington. A centralized Federal program of financing medical care under social security is unnecessary. Existing voluntary and local governmental programs are meeting the need.

POLICY ON CARE OF THE AGING

The Illinois State Medical Society has demonstrated its concern for the health care of the aging by conducting a very active program on the aging. The society has maintained an active committee on aging for many years. Our activities, interest, and concern are largely summarized in the 12-point policy statement issued January 1961 appended to this report.

In it, the society reaffirms its position that no patient, aged or otherwise, need go without medical services because of inability to pay. Further, that it is striving to improve medical and related facilities and services for the aging through various means of communication.

The latest developments of the society's public information program include television, newspaper, and radio series pertaining to health care, which are informative not only to the public in general, but to the aging in particular.

In cooperation with the Illinois Department of Public Health, the society coordinated the emergency medical self-selp training course which was televised each week and had over 10,000 individuals enrolled of the estimated 200,000 viewers.

Our monthly scientific medical journal has contained articles on such vital topics as "Kerr-Mills in Illinois" and health insurance plans for the over 65.

The society has been highly commended by governmental and private agencies for its postgraduate programs on the rehabilitation of the stroke patient carried out under the direction of the society's committee on aging. Demand for the program was so great, the society produced a film entitled, "Stroke—Early Restorative Measures in Your Hospital" in cooperation with the department of public health. Copies have been purchased by government agencies, scientific organizations, medical libraries, departments of public health, and hospitals.

COMMUNITY HEALTH ACTIVITIES

The society works with numerous community groups in developing services and facilities on behalf of the aging population. Many community groups in the State have stepped up their activities in the health and hospital fields, particularly with respect to the aging. One specific example is a project at Hopedale, Ill., involving a residence for elderly people, known as Hopedale House. This has been added to the Hopedale complex of medical facilities formerly consisting of a hospital and nursing home. The project was financed on a voluntary basis through the sale of bonds to residents of Hopedale and nearby communities. This is an excellent example of what can be done for the aging without tax support.

There also are seven organized home care programs in Illinois. Three of the four programs in Cook County and one of the three downstate programs are operated by nonprofit community hospitals. Two of the downstate programs are operated by nonprofit groups through voluntary community financing. These programs enable many of the aged to receive needed medical services in their homes without expensive bureaucratic organization and without the need for hospitalization. The Illinois State Medical Society's Committee on Aging continues to encourage and sponsor the development of more organized home care programs. Such voluntary community effort would be impeded by the Government's willingness to institutionalize patients under arbitrary rules and regulations promulgated in Washington, without regard for patient requirements and community needs.

Countywide home nursing service has been jointly developed by the local health department and the Visiting Nurses' Association in three Illinois areas. These efforts are good examples of how voluntary effort can be supplemented by local government to provide health services when the local community cannot do the whole job. Visiting nurses' services are available in many counties in

Illinois and are financed by voluntary effort. In most cases this is done through the United Fund. Cooperative action of this sort, at tremendous tax savings to individuals, is possible under a voluntary system as we know it today.

Incentive to continue and expand such activities would be reduced, if not destroyed, to the detriment of the public if Government medicine came into existence through the enactment of pending legislation.

SUPPORT HEALTH INSURANCE FOR AGING

We continue to work actively with the private health insurance industry to improve coverage in all possible ways for those over 65.

A special medical plan for the aged was developed by Illinois Blue Shield in 1959. The Blue Shield "Over 65 Plan" was broadened and remarketed in October 1962. Membership rose to a new high. The addition of new subscribers now gives Blue Shield in Illinois a total membership of 225,000 aged individuals. The fact that over 7,000 Illinois physicians have signed the Blue Shield participating physician's agreement to accept reduced fees as payment in full for services rendered to beneficiaries, once again indicates that our system of voluntary health care is responding with vigor to meet the needs of the over 65.

The health insurance industry, supported by organized medicine, has shown remarkable progress particularly in covering those over 65 who need and want such coverage. In fact, the proportion of the aged in this country with health insurance has more than doubled since 1952. In terms of absolute numbers, the 26 percent insured in 1952 represented only slightly over 3 million individuals whereas more than 10 million or 60 percent of the over 65 are covered today.

STATUS OF ILLINOIS AGING

The University of Illinois, in 1961, conducted a survey of the aged in Decatur. The results indicated that 68 percent of the over 65 had health insurance. Of those not covered, 13 percent indicated that they did not want to be. And 96 percent reported no unmet physicians' needs due to financial reasons.

Of the 995,000 individuals in Illinois over 65, it is estimated that 225,000 are employed or are the wives of employed persons; an estimated 100,000 receive veterans' and other types of Government pensions such as railroad retirement or civil service; 109,000 are estimated to be receiving private pensions or annuities; and 50 percent are estimated to have some income from assets in the form of interest dividends and rent. Estimates are based on official U.S. Government data. About 558,000 are recipients of OASI; 62,000—only 6.3 percent—receive old-age assistance benefits—a percentage significantly below the national average of 12.9 percent. The University of Illinois study of senior citizens indicated their median income to be about $4,000 per year; the 1960 census indicated their income to be over $3,700—more than a twofold increase since the 1950 census.

Approximately 12,000 older citizens in Illinois are inmates of the 12 Illinois mental institutions; others are inmates of prisons and State and Federal institutions where they receive their medical care from the government. An undetermined number receive medical care from the Veterans' Administration medical care programs for retired military personnel and their dependents; some are in homes for the aged financed by religious organizations, fraternal orders, and other groups where medical care is provided.

These data support the position that a large percentage of the aged in Illinois are able to provide for their medical care and that their economic position points to a constantly improving situation. Yet, the pending legislation postulates a future where all changes in the economic status of the aged are adverse.

Such legislation, if enacted, would result in needless waste and inhibit the future progress of voluntary organizations operating in a free society. Furthermore, such legislation would make medical care available to all over 65 as a matter of "right" resulting in less care for those in need than it otherwise would be. With high levels of taxation it is not possible to combine more benefits for those in need with the principle of equal benefits for all. Public aid programs in Illinois, available to qualified applicants, are designed to help those in actual need.

PROVISIONS OF KERR-MILLS PROGRAM

Since August 1, 1961, qualified applicants have received hospital services without limitations on length of stay, including all inpatient hospital services and drugs without limitation; physicians' services while hospitalized (except in Cook County where such services are available to needy patients at no charge in

the Cook County Hospital); and physicians' home and office calls for a 30-day recovery period following hospitalization. Single persons 65 years of age or over with annual incomes of $1,800 or less, and couples with $2,400 or less, may qualify for payment if they possess not more than a like amount of liquid or marketable assets. The homestead and contiguous real estate, regardless of value, and limited life insurance are exempt from these calculations.

ABOUT 10,000 INDIVIDUALS BENEFITED

During the first 24 months of operation about 10,000 persons over 65 have received care under the Kerr-Mills program with payments for individual patients ranging from a low of $4 to a high of $5,200. Of the initial $20 million appropriation for the Kerr-Mills program for the biennium ending June 30, 1963, just under $6 million had been paid out.

To provide for a sharing of responsibility, the original Kerr-Mills law in Illinois required the recipient to pay an amount equal to 10 percent of his income toward his medical bill. Kerr-Mills medical assistance covered the balance for qualified recipients.

At our request the 1963 State legislature, by amendment, changed the provision for deducting 10 percent of income in establishing eligibility, to deducting a portion of income or assets in accordance with standards prescribed by the Illinois Department of Public Aid. This has now been liberalized to where the first $1,200 of income is exempt for qualified individuals and the first $1,800 is exempt from contribution for married couples. The amendment also changed the amount of life insurance exempted as a resource from $1,000 face value to "life insurance having a cash value of $1,000 or less."

BENEFITS ADDED, IMPROVED SPIRIT OF COOPERATION

At the conclusion of 23 months' experience with Kerr-Mills in Illinois during the 1961–63 biennium, steps were taken to evaluate the program. Numerous joint meetings were held with the department of public aid to consider expansion of the benefits offered to recipients under the program within financial limits.

We are particularly happy that the Kerr-Mills program has been extended to provide for the cost of drugs during visits within the 30 days' posthospitalization. In addition, the extended program includes up to 90 days' posthospitalization nursing home care including physicians' services and drugs connected with such care; or up to 90 days' rehabilitation nursing home care also including physicians' services and drugs.

Since the Kerr-Mills program was first implemented in Illinois, administrative changes within the department of public aid have led to a greatly improved spirit of cooperation between its administrators and the purveyors of medical services. A firm feeling now exists that all medically needy aged citizens in Illinois can be cared for adequately under this program. This rapport has been developed with the cooperation of the Governor of Illinois and his staff.

OTHER WELFARE PROGRAMS

In addition to Kerr-Mills, Illinois pays for comprehensive medical care for the indigent of all ages and not for just those over 65. This program, referred to as aid to the medically indigent (AMI), is operated at the township level and is financed through funds from general assistance in the State without financial assistance or controls from the Federal Government. The AMI program may finance services for the indigent aged that are not presently provided by Kerr-Mills, thereby dovetailing the two programs.

We also have Cook County Hospital, where patients may receive care who are unable to pay for it. Old-age assistance recipients discharged in 1962 received a total of 51,052 days' care in Cook County Hospital.

The Illinois State Medical Society actively cooperates with the Illinois Department of Public Aid in the operation of all medical programs by providing active advisory committees to the medical division at the State and county levels. These committees meet regularly to recommend standards of quality, quantity, and cost of the various programs.

The existing public programs provide medical care to those over 65 as well as those under 65 who need and want it. They are administered locally and are economical. The programs that we have in existence will maintain rather than discourage high-quality medical care and can be expanded, as we have experienced with Kerr-Mills, to meet the need when the need is indicated.

CONCLUSION

One of the fundamental issues of providing medical care to the over-65 age group is whether the supply of that care should be based on the principle of individual choice or be made the subject of collective provision; whether the providers of medical care to this group should charge for their services; or whether medical services should be supplied free with costs being met from social security taxes and the quantity of services being regulated by Federal administrative decision.

The issues cannot be decided upon technical grounds; they lie beyond economics and are based on one's beliefs of what constitutes a good society. The Illinois State Medical Society takes the position that the provision of medical care rests firmly on individual financial responsibility, then on local private resources to which have been added health care programs designed to meet the specific need financed by local government, State government, and finally, as a last resort, by the Federal Government. In keeping with the principles of providing for those in medical need, the Kerr-Mills program is designed to finance the cost of health care for that segment of our population not on public assistance and who fall within certain need criteria.

We favor the Illinois Kerr-Mills law as a way of helping those who need help, and voluntary health insurance and prepayment plans for those who can afford them. Our society reaffirms its position that no patient, aged or otherwise, need go without medical services because of inability to pay.

In the interest of the general welfare, and the promulgation of programs sponsored by the Illinois State Medical Society and other voluntary groups, as well as for other reasons included in our statement, we strongly oppose medical care costs being met from social security taxes and care being made available to all as a matter of right.

We have set forth the views of the Illinois State Medical Society on financing medical care for the aged and submit them for your wise deliberations.

APPENDIX

TWELVE-POINT POLICY STATEMENT, ILLINOIS STATE MEDICAL SOCIETY, JANUARY 1961

1. The society is exerting its effort to maintain the older individual as a healthy participant in the family, civic, economic, and political life of the community.
2. The society feels that the responsibility for financing health care of the aged rests primarily on the individual, then his family, then voluntary community agencies. Should these be inadequate, the responsibility should rest with government on an ascending level with Federal participation limited to financial assistance to the State for locally administered and locally operated programs.
3. The society is taking active leadership in the development of prepayment and insurance plans for the aged in low-income groups.
4. The society reaffirms its position that no patient, aged or otherwise, need go without medical services because of inability to pay.
5. The society supports the extension of governmental programs for medical aid to the aged through the Kerr-Mills approach.
6. The society is continuing its efforts to expand skilled personnel training programs at all levels in the health field.
7. The society is continuing its efforts to improve medical and related facilities and services for the aged.
8. The society strongly advocates health maintenance programs.
9. The physicians of Illinois support the development and wider use of restorative and rehabilitative services for all who need them.
10. The society endorses community activities for older people such as may be found in churches, senior achievement groups, "Golden Age Clubs," and day centers.
11. The society strongly supports the extension of research and is cooperating with organizations in undertaking research on numerous socioeconomic aspects of aging.
12. The society urges all county medical societies to form special committees on aging and to take local leadership in the development of specific programs to improve the care of the aged. Thirty-one county medical societies in Illinois currently have active committees on aging.

ILLINOIS STATE MEDICAL SOCIETY,
Chicago, Ill.

ISMS MEMBERS OPPOSE SOCIAL SECURITY COVERAGE

The Illinois State Medical Society has been on record for many years in opposing mandatory social security coverage of physicians.

Several polls have been taken on this subject. The most recent poll which was taken of 10,000 physicians asked the following questions:

1. Are you now covered by social security?
2. If you are now covered by social security, do you wish to remain so?
3. Are you in favor of compulsory social security coverage for all physicians?
4. Your age?

Over 6,000 survey forms were returned to the State society for tabulation. Of the 6,132 physicians who responded to the key question (Are you in favor of compulsory social security coverage for all physicians?), 54 percent or 3,323 voted their opposition to compulsory social security coverage.

[From the Chicago Tribune]

THE DOCTORS FACE SURGERY

When a doctor is about to perform surgery, it is customary whenever possible to obtain the consent of the patient before wheeling him into the operating room. This is so even when the patient is a Member of Congress.

But Congressmen don't seem to feel the same obligation toward doctors. The House Rules Committee has approved a number of social security changes, one of which would force the country's 170,000 self-employed doctors under compulsory social security even though most of them, according to the American Medical Association, do not wish to be dragooned into the system. A doctor would be separated from 5.7 percent of the first $5,400 of his annual income. Nearly all doctors would thus pay the maximum, $307.80 a year (subject, of course, to later increases by Congress).

In recent years the social security maelstrom has sucked in self-employed architects, lawyers, and dentists. Medicine is the largest profession not yet under control.

Doctors have particularly valid reasons for wanting to stay out. A self-employed doctor can rarely count on retiring at the age of 65, partly because he probably won't want to retire; partly because his patients won't want him to retire, and partly because there is a shortage of doctors and his services will be needed as long as he can provide them. More than half the Nation's doctors, according to the AMA, don't retire until they are 74 years old or older and thus would not begin receiving social security benefits until age 72 when the law permits payments regardless of earnings. Most of them are well able to care for themselves during their remaining years and to provide for their widows.

The only doctors who have to retire at 65 are those employed by others, such as corporations and institutions, and they are covered by social security already.

As long as there is no evidence that most doctors want to be under social security or that it would benefit them, the administration's proposal must be regarded as a means of extracting sizable payments from self-employed doctors in order to subsidize other beneficiaries of social security. The fact that our so-called old age "insurance" system is already so full of glaring examples of trickery is no reason for Congress to add another.

We can think of one more outrageous possibility, and that is that the present plan is a calculated threat which the administration might be willing to forget if the medical profession consented to go along with an even more ominous extension of social security. That is the Kennedy-Johnson plan to extend the system to cover medical care for the elderly. Any such step would be nothing less than blackmail.

STATEMENT OF THE MISSISSIPPI STATE MEDICAL ASSOCIATION, JACKSON, MISS., WITH RESPECT TO H.R. 11865

Purpose of statement.—The Mississippi State Medical Association is a scientific professional society of physicians founded in 1856. It is a constituent association of the American Medical Association and the authoritative voice of the medical profession in Mississippi. The association is grateful for the opportunity of presenting its views to the Senate Committee on Finance with respect to one portion of H.R. 11865, Social Security Amendments of 1964. Although the association has formally stated its opposition to proposed amendments to the act relating to compulsory Federal medical care for the aging, as contemplated in the various Forand-King-Anderson bills, it has never voiced approval or disapproval of the act itself.

It is the purpose of this statement to reiterate a policy of long standing with respect to compulsory inclusion of self-employed physicians under title II, OASDI, which is opposed by the association. Such compulsory inclusion is proposed in H.R. 11865, now pending before the committee, as passed by the House of Representatives. An identical position as assumed by the association in 1960 when the Senate removed the requirement for compulsory inclusion of self-employed physicians in the enactment of amendments to the act at that time.

Position of the association.—Our association has, on three occasions since 1959, conducted record votes in its house of delegates with respect to compulsory inclusion of self-employed physicians under OASDI. In all instances, delegates voted to oppose inclusion. Our delegates to the American Medical Association have so voted, and it is a matter of record that the American Medical Association has voiced opposition to this proposal at least annually for several years, including action at its 113th annual convention at San Francisco, June 21–25, 1964.

The compulsory social security tax upon self-employed physicians would escalate to 7.2 percent on the taxable base of $5,400 per annum or $388.80 in taxes under the pending legislation. Since OASDI is founded on the so-called social insurance concept of taxing all individuals included in a compulsory scheme in amounts sufficient to meet current payments made to beneficiaries, the tax can be expected to rise, as has been the constant and consistent pattern since 1935. Compounding the paradox of there being no vestment to the credit of the individual so taxed nor guarantee of benefits, very few physicians could or would ever avail themselves of OASDI benefits.

Pattern of medical practice.—Historically, American physicians in overwhelming numbers continue to practice until death. As recently as July 13, 1964, the American Medical Association reported that, as of that date, there were 282,928 physicians in the United States and its territorial possessions. Among these, only 10,790 have retired, less than 4 percent. A total of 4,168 are known not to be in practice (but not necessarily retired from other or nonmedical endeavor), a combined total (with the retired) of slightly over 5 percent.

The same national studies show that of 177,314 physicians in active private practice, only 22,027 are over age 65, slightly over 12 percent. This demonstrates the "younging" trend in the medical profession, resulting from greatly accelerated training facilities development and the progressively increasing numbers of M.D. graduates in the United States.

In 1947 in Mississippi, 45.5 percent of all physicians were aged 60 and over. On December 31, 1963, only 21.6 percent of the State's physicians were aged 60 and over. Astonishingly enough—as a result of our Mississippi State Medical Education Board program and our new and excellent University of Mississippi School of Medicine—61 percent of all Mississippi physicians today are under age 49, and 34 percent are under age 40. Yet, our total of physicians has increased 22 percent since 1946, a rate much greater than that of general population increase.

It is therefore obvious that compulsory social security inclusion with respect to physicians is both unnecessary and grossly unfair. They would generally receive nothing in return for taxes thus exacted.

Practice incentives and tax equality.—From enactment of the Social Security Act in 1935 to passage of the Keogh-Smathers measure for voluntary retirement programs for the self-employed, the latter, including physicians, were at a distinct disadvantage as to tax benefits for retirement accumulations. This has been partially corrected by the Congress. Enactment of compulsory inclusion under OASDI cannot and does not assist the goal of tax equality. On the contrary, it negates the partial degree of correction so recently provided.

Studies published by the Illinois State Medical Society show that a decreasing term life insurance policy equivalent to a capital investment of $31,000 affords a physician or other self-employed individual the same protection the self-employed social security tax (now proposed at a final tax cost of $388.80 per year) for a premium of only $98 per year. A $20,000 ordinary life policy with a 20-year family income rider would provide a physician acquiring it at age 30 more survivor income protection plus a final lump sum of $18,160 than social security can provide under similar circumstances—in brief, much more guaranteed benefits for the same costs.

Finally, a social security beneficiary is limited to a very small earned income, if his eligibility for OASDI retirement is to continue. Yet, it is clear that physicians do not, in fact, retire. To do so would be to decrease the quantity of medical care and to force those retiring to lower income levels. This appears highly undesirable both from health care resources and general economic standpoints. The sum of American medical manpower and knowledge should be utilized to the utmost, and retirement based upon chronological age alone is both wasteful and fallacious.

Position on H.R. 11865.—The Mississippi State Medical Association, therefore, opposes that portion of the pending legislation which would force doctors of medicine under OASDI, and for the reasons stated, respectfully urges your committee to delete this provision from the bill.

MONTANA MEDICAL ASSOCIATION,
Billings, Mont., August 7, 1964.

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

DEAR SENATOR BYRD: On behalf of the members of the Montana Medical Association, and with the approval of its house of delegates, may I submit for the record of the Finance Committee of the U.S. Senate the following statement in opposition to the passage of any health care legislation under the social security system:

Our medical association in Montana was founded in 1879. It has, as of August 1964, 585 active members, which represent more than 95 percent of the physicians actively engaged in the practice of medicine in our State. There is in Montana a ratio of 1 physician for approximately every 1,000 people.

The purpose of the Montana Medical Association as stated in its constitution is "to extend medical knowledge and advance medical science; to elevate the standards of medical education; to secure the enactment and enforcement of just medical laws for the protection of the citizens of Montana; to promote public health; to be active in the prevention and cure of diseases and in prolonging and adding comfort to life."

The Montana Medical Association has constantly endeavored to carry out these general purposes and has, through its members, devoted its energy to the task of helping to provide medical care to all of the aged of our State. One of the efforts of the Montana Medical Association to insure ample medical care for the aged, and, in fact, for all age groups, is our support as an association of the Montana public welfare program. Physicians of Montana have always provided medical care for all persons whenever necessary regardless of the patient's ability to pay.

Under the constitution of the State of Montana, it is the responsibility of the 56 counties to care for the indigent and the medically indigent citizens. To do this, each county may levy a tax, not to exceed 17.5 mills, on taxable property valuation. State and Federal funds to supplement the county mill levy are used only in the following areas of public assistance: old-age assistance; aid to the needy blind; aid to dependent children; aid to totally disabled; and certain other categories of general assistance. All medical and hospital care activities of the public welfare program are financed entirely by county funds except in those rare instances where the county has levied the maximum permissive tax and is still unable to finance the complete care program. In the past year only three counties required grants-in-aid from the Department of Public Welfare of the State of Montana. These were Silver Bow County, Cascade County, and Lincoln County. (The latter county received only about $1,700.) The money required for these grants-in-aid from the department of public

welfare is appropriated by the Montana Legislative Assembly from the general fund for this purpose.

Each county in Montana operates its own welfare program. Many counties allow free choice of physicians by the indigent or medically indigent recipients of welfare and in most of these a fee schedule basis is in effect. During the past year two counties (Blaine and Missoula) have contracted with Blue Cross on a per capita basis to supply hospital and medical care to their indigent and medically indigent citizens. Not enough time has elapsed as yet for us to present a report of the efficacy of this Blue Cross contractual arrangement with the counties.

During the recent legislative session of Montana in January and February 1963, two different items of legislation to revise the Montana statutes upon health care of the aged were introduced. One was a bill to implement the Kerr-Mills law and the second, a bill called "Montcare" which would provide for an appropriation of State funds to the counties to supplement their own funds in the care of the indigent and the medically indigent. It is noteworthy that the county commissioners organization in the State of Montana did not press for passage of either of these bills and especially it should be noted that there has been no influence exerted by any of the boards of county commissioners or by the State Department of Public Welfare of Montana for Federal funds. Neither of these bills was passed by the legislature.

Because of the simplicity of the plan used in Montana the amount of administrative work is kept at a minimum. If Federal funds were used, a considerable increase in administrative staff would be required. Even at the present time, the State department of public welfare must report how much time each of its workers spends in old-age assistance or in any of the other categories mentioned above since the Federal Government pays a varying proportion of the cost, depending upon the category in which the time is spent. If the Kerr-Mills law were implemented in the State of Montana, the administrative cost would rise tremendously. A full-time physician doing only administrative work would be required; reporting would increase; statistical work would be increased; it would be necessary to send three to four checks monthly to the hospital for each patient, etc.

There are two other facets of the care of aged in Montana which deserve mention. In the past 3.5 years, enrollment in Montana Physicians' Service (Blue Shield) has shown an increase of 20.9 percent in employed groups over 65 years of age and it may be safe to assume that the increase in the participation in commercial medical and hospital plans of persons over 65 years of age has increased proportionately. A second item concerns a study made by A. M. Fulton, M.D., at the Billings Deaconess Hospital from January to July 1961. A survey of the status of the accounts of a group of elderly patients, age 65 and older, indicated that 93 percent had paid their hospital bills in full within 6 months after their discharge from the hospital. Only 1.4 percent of the patients in this group (age 65 and older) had made no payments on their bills at the end of the 6 months. Furthermore, the unpaid hospital charges of patients over 65 years of age amounted to only 0.2 percent of the total unpaid charges of all patients admitted to the hospital. This study would appear to indicate clearly that the major collection loss of this hospital was incurred by those patients who were less than 65 years of age.

In summary, therefore, Montana feels that it is handling and can continue to handle amply, on a local and county level, its problems concerning the health care of the aged. Montana also believes that it can take care of its indigent and medically indigent with its present type of program at far less expense than it could under a Federal grant-in-aid program because of the greatly increased administrative expense under such a Federal program. Also, Montana feels that the best medical care can be given to indigent and medically indigent aged persons locally. Montana does not feel that it is wise to remove people from their home environment in the later years of their life and to place them in an impersonal, even though aseptic, steel and concrete building, miles or even hundreds of miles away from their friends and families.

Sincerely yours,

JOHN A. LAYNE, M.D.,
Legislative Liaison Representative.

STATEMENT SUBMITTED BY RICHARD C. ERICKSON, EXECUTIVE SECRETARY, SOUTH DAKOTA STATE MEDICAL ASSOCIATION, SIOUX FALLS, S. DAK., ON H.R. 11865

For the purpose of identifying the organization making this statement we would like to point out that the South Dakota State Medical Association was organized in 1882, nearly 80 years ago. It has been an effective organization since that time. Membership is voluntary and virtually all doctors belong. We have 485 licensed physicians in the State and 477 are members. We are organized into an association to assure continuing improvement in the medical care received by our people. Our services to the public and to our members encompass all fields that affect the health of the people. We actively support programs designed to decrease infant mortality, to prevent or treat congenital defects, to alleviate the affects of acquired defects. Rehabilitation programs, mental health programs, immunization for all, and a host of other related programs are given continuing interest. We actively support medical education and nursing education both in advisory capacities and by lending financial support. Available to our members are efficiency rating programs designed to increase individual physician diagnostic ability. We enter into legislative activity only when proposed legislation might influence directly the health care of our patients or when a program is proposed, which program would alter or change the basic concepts of the practice of medicine as we know them.

Our association has long been concerned with the quality and quantity of medical care available to the indigent and to the near needy. This is best demonstrated by our successful efforts introducing and supporting legislation for adequate and high quality care for those on old-age assistance in 1957 and 1961. It is further demonstrated by our active support for the Kerr-Mills legislation both on a National and a State level. We believe the Kerr-Mills law, properly implemented, will provide an equitable and honorable means for providing medical aid to the aged at the time such need develops. We believe people of all ages are deserving of the same opportunity. We do not believe that individuals of any age should receive community, State, or Federal aid for their medical care in the absence of demonstrated need.

In South Dakota there are 7,500 people over 65 on old-age assistance. In 1940 there were approximately 15,000. A small number presently on old-age assistance also receive minimal social security benefits. The number is variously stated to be between 60 and 100.

Our medical program for the so-called indigent aged includes physician and hospital coverage both in and out of the hospital or nursing home; the counties provide the financial aid for drugs and related items. The program also provides some dental care.

In addition to the OAA programs, our State legislature approved an NAA program for South Dakota. An early estimate saw some 1,000 persons initially on the rolls. To date only 180 eligible persons have applied, and have been approved, for coverage under the South Dakota NAA program.

Our actions, our attitudes, our waiting rooms testify to our concern for proper care of all age groups, not just the aged. Our presentation demonstrates our acknowledgment of the existence of a problem; but more important specifically demonstrates that we thoroughly believe existing Federal legislation will make possible and probable solution of the problems of the care of the needy aged within the foreseeable future.

Our objections are basically four, though each objection has ramifications covered adequately by other opposition witnesses.

First, we believe the actual financial need of the majority of the aged during the times of illness has not been demonstrated. The picture of past and present actions in South Dakota as they relate to medical care of the aged supports our position.

Second, we object to the proposed change in the entire philosophy of social security from a program of payment of moneys to one of provision of services. The inherent danger of the change is that it puts the Government into the field of paying for services where, it must, by the nature of government itself, control those services.

Third, we believe the placing of government in control of services will result, over a period of time, in deterioration of the quality of care offered. This con-

clusion is nearly always expressed when men of high professional stature meet to discuss means to solve the known problem of providing care to all. Involved here are problems which would be created by overutilization of services, by increased difficulties of recruiting properly motivated people to be physicians or trained paramedical personnel. Specific discussion of these points will receive coverage, we believe, by other opposition witnesses.

Fourth, we believe the cost of such a program as proposed by an aged medical care amendment to H.R. 11865 is almost impossible of prediction. That the cost would exceed predictions is almost certain. The economic forecast set loose by high-level benefits and the necessary taxes are frightening. Again our thoughts concerning costs and taxes are conclusions generally held by physicians; and actual tabulation and expectations fell more into areas covered by other opposition witnesses.

We in South Dakota believe the problem of medical care for the needy and needy aged can be and is being solved gradually under existing legislation through cooperation of the governmental agencies involved, and those who now actually provide the services.

OHIO STATE MEDICAL ASSOCIATION,
Columbus, Ohio, August 10, 1964.

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

DEAR SENATOR BYRD: I respectfully submit for consideration by you and the members of the Senate Finance Committee this statement pertaining to proposals to add health care under social security to H.R. 11865, and further to request that the statement be included in the record of the current hearings on this bill.

The purpose of this statement is to provide you and the members of your committee with: (1) the position of the Ohio State Medical Association regarding compulsory Government health care; and (2) some pertinent facts and comments on the major work being carried out in Ohio to cope with the health problems and other problems of our senior citizens.

Please be assured that the Ohio State Medical Association has consistently supported sound programs, private and public, designed to help solve these problems.

In the knowledge that a wrongful solution to a problem only complicates and intensifies it, this association consistently has opposed enactment of any plan or scheme of Govrenment-controlled health care, whether it be compulsory or voluntary.

A government health care program under the social security system—

(1) Would not meet the fundamental needs of the situation; namely, it would not help those who need help;

(2) Would lead inevitably to a Federal compulsory health care program for the entire population;

(3) Is totally unnecessary and would be increasingly costly.

(4) Would lead eventually and inevitably to the destruction of private and voluntary hospital and medical insurance programs;

(5) Would destroy the basic and important concept of providing social security dollars, rather than services, to beneficiaries by making the Federal Government a direct purchaser of services for private citizens;

(6) Would force into hospitals patients who otherwise could be treated by private physicians on an ambulatory basis;

(7) Would enlarge an already huge Federal bureaucracy;

(8) Would interfere with the independence of hospitals and physicians and their relationships with the patient.

(9) Would work additional and unnecessary hardship on younger family heads by increasing the already heavy taxes on their income at the time when their family needs are greatest.

(10) Would tend to endanger existing and necessary welfare programs administered by State and local governments since a social security program would likely influence legislative bodies toward reducing appropriations to finance important programs now in operation.

(11) Would create additional monetary demand on the already financially strained social security trust fund.

Problems faced by senior citizens are not intended to health, but also include economic, psychological, and social problems. These same problems are encountered by persons in all age groups.

The medical profession recognizes that some of the aging are not in a position to solve their problems. Therefore, the doctors of Ohio have long worked with their aged patients and with other individuals and groups to meet this challenge.

American medicine, private enterprise, and volunteer groups have joined to help solve the problems of the aging, and the substantial progress being made is additional proof that a Government health care program is completely unnecessary.

Ohioans can point with pride to their own State as proof of concrete progress. For example, the Ohio General Assembly provided $20,687,000 for the Ohio Division of Aid for the Aged fiscal 1964–65 health care program, an increase of $1 million over fiscal 1963–64, and an increase of more than $3 million over fiscal 1961–62.

Ohioans in this age group who need assistance in meeting their economic, medical, hospital, nursing, and other health needs are receiving such help under the regular health care program of the division of aid for the aged.

Since 1946, Ohio has had an active and very liberal program to provide these services. It was expanded in 1955 and again in 1961. It sets no income limits for eligibility but provides assistance on the basis of need. In addition, the State has a "medical only" program for those senior citizens who are able to meet their day-to-day living needs but not their health care expenses.

For example, in one month, June 1964, 79,625 persons received financial assistance from the division and 4,504 persons received "medical only" assistance.

This association supported the 1961 decision of Ohio General Assembly leaders to add a "medical only" program to regular aid-for-aged assistance, under the Mills section of the Kerr-Mills Act.

Active support was given by the association to the successful move to increase aid-for-aged appropriations for medical care activities. Should additional Ohio funds be required for the "medical only" program, this association will be among the first to support any sound proposals.

To repeat for emphasis, Ohio has a sound and liberal medical assistance program for the needy aged. This program deserves further commendation because it—

(1) Helps those who have proven needs determined locally;

(2) Provides a mechanism to supplement, not supplant, individual voluntary health insurance and prepayment plans;

(3) Is more economical because hospitalization is not required for participation in the program;

(4) Preserves the physician-patient relationship; and

(5) Is a hometown program administered on a local basis.

Another important step taken in Ohio was legislation passed by the general assembly in 1963 to permit insurance companies to pool health insurance coverage for senior citizens. Such a program is about to be launched in Ohio.

In 1961, with the encouragement of the medical profession, Ohio's Blue Shield plan offered an extensive, low-cost senior citizens policy, for which 75,000 persons enrolled in a 10-day period. In 1962, an additional 22,000 enrolled in this plan.

The Blue Shield figures do not include those regular subscribers whose policies are continued after they reach the age of 65, nor do they include those covered by other insurance institutions.

This association encourages emphasis in the field of the aging through the following constructive programs:

1. Recognition and respect of the aging as responsible, individual citizens rather than depicting them as an 18-million-member national problem that should be walled off from society.

2. Immediate abolition of the completely unrealistic retirement-at-65 attitude. Retirement at 65 was developed by Bismarck in the past century when life expectancy was far less than 65 years, as compared with the present life expectancy of 70 years-plus.

3. Recognition of the fact that older workers have skills and productive abilities, rather than arbitrarily, through forced retirement, denying them a productive, enjoyable life.

4. Much greater emphasis on mental, physical, social, and financial preparation for retirement during the productive years.

5. Continued improvement in Federal income tax laws to ease the tax burden on the low-income aged and those who support them.

6. Continuation, on an individual basis, of insurance coverage originally provided by group insurance, by conversion of policy on retirement; continuation of

group insurance on workers who retire, and their dependents, and offering group policies for retired persons.

7. Development of insurance policies that become paid up at 65, enabling the policyholder to provide for his retirement health needs during his productive years.

I cannot emphasize too strongly the paramount factor that all these programs are preventive in nature. This is the age of preventive medicine and the profession and private enterprise are taking the leadership by advocating programs that either forestall the development of financial problems of the aging or provide solutions for their problems, once they do develop.

In sharp contract, a social security health care program offers a completely unsound device, is not an insurance system but, instead, a direct payroll tax from which revenues undoubtedly would not be sufficient to meet the demands.

In summary, there is ample evidence that:

1. The basic problems of the aged, which are much the same as those of all age groups, are being steadily overcome through existing welfare programs, the voluntary programs, and private enterprise.

2. More and more emphasis is being placed, successfully, on adjustment for the latter years, medically, socially, and financially, through better preparation for retirement during the productive years.

3. This Nation's social security system must be preserved. The recorded fact is that the several amendments to the Social Security Act over the past several years have added benefits to the programs, such benefits having proved consistently to be more costly than was anticipated. This has caused considerable inroads into social security reserves.

Money benefits retired persons, disabled persons, and dependents receive through social security play a tremendous role in the economic well-being of these persons. It would be foolhardy to place additional jeopardy on the social security fund by adding another, totally unnecessary, deficit program.

Thank you for your courteous attention.

Sincerely,

R. E. TSCHANTZ, M.D., *President.*

U.S. SENATE,
COMMITTEE ON GOVERNMENT OPERATIONS,
July 22, 1964.

Hon. HARRY F. BYRD,
Chairman, Senate Finance Committee,
U.S. Senate,
Washington, D.C.

DEAR HARRY: I am writing to express my support for H.R. 11865, social security for physicians, which is expected to be considered by your committee in the near future.

A poll conducted by the Maine Medical Association in the State of Maine in the fall of 1963 clearly shows that our physicians favor this proposal two to one.

Furthermore, there is evidence that the American Medical Association, which has in the past expressed its opposition to social security for physicians, does not in fact speak for a majority of the medical profession on this issue; polls conducted in other States clearly seem to indicate support for this legislation.

Already 25 to 35 percent of our physicians are covered by social security as employees of private corporations. It does not seem logical that family doctors should be excluded from the program simply because they are self-employed.

Recognizing fully your prerogatives as chairman and appreciating your conscientious desire to give thorough consideration to all matters which come before your committee, I simply write to communicate my position on this subject.

Sincerely,

EDMUND S. MUSKIE, *U.S. Senator.*

TRAVIS COUNTY MEDICAL SOCIETY,
Austin, Tex., July 21, 1964.

Senator HARRY F. BYRD,
U.S. Senate,
Washington, D.C.

DEAR SENATOR BYRD: This is to advise you that the board of directors of the Travis County Medical Society in a recent meeting took official unanimous action in opposing the proposed legislation whereby self-employed physicians would be placed under the social security program. Specific reasons cited for this opposition include:

1. The majority of self-employed physicians desire the privilege of establishing their own retirement benefits program on a voluntary, not compulsory basis;

2. Compulsory participation in the social security program by self-employed physicians would represent still another costly tax, already scheduled to reach 7.2 percent by 1971, on physicians; and

3. Most self-employed physicians will have little if any prospect of enjoying social security retirement benefits before age 72 at the earliest, even though the benefits may begin at age 65, as the majority of self-employed physicians are still in the active practice of medicine until age 72 or later and, consequently, would be ineligible for benefits.

For these reasons and others we respectfully request your full efforts in urging the Senate Finance Committee to delete the provision in H.R. 11865 which would require participation by self-employed physicians in the social security program.

Your assistance in this regard is sincerely appreciated and gratefully acknowledged.

Sincerely,

DOUGLAS F. BARKLEY, M.D.,
President.

TRAVIS COUNTY MEDICAL SOCIETY,
Austin, Tex., July 23, 1964.

Senator HARRY F. BYRD,
U.S. Senate,
Washington, D.C.

DEAR SENATOR BYRD: Reference my letter of July 21, 1964, advising you of the unanimous action taken recently by the board of directors of the Travis County Medical Society in opposition to that portion of H.R. 11865 which provides for compulsory inclusion of self-employed physicians under the social security program.

This is to further advise you that the members of the Travis County Medical Society present and voting at a called meeting of the society last evening, July 22, 1964, took unanimous action opposing the same provision.

We thought you would want to know of this further action by the society membership. We sincerely hope that you will use your full influence toward deletion of this provision of H.R. 11865.

Our continuing appreciation to you for your efforts in this regard.

Sincerely yours,

DOUGLAS F. BARKLEY, M.D.,
President.

U.S. SENATE,
MINORITY LEADER,
June 8, 1961.

Mrs. ELIZABETH B. SPRINGER,
Chief Clerk, Finance Committee,
U.S. Senate, Washington, D.C.

MY DEAR MRS. SPRINGER: If and when hearings are held on S. 909, the Effingham County Medical Association of Effingham, Ill., has asked that the following statement be inserted in the hearings. It is as follows:

"The Effingham County Medical Society is opposed in its entirety to H.R. 4222 and S. 900 (the King and Anderson bills). Our reason for opposing these bills is that they are a form of socialized medicine and as such, have no place in the American way of life. We firmly believe that they will be of no actual assistance to the patient or the doctor."

Sincerely,

EVERETT MCKINLEY DIRKSEN.

STATEMENT OF H. PHILLIP HAMPTON, M.D., PRESIDENT-ELECT, FLORIDA MEDICAL ASSOCIATION, INC., RE HEALTH SERVICES AVAILABLE TO NEEDY SICK IN FLORIDA

Since 1956 Florida has operated a State plan providing hospital care for the needy sick of all ages through a State and county matching fund which pays hospitals actual per diem costs for those considered eligible for tax-paid health services.

In 1958, the 12-month expenditure for hospital services through the fund amounted to $4 million, which was less than a fourth of the estimated cost of hospital care given indigents in Florida. The remainder of the cost of health services to all those considered in need was provided by the individual counties at an estimated annual cost of $15 million.

After enactment of the Mills-Kerr law, Federal funds became available to reimburse the State for health services expenditures to public assistancce recipients. In calendar year 1961, a total of $35 million of tax funds were expended in Florida for health services to the needy sick of all aged and categories (not including State psychiatric and tuberculosis hospital care). These tax funds were derived from sources as indicated in chart I in comparison with estimated expenditures for 1958 and 1964.

On July 1, 1963, a medical aid for the aged program was inaugurated in Florida where 60 percent Federal reimbursement would be available on expenditures made for hospital care and home nursing visits to the aged needy sick. A total of $8 million in State and Federal funds will be available to provide those services during the subsequent 24 months and these funds may be increased if necessary by agreement for Federal reimursement of county expenditures.

For the next 24 months the tax funds budgeted by the recent Florida Legislature to provide health services to the needy sick amount to $13,272,099 in State funds and $30,822,676 in Federal funds. If the counties spend sums similar to those spent in the past 2 years, a grand total of $90 million will be available to provide health services to the needy sick in Florida for the next 2 years (chart II).

The present population of Florida is estimated at 5,158,100 and those 65 years of age and over number about 600,000, or 12 percent; 70,000 are old-age assistance recipients and receive State and Federal tax-supported hospital services, nursing home care and drugs. However, of those needy sick of all ages (not public assistance recipients) receiving hospital care from State and county tax funds, only 16 percent in 1962 were age 65 and over. The percentage of elderly needing tax-supported health services in Florida has declined in the past 3 years, which we expect to continue with the increase of voluntary health insurance and pension plans.

Our experience has convinced us that successful operation of tax-supported health-care programs for the needy sick requires the cooperative effort and responsibility of several State agencies and nongovernmental associations. Our advisory board of these programs has been strengthened by the inclusion of representatives of the State medical association, State hospital association, association of county commissioners, and members of the legislature. The State board of health has administered the hospital-care programs by contract with the department of public welfare.

The definition of eligibility to receive medical aid for aged Florida residents is flexible enough to meet the need of all aged who require help: "Has not sufficient income, resources, or assets as determined by the State department of public welfare to provide needed medical care without utilizing his resources required to meet his basic needs for shelter, food, clothing, and personal expenses."

Florida has a program of tax-supported health services for the needy sick of all ages which we believe is adequate. Additional Federal law and Federal funds are not needed to fulfill the constitutional responsibilities of local and State government in providing for the needy sick.

TAX-SUPPORTED EXPENDITURES FOR HEALTH CARE IN FLORIDA

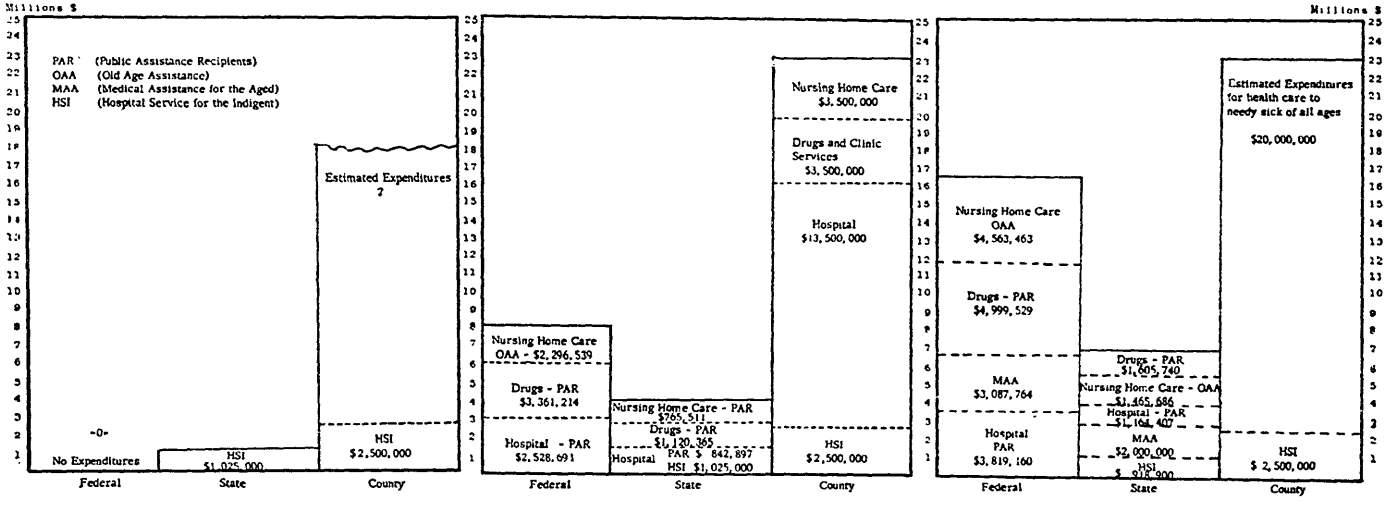

CHART I

The Mills-Kerr law has aided and stimulated development of the Florida health-care program. Minor changes in the law or regulations may provide the States further latitude in developing and improving their program of health services for the needy.

We recommend (1) that Federal law permit administration of health-care programs by State agencies other than the agency administering welfare; (2) permitting the program of medical aid to the aged to encourage voluntary health insurance among the near-needy aged by cooperating with them in the payment of health insurance premiums and (3) prescribing by regulations the manner of collection from the State of residence for health services rendered their eligible transiently absent residents.

CHART II.—*Budgeted tax funds for health services to needy sick in Florida, biennium 1963–65*

Service	Federal	State	County	Total
Drugs, PAR	$9,829,759	$3,157,195	0	$12,986,954
Nursing home, OAA	8,633,229	2,772,807	0	11,406,036
Hospital:				
PAR	7,478,042	2,283,297	0	9,761,339
MAA	4,881,646	3,250,000	0	8,131,646
HSI	0	1,803,800	$5,158,000	6,966,800
Subtotal				49,252,775
County expenditures for additional health services to needy sick, estimated from past 2 years' experience			40,000,000	40,000,000
Total	30,822,676	13,272,099	45,158,000	89,252,775

STATEMENT OF THE MEDICAL ASSOCIATION OF THE STATE OF ALABAMA IN OPPOSITION TO SOCIAL SECURITY-FINANCED MEDICARE

An indigent medical care bill was enacted by the Legislature of Alabama in 1958. The passage of this bill was strongly supported by the Medical Association of the State of Alabama. This program, which is administered by the State department of health, allocates funds to each county on a matching basis. These funds are available to residents of Alabama who are seriously ill and need hospitalization but are unable to pay for the services. The determination of ability to pay is rendered on a local level by nonmedical personnel. The physicians of Alabama on numerous occasions have agreed to render services to the medically indigent without charge.

In February of 1961 the State department of pensions and security and the Governor signed a corporate agreement defining certain responsibilities for a medical-care program to be instituted under the provisions of the 1960 amendments to the Social Security Act, Public Law 86–778. Under the terms of this agreement, the State department of health would provide medical supervision and would be responsible for negotiations between hospitals and the medical profession in a program providing hospitalization for the State's old-age pension recipients. The program was activated on April 1, 1961, providing for 10 days of hospital care for recipients during the next 6 months. At the beginning of 1962, the number of days of hospital care had been raised to 15 days.

The Medical Association of the State of Alabama actively engaged in urging the passage of enabling legislation in Alabama to provide adequate appropriations to initiate a program of medical assistance for the aged under the Kerr-Mills legislation. Such legislation was passed during the 1961 session of the legislature of Alabama and was put into operation October 1, 1961.

On February 1, 1962, the medical care program was expanded to provide 15 days of hospital care to persons 65 or over who were not receiving an old age pension but who were found by the department of pensions and security to be medically indigent and entitled to medical assistance for the aged (MAA). At the same time provision was made for payments to physicians for office visits providing posthospital care within 30 days following discharge from the hospital, when hospitalization had been approved under the program for old age assistance (OAA) or medical assistance for the aged (MAA).

Several changes and additions were made in these programs during 1962. The number of days of hospital care was increased to 30 days under the OAA program on June 1, 1962, and the MAA program on October 1, 1962. Payment for additional physician's services also was provided beginning October 1, 1962,

including home visits, electrocardiograms, blood examinations, and X-ray evaluations.

At the 1961 annual session of the Medical Association of the State of Alabama, it was resolved that "The Kerr-Mills law, with its voluntary provisions at the State level should be given an opportunity to prove that it is the best method to provide medical care for those who need medical care and hospitalization." This program is working in Alabama and has been expanded steadily and regularly since its initiation as evidenced by the foregoing statements.

The major fallacy of providing medical care for the aged under social security is that it is based on the erroneous assumption that a majority of the aged are in need of this type of care.

The problem of the medical needs of the aged must be placed in its perspective. They are individuals and not a homogenous group. A large majority of the aged population are either able to provide for their own medical needs through their own resources or have some form of health insurance. The insurance industry estimates that by 1970, 90 percent of the aged wanting coverage will have it.

Those who are in need and who cannot afford private insurance can receive care under the Kerr-Mills programs (either OAA or MAA), through veterans' medical care, or medical care programs for retired military personnel and their dependents.

Proposed medicare legislation such as King-Anderson is unnecessary legislation, as the Kerr-Mills Act provides for broader health coverage for the needy aged with far fewer restrictions. The Kerr-Mills Act provides payments for all kinds of medical care, including hospitalization, nursing home care, outpatient and diagnostic treatments, fees for physicians, drugs, eyeglasses, prostheses, and dental care. In fact, there are practically no restrictions on what can be supplied to the medically indigent under Kerr-Mills.

The Medical Association of the State of Alabama firmly believes that the Kerr-Mills program, the humanitarian willingness of its members to render medical care to all who are in need regardless of their ability to pay, and the voluntary health insurance mechanisms can adequately meet the medical needs of our aged indigent citizens; and that passage of a social security financed medicare bill is unnecessary and would undermine the free enterprise system which has made this Nation the greatest in the world.

STATEMENT OF THE ASSOCIATION OF AMERICAN PHYSICIANS AND SURGEONS

In opposition to H.R. 3920, 88th Congress, Hospital Insurance Act of 1963; in opposition to the Javits Federal medical care for the aged (S. 2431); and in opposition to the compulsory inclusion of physicians in social security (H.R. 11865)

(By Thomas Parker, M.D., president)

Mr. Chairman and members of the committee, the Association of American Physicians and Surgeons is grateful for this opportunity of expressing its views of opposition to H.R. 3920, 88th Congress, Hospital Insurance Act of 1963; to the Federal Javits medical care for the aged bill (S. 2431), and all similar legislation; and opposition to the compulsory inclusion of physicians in social security as provided for in H.R. 11865.

My name is Thomas Parker and I live in Greenville, S.C., where I am engaged in the general practice of medicine. I was elected president of the Association of American Physicians and Surgeons on October 10, 1963, and assumed office on October 12, 1963.

My testimony is in three parts: Part I, "The Basis for Opposition to King-Anderson Type Legislation (H.R. 3920)," to the Javits-type legislation (S. 2431), and to all similar legislation. Part II offers statistical evidence that there is no demonstrated need for this medicare legislation or similar legislation. Part III offers the reasons for our objection to having physicians compulsorily included in social security (H.R. 11865).

PART I

The premises of King-Anderson type legislation and all similar legislation are that it is the duty of the Federal Government to provide medical care for the aged because the aged are sick and poor and unable to provide for themselves, and because their families cannot be expected to provide for them either; and that participation in such Government-provided care shall be compulsory, since

it will, of course, be supported by taxation. At present the Federal Government proposes to provide incomplete medical care for a designated group of the population in institutions that meet standards set by the Federal Government, but surely it does not require clairvoyance to understand that this program if adoped will be expanded to provide complete medical care for the entire population and that such expansion is both inevitable and necessary from the political point of view.

The premises are false.

For those who believe that the Federal Constitution means what it says, who believe that the happiness of the people depends upon the limitation of the power of government, who believe that the Federal authority was created "in order to form a more perfect union, establish justice, insure domestic tranquillity, provide for the common defense, promote the general welfare and secure the blessings of liberty to ourselves and our posterity," there is no basis in law for the assumption of the care of the aged by the Federal Government.

For those who revere statistics, there are abundant figures (see pt. II of testimony, pp. 4 and 5) to show that, as a group, the aged are as well able to take care of themsleves financially as any other group of the population.

Some students will recall that a British commission was established to determine what constituted optimum medical care, so that the British National Health Service could provide it; and that after 2 years' study, the commission reported that it was unable to establish such a standard and was disbanded.[1] It follows from this that it is absolutely impossible to estimate accurately the cost of providing adequate medical care for the population or any portion of it.

In fiscal 1961, Britain spent $2.2 billion for the national health service, $4.6 billion for defense.[2] If we matched the British standard, and surely we would not wish a health service inferior to that of the British, in terms of our present budget we would be talking about a health expenditure of $25 billion annually at least; an expenditure which, in terms of the Federal personal income tax, would require almost a 50 percent increase.

For the politically experienced, the matter of the budget arises. The needs of the people for medical care will compete with their needs for education, defense, foreign aid, etc. Should the medical share be inadequate, some services will have to be curtailed. The easiest services to be curtailed are those for new hospitals and for research. Is this what Americans want?

For the religious, it is apparent that the provision of medical and other needs of individuals by the Federal Government is founded upon a basis of materialism, upon the assumption that what those in need need is money. Some old people do need money; but all people need love, and this cannot be supplied by government.

Taxation for purposes of welfare is a contradiction in terms. True charity depends upon love on the part of the donor and gratitude on the part of the recipient and produces spiritual growth of both. When funds for the aid of the needy are no longer derived from free-will offerings but from compulsory taxation, the psychological climate is changed. The willing giver becomes the resentful taxpayer; the grateful recipient becomes the dissatisfied voter seeking for office-holders who will promise him more of his "rights." When medical care is involved, to the patient, the doctor becomes the selfish bureaucrat; to the doctor, the patient becomes the exploiter of underpaid labor. The friendly, trusting, doctor-patient relationship is destroyed by the intrusion of the third party payor. Moreover, for all citizens, to the already crushing load of taxation will be added an additional exorbitant tax, making it even more impossible for the average citizen to provide for himself and his family, so that he will have to depend upon government for his basic needs, thus forcing our citizens into a socialistic welfare state.

For those who favor socialism, King-Anderson type legislation and all similar legislation, is just what the doctor ordered.

PART II. THERE IS NO DEMONSTRATED NEED FOR SOCIAL SECURITY FINANCED MEDICAL CARE FOR THE AGED

Health insurance for those over 65 years of age is now leading all other areas of health insurance in terms of growth. Older people are buying such insurance at a faster rate than any other segment of the population. More than half, 53 percent of the aged, who are not now in institutions, had some form of voluntary health insurance at the end of 1961. In 1952 only 26 percent of the aged popula-

[1] Helmut Schoeck, "Financing Medical Care," Caxton Press, 1963, p. 73.

[2] Op. cit., pp. 50, 70.

tion were so insured. By 1970, insurance actuaries estimate that the coverage of the aged will rise from 53 percent to between 89 and 90 percent. Source of the above information: Health Insurance Institute.

There are approximately 17 million persons age 65 or over in the United States. As of December 1960, 64 percent of those 65 and over were receiving OASDI cash benefits, about 10.9 million people. OASDI and OAA payments were being made to 74 percent of those over 65 years of age. Veteran's pensions afford income support for almost 10 percent of the aged population—1¾ million persons over 65 now receive these pensions. Source: Social Security Bulletin of July 1961.

About 4 million of the over-65 group pay Federal income tax. Source: U.S. Treasury Department.

About 4 million of the over-65 group are now working. Railroad and civil service pensions now go to approximately 1,700,000 persons 65 and over. About 600,000 of the over-65 group now receive payments from privately purchased annuities. In 1957 the net worth of an OASDI recipient with a wife also entitled to benefits was $9,616—up 71 percent over the 1951 figure of $5,610. Men over 65 increased their median income by 56 percent from 1951 to 1959. As a comparison, the median income of all men from age 14 and above increased only 35 percent in the same period. Source: U.S. Bureau of Census.

More than 70 percent of the aged OASDI beneficiary couples owned their own homes in 1958—and 87 percent of these homes were mortgage free. The liquid assets of persons over 65 have increased more rapidly than any other age group and now are the highest of any age group. Indebtedness in the group 65 years of age and over is the lowest of any age group. Source: Federal Reserve Board's Survey of Consumer Finances.

The Association of American Physicians and Surgeons maintains that the favorable economic status of persons 65 and over constitutes strong evidence that there is no need for a medical care program for the aged financed through social security. Members of the Association of American Physicians and Surgeons believe that the American people of all ages (not only the aged) should receive the highest quality of medical care that can be rendered, regardless of the ability of the patient to pay for such care. To our knowledge, no individual is being denied quality medical care because of inability to pay for it—regardless of age. New Medical Material (May 1961) stated that every year physicians give millions of dollars worth of medical treatment to the indigent free of charge, and estimated the annual amount of such free care in 1960 was $657½ million. Many county medical societies throughout the country publicize through paid advertising and newspapers their programs' "guaranteeing the services of a physician to all who need him." We believe this is further indication that there is no demonstrated need for the provisions of the King-Anderson legislation (H.R. 3920 and S. 880), (or any similar legislation of a Federal and/or compulsory nature).

For these reasons, and for many others presented to this committee, we urge committee members to stand unalterably opposed to H.R. 3920 (King-Anderson) S. 2431, Javits bill and to all similar legislation, and to support their convictions with their votes.

PART III. OPPOSITION TO THE COMPULSORY INCLUSION OF PHYSICIANS IN SOCIAL SECURITY (H.R. 11865)

The vast majority of physicians in the United States oppose their compulsory inclusion in social security because of the following reasons, and many others:

1. Social security is not insurance. There is no contract with the Government as insured individuals have with legitimate insurance companies. Social security is an outright dole financed by taxes.

2. There is no guarantee on stabilizing the costs of social security. The taxable wage base and the tax rate have been raised several times by Congress in election years. The original taxable wage base was $3,000; the present taxable wage base is $4,800; the new legislation (H.R. 11865) once again increases the wage base from $4,800 to $5,400 and would require physicians (self-employed) to pay a tax rate in 1965 of 5.4 percent.

3. The taxes for the social security dole, particularly for the self-employed, are exorbitant. For the self-employed (physicians) the tax next year would go from $259.20 to $307.80. Already scheduled increases in tax rates for 1966, again in 1968, and after 1970 will bring the rate of the self-employed up to 7.2 percent or $388.80 per year.

4. The amount of the dole from social security is not assured; there is no relation between so-called benefits and the amount of taxes paid; and indications are that the tax rate and the wage base will be further increased if future Congresses follow the election year pattern of past Congresses. It is common knowledge that some members of the HEW staff have publicly declared that at some time the social security wage base must be increased to $10,000, nearly double the amount provided for in the House passed social security legislation; and Mr. Celebrezze stated in testimony before the Senate Finance Committee on August 6 that he saw no reason why social security "contributions" should be limited to 10 percent.

Summed up, here are some of the defects of social security, none of which are found in bona fide insurance:

A. No certainty as to the amount of the tax.

B. No guaranteed benefits.

C. No real reserves to assure the payments of any claims at all.

D. No real investment of the tax income of the "company" which constantly borrows from the taxpayers in order to make additions to its "reserves" to compensate for the continuing deficit operation.

E. No solvency of the "insurance company" which from time to time operates in the red and is deep in debt.

F. No loan value.

G. No cash or surrender value; in fact, no possibility of dropping the "policy."

H. Under social security one pays what the Congress says he pays, and gets what the Congress says he gets. Either tax or "benefits" can be changed at any time without permission of the "policyholders." As the social security law reads now, a physician will get no benefits in his old age before he is 72 unless he is disabled or decides to sit on his laurels from age 62 on. If he works until he dies, as most physicians do, and dies before age 72, he will not have received a penny of the $17,280 he paid in between the ages of 25 and 65. This is certainly not good old-age insurance.

5. If permitted to do so, physicians can use the amount of their social security tax to purchase far better and safer insurance and annuities from regular insurance companies, where they would have a guarantee of benefits commensurate with established and unchanging premiums.

For these reasons, and for many others, we urge the members of the Senate Finance Committee to stand unlaterably opposed to the compulsory inclusion of doctors in social security and to support their convictions with their votes.

Respectfully submitted.

STATEMENT OF ORLAN J. JOHNSON, M.D., PRESIDENT, MICHIGAN STATE MEDICAL SOCIETY, RE H.R. 11865, SOCIAL SECURITY AMENDMENTS OF 1964

The State of Michigan was the first of the 50 States to enact legislation to implement the Kerr-Mills law, and Michigan was the first of the 50 States to have its implementing program approved by the U.S. Department of Health, Education, and Welfare. Since that initial approval, the Michigan program has twice been liberalized by the State legislature.

The Michigan program has been properly designed to meet the special needs of the aging population. Michigan's program for providing medical assistance to the aged is designed to give maximum help to those who need help, and it has been doing the job for which it was intended.

When the Congress enacted the Kerr-Mills law, it gave to the States a tool by means of which they could solve such problems as existed within their several borders with respect to those persons, 65 years of age and over, who are able to provide for their own needs of daily living but cannot afford a medical emergency.

Michigan's medical assistance to the aged (MAA) law entitles such persons, who qualify for its benefits, to comprehensive hospital care and to all those

physicians' and surgeons' services, from practitioners of their own choosing, which are available to citizens of Michigan having the best Blue Cross-Blue Shield coverage available in the State. This hospital and medical coverage is comparable to the best in the Nation, with no limiting factors on the services themselves, such as time limits. Also provided are unlimited home nursing services and care in State-licensed nursing homes, including drugs.

Thirty-six months ago, and again 8 months ago, testimony was presented to the Ways and Means Committee of the U.S. House of Representatives on behalf of the doctors of medicine of the State of Michigan that in their State, at least, the King-Anderson bill was totally unnecessary. Nearly 4 years of experience has proven that the Kerr-Mills law is infinitely more practical and effective a means of providing health care coverage for the aged.

The U.S. Senate Finance Committee is now being asked by the Department of Health, Education, and Welfare, and others, to approve the King-Anderson bill by "tacking it on" H.R. 11865. This King-Anderson proposal, which would provide only a minor fraction of the hospital and medical benefits already provided our Michigan elderly citizens by our legislatively adopted, locally controlled, and voluntary Kerr-Mills program should, in our view, be totally rejected.

Under the Michigan MAA Act comprehensive care is provided for aged Michigan residents who need help to pay for their health care.

The fact is, Michigan has not one, but many, programs for those unable to provide for their own health care. In addition to our excellent MAA (Kerr-Mills) program for the medically indigent, complete health care is also provided for the fully indigent through Michigan's participation in the old-age assistance program. Michigan also participates in excellent aid to the blind and aid to the disabled programs, and in addition each of our 83 counties, plus the great city of Detroit, have welfare programs.

Of the approximately 650,000 people in Michigan over the age of 65, the well-established average estimate is that about one out of six, or 17 percent,[1] can expect to require hospitalization in any 12-month period. Now, how many of that 17 percent who will require hospitalization in any given year actually need help in paying for their health care? How effectively do Michigan's present programs serve the elderly of our State who need such help?

On a day selected at random—July 11, 1963, to be exact—an independent survey of the total adult population in 182 Michigan general hospitals was conducted by the Michigan Hospital Association to determine how each bill was actually paid.[2]

On that day there were 19,870 adults hospitalized in these 182 general hospitals, and slightly over 26 percent of them, or 5,295, were patients aged 65 and over. Here are the results of the survey for those over 65:

Source of payment	Number of patients	Percent of total
Those requiring no public assistance:		
Blue Cross	2,564	48.4
Commercial insurance	827	15.6
Private payment	706	13.3
Subtotal	4,097	77.8
Those requiring public assistance from all reported sources:		
MAA (Michigan medical assistance to the aged)	542	10.2
Old-age assistance	294	5.6
County welfare	255	4.8
Other or unknown (including bad debts)	107	2.0
Subtotal	1,198	22.6
Total	5,295	99.9

[1] Reference No. 1, attached.
[2] Reference No. 2, attached.

These figures present more-than-graphic evidence of the success of Michigan' present program. On the average only about 17 percent of the over-age-65 population will be hospitalized during any 12-month period. The committee's attention is invited to the fact that on a day selected at random 26 percent of those hospitalized were over age 65, and over three-quarters of these (77.3 percent) had no need to avail themselves of any public assistance.

Please note: All but 2 percent of the total number of patients in the reported study were paying their own bill, covered by insurance plans, or were receiving help from existing public programs. This has been the case for 3 years.

An identical study was conducted by the Michigan Hospital Association in a similar large number of Michigan hospitals in 1962, with almost identical results. A slightly larger fraction (between 2 percent and 3 percent) of the total hospitalized had no apparent source of public assistance under present programs. This year, the study is expected to find a number even less than the 2 percent of 1963.

Thus, Michigan's fully indigent receive comprehensive care under the old-age assistance program; Michigan's medically indigent receive the comprehensive care they require under MAA. These two major programs, buttressed by other available mechanisms for providing needed health care, are doing the job.

Michigan's medical assistance to the aged program is being continually analyzed and improvements found to be necessary are being made with the encouragement and support of Michigan's doctors of medicine. For example, during the just-completed session of the State legislature the permissible income limits of both single and married MAA applicants were raised, and in computing the applicant's income the legislature removed the previous requirement that the contribution which responsible relatives could make would have to be taken into account.

This was the second major liberalization of the program since its original adoption in the fall of 1960.

A total of 70,859 certifications for necessary health care have been granted under Michigan's Kerr-Mills program in the first 45 months of its existence—an average of over 1,500 per month. A total of more than $65 million of Federal, State, and county funds have been devoted to the health care of Michigan's senior citizens under this program in the 45 months.[3]

Michigan's doctors of medicine vigorously supported the adoption of the Michigan Kerr-Mills MAA law,[4] and successfully twice labored for its later liberalization when need for amendment was indicated. This law is a part of the physicians' positive program for the provision of the full range of medical and hospital care which a medically indigent senior citizen requires. It is obviously doing the job. Michigan does not need the King-Anderson bill.

The King-Anderson proposal, in fact, would impose upon Michigan citizens an additional social security tax burden exceeding $110 million per year (in the first year alone).[5] For this huge sum, the proposed bill would furnish only limited hospital and medical benefits, providing such benefits to all, even those who did not need Government assistance.

This more than $110 million would largely be paid by Michigan taxpayers whose annual incomes are less than $5,400 per year.

In our view, members of the committee, those who persist in advocating the King-Anderson bill should prove the need for such costly Federal monopoly of health care. We point out that the need cannot be found in Michigan. Furthermore, we insist that they prove the need for such a program by the use of facts, not emotional slogans.

The Michigan State Medical Society is deeply appreciative of the opportunity to submit this statement, along with the attached references, for the committee's record.

[Reference No. 1]

The aged person has a 1-in-6 chance of going to a hospital in a given year, somewhat higher odds than for the person under 65.

Source: Background facts on the financing of the Health Care of the Aged, Special Committee on Aging, U.S. Senate. Excerpts from the "Report of the Division of Program Research, Social Security Administration, Department of Health, Education, and Welfare," May 24, 1962. Printed for the use of the Special Committee on Aging, U.S. Government Printing Office.

[3] Reference No. 3, attached.
[4] Reference No. 4, attached.
[5] Reference No. 5, attached.

Michigan Hospital Association, inventory of hospitalized aged, July 11, 1962, and July 11, 1963

[Reference No. 2]

	Wayne County		Total Michigan	
	1962	1963	1962	1963
Total adult patients:				
Number	8,035	7,480	17,967	19,870
Percent	100	100	100	100
Patients 65 and over:				
Number	1,720	1,734	4,545	5,295
Percent	21.3	23.2	25.3	26.6
Number of replies	48	44	174	182
Sources of payment for patients 65 years and over:				
Medical assistance for the aged (MAA):				
Number	87	128	398	542
Percent	5.1	7.4	8.8	10.2
Old-age assistance (OAA):				
Number	38	56	223	294
Percent	2.2	3.2	4.9	5.6
County welfare:				
Number	37	67	207	255
Percent	2.1	3.9	4.6	4.8
Blue Cross:				
Number	1,097	1,097	2,242	2,564
Percent	63.8	63.3	49.3	48.4
Commercial insurance:				
Number	148	159	672	827
Percent	8.6	9.2	14.8	15.6
Private payment:				
Number	213	185	652	706
Percent	12.4	10.7	14.3	13.3
Other or unknown:				
Number	100	42	151	107
Percent	5.8	2.4	3.3	2.0

Average rate of pay for hospitilization of MAA patients

	1962	1963	Percent change
Wayne County	$27.19	$27.48	+1.1
Total Michigan	24.17	25.11	+3.5

[Reference No. 3]

Medical assistance for the aged—Cumulative data beginning of program through June 1964

Classification of certification and expenditure	Cumulative total	Average per month [1]	June 1964
Total certifications	70,859	1,575	1,692
Class of service:			
Inpatient hospital care	46,906	1,042	1,103
Medical care facility	10,846	241	234
Outpatient clinic	6,692	149	161
Physician's office	582	13	10
Home nursing	2,293	64	68
Nursing home	3,540	98	116
Recertification	23,594	524	567
Initial certifications (no prior service or reopened)	47,265	1,051	1,125
Prior assistance:			
Old age assistance	5,655	126	73
Aid to the blind	46	1	0
Aid to the disabled	138	3	3
Direct relief	430	10	4
No prior aid	40,996	911	1,045
Initial certification (no prior service) [2]	36,540	812	837
Certifications reopening case	10,725	239	488
Applications denied or withdrawn	12,419	276	246
Total expenditures (100 percent)	$65,179,912.55	$1,481,361.65	$2,000,199.49
Hospital inpatient care	29,580,793.12	672,290.75	850,729.24
Medical care facility	31,690,070.46	720,228.88	1,018,348.18
Outpatient clinic	112,754.82	2,562.61	3,340.15
Physicians' services	2,413,777.53	54,858.58	69,584.71
Home nursing	113,439.02	3,241.11	4,031.13
Nursing home care	1,269,077.60	36,259.36	53,766.08

[1] Certifications divided by 45 months (October 1960 to June 1964) except home nursing and nursing home care (divided by 36 months). Expenditures divided by 44 months (November 1960 to June 1964) except home nursing and nursing home care (divided by 35 months).

[2] Unduplicated count of different persons certified for service under MAA since beginning of program.

Source: State of Michigan, Department of Social Welfare, July 24, 1964.

[Reference No. 4]

STATE OF MICHIGAN

PUBLIC ACT NO. 2 OF 1960 (THE MEDICAL ASSISTANCE TO THE AGED LAW), AS AMENDED, 1961, 1964

An ACT to provide medical assistance for the aged; to prescribe the terms and conditions for such medical assistance; to prescribe the powers and duties of the state department of social welfare and certain other state officers and agencies; to authorize the transfer and expenditure of state funds; and to prescribe penalties for the violation of this act.

The People of the State of Michigan enact:

SEC. 1. This act shall be known and may be cited as the "medical assistance for the aged act."

SEC. 2. As used in this act:

(a) "State department" means the state department of social welfare.

(b) "Commission" means the Michigan social welfare commission.

(c) "County bureau" means the county bureau of social aid.

(d) "Medical assistance for the aged" means medical and ancillary services as described and circumscribed in this act rendered persons eligible therefor.

(e) "Annual income" means income received during the 12 months preceding or anticipated during the 12 months following application for medical assistance under this act.

(f) "Medical institution" means a hospital certified by the state health commissioner or a county medical care facility.

SEC. 3. The state department shall establish a program for medical assistance for the aged under Title I of the federal social security act, as amended by Public Law No. 778 of the 86th Congress. Medical assistance for the aged shall

be granted to any resident of this state 65 years of age or older who meets all of the following conditions:

(a) He has made application therefor in the manner required by the state department.

(b) He is not receiving old age assistance.

(c) His need for the type of medical care available under this act for which application has been made has been professionally established and no payment for it is available through the legal obligation of a contractor, public or private, to pay or provide for such care without regard to the income or resources of the patient. No payment shall be made under this act for any hospital service for any injury, disease or disability for which the patient is entitled to hospitalization or the cost thereof under the workmen's compensation law; except that payment may be made if an appropriate application for hospitalization or the cost thereof has been made under the workmen's compensation law entitlement thereto has not been finally determined, and an arrangement satisfactory to the state department has been made for reimbursement if the claim under the workmen's compensation law is finally sustained.

(d) He, if unmarried, or not living with the spouse, has an annual income from all sources of not more than $1,900.00. If he is married and living with the spouse, he may have an annual income, including the annual income of the spouse, of not more than $2,700.00.

(e) He if unmarried, has liquid or marketable assets of not more than $1,500.00 in value, or, if married, he and the spouse have liquid or marketable assets of not more than $2,000.00 in value. Excluded in making the determination of the value of liquid or marketable assets are the values of (1) the homestead, (2) clothing and household effects, (3) cash surrender value of life insurance, and (4) not to exceed $1,000.00 of the fair market value of tangible personal property used in earning income.

(f) He has made no assignment or transfer of any real or personal property or income within 5 years immediately preceding the date of application for assistance under this act for the purpose of qualifying for medical assistance for the aged or for any form of assistance granted under the social welfare act, or for the purpose of increasing the amount of medical assistance for the aged or any form of assistance granted under the social welfare act or for the purpose of precluding recovery.

(g) He is not a patient in any institution as a result of a diagnosis of tuberculosis or mental disease.

(h) He is not an inmate of a public institution except as a patient in a medical institution.

SEC. 4. Eligibility for medical assistance for the aged shall be determined by the county bureau in which the application was filed. When eligibility has been established, the county bureau shall notify the county social welfare board of the county in which the applicant resides and list the type of services under this act which are required. The county social welfare board shall make provision for the services as long as needed or until notified by the county bureau that eligibility no longer exists. Service shall not be resumed after discontinuance without a new notification from the county bureau. The state department shall pay the county social welfare board for services provided under this act, after approval of each invoice by the county bureau, not less than 90% of the amount thereof from moneys available in a special medical assistance for the aged subaccount hereby established as part of the medical assistance account created by section 11 of the social welfare act, as amended. The commission may reduce the services available under this act to the extent necessary to keep payments from the subaccount within the appropriation available. The state department may determine the propriety of all claims for services rendered under this act.

SEC. 5. The state department may file a claim for reimbursement from the estate of a deceased recipient of medical assistance for the aged for payments made during his lifetime but no claim shall be paid until after the death of a surviving spouse if there is one except a claim made in respect to improper payments of medical assistance. All claims under this section shall be fifth class claims.

SEC. 6. The powers and duties of the state department and the county departments of social welfare relating to the administration of federally subsidized programs under the social welfare act are hereby granted and imposed on these departments insofar as applicable to medical assistance for the aged. Such rules and regulations shall provide safeguards which restrict the use or disclosure

of information concerning applicants and recipients to purposes directly connected with the administration of this act. A hearing shall be provided any applicant or recipient of medical assistance under this act as provided in sections 9 and 37 of the social welfare act. The commission shall adopt all necessary rules and regulations for implementation of this act in accordance with Act No. 88 of the Public Acts of 1943, as amended, being sections 24.71 to 24.82 of the Compiled Laws of 1948, and subject to the Act No. 197 of the Public Acts of 1952, as amended, being sections 24.101 to 24.110 of the Compiled Laws of 1948.

SEC. 7. Persons eligible for medical assistance shall be entitled to the services enumerated in section 8, 9, and 10 of this act. Such services shall be rendered upon certification by the attending licensed physician that a service is required for the medical treatment of an individual. The services of a medical institution shall be rendered only after referral by a licensed physician and certification by him that the services of the medical institution are required for the medical treatment of the individual, except that referral shall not be necessary in case of an emergency. Periodic recertification that medical treatment which extends over a period of time is required in accordance with regulations of the State department shall be a condition of continuing eligibility to receive medical assistance.

SEC. 8. Hospital services to which an eligible person is entitled, when furnished by a hospital certified by the state health commissioner or by a county medical facility approved by the department, shall not exceed those services furnished by the Michigan hospital service corporation under its comprehensive hospital care certificate in effect on September 1, 1960, and on file with the state commissioner of insurance, as determined by the state department. The period of inpatient hospital service shall be the minimum period necessary in this type of facility for the proper care and treatment of the individual.

SEC. 9. Physicians' services to which an eligible person is entitled shall not exceed those services furnished by the Michigan Medical Service under its M–75 Blue Shield plan in effect on September 1, 1960, and on file with the state commissioner of insurance, as determined by the state department.

SEC. 10. Effective July 1, 1961, home nursing service may be provided to the extent found necessary by the attending physician and the state department. Following hospitalization for acute illness, care in a state licensed nursing home may be provided for not to exceed 90 days in any 12 months' period.

[Reference No. 5]

ECONOMIC IMPLICATIONS OF THE PROPOSED HOSPITAL INSURANCE ACT OF 1963 (KING-ANDERSON) (NOT TAKING INTO ACCOUNT THE TAXING FEATURES OF H.R. 11865)

COST TO THE EMPLOYER AND EMPLOYEE

The projected social security tax on employer and employee under the present social security law, and excluding King-Anderson, will be 7¼ percent on the first $4,800 of income as of January 1, 1965.

7¼ percent of $4,800=$348

King-Anderson would increase this tax rate from 7¼ percent on the first $4,800 of income to 7¾ percent of the first $5,200 of income beginning January 1, 1965.

7¾ percent of $5,200=$403

This would result in a tax increase of $55.

$403−$348=$55

This represents an increase of 15.8 percent.

$$348\overline{)55.00} = .158 = 15.8\%$$

COST TO MICHIGAN

Estimates as to the effect of the above provisions on Michigan social security taxpayers hinge upon two considerations:

(1) The normal social security tax picture in 1965 excluding King-Anderson;

(2) The overall percentage increase indicated by King-Anderson (recognizing that not all social security taxpayers would be subject to the maximum taxable base of $5,200).

The Michigan State Medical Society Economic Department, in consultation with the AMA Department of Economic Research, has made estimates regarding these two critical items as follows:

(1) The anticipated social security taxes to be paid in 1965, excluding King-Anderson, are estimated at $915.1 million.

(2) The overall percentage rate of increase indicated by King-Anderson is estimated at 12.1 percent.

This means that under King-Anderson the estimated additional 1965 tax payments for Michigan social security taxpayers will be $110.7 million.

$915.1×12.1 percent=$110.7

For this same expenditure Michigan could build a Mackinac Bridge every year and still have a surplus of $10 million.

STATEMENT OF THE KENTUCKY STATE MEDICAL ASSOCIATION ON H.R. 11865, 88TH CONGRESS, BY GEORGE P. ARCHER, M.D., PRESIDENT

Mr. Chairman and members of the committee, the Kentucky State Medical Association is grateful for this opportunity to express its views on H.R. 11865. This is a subject in which the medical profession has a deep and continuing interest. The association hopes that you will find its comments helpful to your committee's discussion and deliberations.

The Kentucky State Medical Association is composed of approximately 2,200 practicing physicians. The association was founded in 1851 with the continuing purpose of extending and elevating the quality of medical science and knowledge, to raise and maintain the standards of medical education and to better the medical profession's service to its patients by uniting with similar State medical societies to form and maintain the American Medical Association. It is consistent and with these purposes that the physicians of Kentucky present evidence to this committee of the adequacy of our current MAA program and to offer information on the scope of coverage under nongovernmental health insurance plans.

Unwarranted criticism

In spite of Kentucky's not being a wealthy State, it was preceded only by Michigan and West Virginia in enacting enabling Kerr-Mills legislation. With this accomplishment the Kentucky Kerr-Mills program has been criticized in the past, and continues to be misrepresented, as being too limited in benefits, too rigid in its eligibility requirements, and too inefficient in terms of administrative costs. We know, and would like to respectfully demonstrate to you, that these criticisms are not warranted.

Eligibility liberalized

Kentucky's indigent medical care program, which includes MAA, was inaugurated on January 1, 1961. This was a new program, and we had no guidelines from past experience to assist in formulating our benefit structure. Understandably, Kentucky wanted the program to grow and develop in a manner both orderly and fiscally sound, so the program began modestly. Since that time, however, it has been revised and expanded as experience and need have demonstrated the desirability to change. For example:

On January 1, 1961, the MAA program was open to persons 65 years of age or older residing in Kentucky who had an annual income of not more than $1,000 if single, and $1,500 if married. The same year, in September 1961, gross annual income was raised to $1,200 for single persons and $1,800 for married couples. Last year, on April 1, 1963, the eligibility requirements were further liberalized, and the annual gross income limits for single persons were raised to $1,600 and for married couples to $2,400.

At the inception of the program, our department of economic security estimated that 87,000 of our population over age 65 were potentially eligible for MAA benefits. By July 1, 1964, 30,549 had applied and of this number 26,744 qualified. Because of deaths, accumulation of assets, other sources of income and transferring from MAA to OAA, only 16,750 recipients were eligible to receive benefits.

Expansion of benefits

Initially, our MAA program benefits were broad in scope, but somewhat limited in extent. The physicians were paid for two home and office visits per month and the hospital was paid for 3 days of service. This, however, did not mean that patients were summarily discharged from the hospital at the conclusion of 3 days' stay. They continued to receive necessary hospitalization and medical care just as they have for past years. Physicians' visits to the hospitals were not included in the coverage, and only certain emergency care by dentists was allowed. Physicians, being taxpayers, agreed as an association that they would be willing to eliminate physicians' fees for in-hospital visits.

The program benefits have been expanded, and today the recipients are eligible to receive hospital care for 10 days per hospital admission with a liberal readmission policy. Among other improvements in the program are dental services which now may include extractions and fillings and the treatment of conditions involving pain, infection, or hemorrhage. Patients are entitled to 18 physician home or office visits per year with additional home and office visits where necessary by authorization.

Program recipients preauthorized to need skilled nursing care are eligible to receive benefits for an indefinite period of time. All licensed nursing homes are eligible to participate on a flat rate basis. Homes meeting high criteria of attainment are eligible to participate on a reimbursable cost basis for 120 days per calendar year.

Projected expansion of program

Although the Kentucky MAA program has been repeatedly broadened and liberalized since its inception, it will not stand still at present levels. Already the program has been projected into the future and further expansion is planned. On July 1, 1965, eligibility will be further liberalized by increasing the annual gross income limits to $2,400 for single persons and $3,000 for married couples.

Benefits have also been projected to July 1965. Payment for hospitalization will be increased from 10 to 14 days with a provision for an extension of an additional 7 days upon authorization. Physicians' coverage will be increased, as will coverage for dental work which will be expanded to include diagnosis and treatment of dental illnesses and the repair of dentures. Provision for "high criteria" nursing home care will be still further expanded to 180 days, and home nursing visits will be added as an entirely new feature of the program.

The Kentucky MAA program has been well accepted by our elderly people, as well as by the vendors of medical service—i.e., hospitals, nursing homes, pharmacists, physicians, and dentists. With the expansion of the hospital benefit period to 10 days per admission, it is now estimated that the program covers 82 percent of the cost incurred by hospitals on program beneficiaries and pays for the total cost incurred by approximately 82 percent of those admitted under the program.

As time goes on and Kentucky's experience grows, the program will be subjected to even further revision. In this way, soundly and with an understanding of the needs of our people, Kentucky is developing a program of medical assistance for the medically needy in which the Kentucky State Medical Association takes pride. A program intentionally contained in a modest beginning is maturing into a record of continuing progress.

Administrative costs

Finally, the question of "administrative costs" has been the object of some concern to those who choose not to believe in Kerr-Mills. These facts should again be examined. In the first 3 or 4 months of the program, administrative costs were approximately $1.24 for each dollar of benefits paid. It should be remembered, however, that the entire concept was new and it took a great deal of money to hire and train staff, set up necessary mechanisms of administration—i.e., rent, office equipment, etc., and develop efficient methods of operation. It also took time to bring into the program those needing financial and/or medical help. Today, the program's administrative costs are only 6 percent of the total, with a foreseeable lowering to 5 percent. It appears then that in the relatively short time that Kerr-Mills has been implemented in Kentucky, administrative costs have fallen from an initial 124 to 6.14 percent as of June 30, 1964. We believe that this answers the charge of excessive administrative cost and demonstrates the ability of Kentucky to care for those who need help in an economic and efficient manner.

More of the Kentucky story

Obviously, the "Kentucky story" is more than our medical assistance to the aged program. Of the 3 million people living in Kentucky, the Health Insurance Institute has reported that as of December 31, 1961, over 1.8 million have purchased health care coverage either through a commercial insurance company or through Blue Cross-Blue Shield. We know that over 85,000 of our aged are covered by Blue Cross-Blue Shield alone, and it would be a realistic assumption to place the number of those over 65 who are covered by a commercial insurance policy at about the same figure. Of the 292,000 senior citizens in Kentucky, approximately 170,000 are protected by privately purchased voluntary health care coverage.

In addition to those presently covered by the voluntary prepayment system, private industries such as Southern Bell Telephone & Telegraph Co., Ford Motor Co., General Motors, United Mine Workers, Green River Steel, Newport Steel, and Armco Steel are now providing health care programs for their retired employees. Other volunteer groups, labor, management, medicine, teaching profession, local government, and the people themselves in Kentucky, have demonstrated beyond the slightest doubt that through our voluntary efforts we are caring for those unable to provide medical care for themselves.

During the 4 years of the Kerr-Mills' existence in Kentucky, we have had an opportunity to observe its growth, and we know it is providing an ever-increasing service to MAA recipients. Private insurance and voluntary efforts continue to grow and fill the needs of the people of our State.

We wish to express our appreciation for the privilege of presenting the association's comments on H.R. 11865 and request that these views be incorporated in the record of your hearings.

INDIANA STATE MEDICAL ASSOCIATION SUBMITTED BY DONALD E. WOOD, M.D., PRESIDENT

AUGUST 12, 1964.

Senator HARRY F. BYRD,
Chairman of the Finance Committee,
U.S. Senate,
Washington, D.C.

DEAR SENATOR AND MEMBERS OF YOUR COMMITTEE: You currently have before you H.R. 11865 (Social Security Amendments for 1964) as adopted by the House, concerning the increasing of benefits under social security and the adding of physicians to those compelled to pay social security taxes.

You are currently holding hearings on this measure and we desire to make the following a matter of record as a statement from the Indiana State Medical Association.

We beg the indulgence of your committee to take action, removing physicians from this bill. Under the provisions, if retained, and physicians are compelled to pay the social security tax, you are, in effect, raising the cost of medical care to the people of the State of Indiana. Under the rates, as projected for physicians, you will be collecting approximately $1¾ million per year from Indiana doctors, which is, naturally, a cost of doing business which will be passed on to the consumer, as are all expenses of doing business.

Physicians, as a group, generally, do not retire from practice until totally disabled, and more often only upon death. Therefore, there is very little likelihood that many of the physicians, or their families, in our State would ever benefit from this program. Should you insist on retaining physicians under this bill, it might be a factor in encouraging about 10 percent of the physicians in Indiana to retire earlier, as has been the case in industry and commercial forms of business. If this would occur, we would be faced with a tremendous physician shortage, which, again, would reflect upon the care and the health of the people of our State. While we are aware that a percentage of physician members of our association are covered by social security for one reason or another, and others are interested in being covered; nevertheless the poll taken of our membership indicates 3-to-1 opposition to compulsory inclusion under social security.

For example, in 1965, under the proposed rates, you would extract $307.80 per physician per year. In 1966 this would increase to $324 per physician per year, in 1968 it would increase to $367.20, and in 1971 to $388.80 per physician per year. The average age of physicians in our State being what it is, a physician of 30 years of age, making a $350-per-year investment in private insurance retirement programs, at age 74, the usual retiring age, if they do retire, would

have a cash value lump sum of $40,395 at 4 percent. If this money were invested in funds producing an 8-percent rate he would have a lump-sum benefit of $124,932, or he would have a monthly life annuity on a 4-percent rate of $388 per month, or a monthly life annuity on an 8-percent rate of $1,199 per month.

A man of 40, investing the same amount of money would accumulate $24,450—$55,519—and monthly life benefits of $235 and $533, respectively. Even a man of 50 years of age, investing $350 per month in private programs would obtain monthly lifetime annuities at $131 and $224.

Most of the physicians have taken advantage of this type of program through private carriers and, therefore, we see no reason for this additional tax which would influence the cost of medical care being added as a burden to the physician and his patients.

We, therefore, urgently request that your committee remove physicians from this proposed legislation.

SOUTH CAROLINA MEDICAL ASSOCIATION

Statement to: The Committee on Finance, U.S. Senate, Washington, D.C.
In behalf of: The South Carolina Medical Association, by Dr. Frank C. Owens, Columbia, S.C., president.
Subject: H.R. 11865, Social Security Amendments for 1964.

The purpose of this statement is (1) to describe the means now available for payment of the medical and hospital care of citizens of South Carolina over age 65, and (2) to emphasize the adequate provisions already made by Government through the Kerr-Mills Act for the care of the aged in South Carolina.

The South Carolina Medical Association is an eleemosynary corporation chartered in the year 1904. Among the purposes stated in its charter and for which it is maintained are: extending medical knowledge and advancing medical science; elevating the standards of medical education, and securing the enactment and enforement of just medical laws; promoting friendly intercourse among physicians; protecting them against imposition; and enlightening and directing public opinion in regard to the great problems of medical care, so that the profession may be more useful to the public in the prevention and cure of disease, and in prolonging and adding comfort to life.

Its membership has approximately doubled in the past 15 years as the number of physicians entering practice has kept pace proportionately with the increase in population of the State.

Since 1944, the association has been engaged in a positive program designed to relate its activities and the services of its members to the needs of the entire population. The initial task undertaken by the association, after the institution of is 10-point program in 1944, was the passage of enabling legislation for the organization of a nonprofit hospital service plan. Previous to that time, the hospital association of the State had made considerable effort along this line, but not until the South Carolina Medical Association began its positive effort in that direction was it possible to secure passage of a statewide law. The act was passed in 1945 and became operative in 1946. It is entirely accurate to say that without the efforts of the doctors of South Carolina through their association, such legislation would not have been enacted at that time, if at all.

The South Carolina Hospital Service (Blue Cross) Plan was organized shortly afterward and has operated successfully since. The scope of its coverage and extent of its services to the citizens of the State have been expanded regularly, and continue to increase.

In April 1948, again through the efforts of the medical association, additional enabling legislation was adopted by the general assembly of the State to provide for the organization of a nonprofit medical service plan. Pursuant to that act, South Carolina's Blue Shield (the South Carolina Medical Care) Plan was formed and operates through the cooperation and participation of the members of the association.

The foregoing facts will demonstrate the association's early interest in the provision of medical care for all the people of the State at prices which they could afford to pay, whatever the income bracket. It will be noted that they antedated by several years the first determined effort in Congress toward compulsory health insurance legislation.

In 1948, the association sponsored and secured passage of an act appropriating State funds for financing eight scholarships at the Medical College of South Carolina, for students of medicine, who, in return for such scholarships, would

agree to practice an equivalent number of years in a rural community designated by the State department of health upon the basis of need for doctors.

Beginning in 1946 and during the ensuing years, this association combined the weight of its influence with that of the trustees and other officials of the Medical College of South Carolina for a broad expansion program at that institution. The then president of the association appeared before a joint meeting of the Senate and House of Representatives of South Carolina to assist in what proved to be a successful effort to obtain appropriation of more than a million dollars by the State toward the cost of such expansion. As a result of the latter, the total number of young doctors graduated each year from the medical college was increased from 40 to 80.

The Kerr-Mills law was passed by Congress in the fall of 1960. At the next session of the General Assembly of South Carolina, in the spring of 1961, officials of the South Carolina Medical Association, in cooperation with the director of the department of public welfare of the State, sponsored legislation to implement the act in South Carolina, the president and other officers appearing at hearings before the committee on ways and means of the State house of representatives in behalf of the bill. It was enacted into law and became effective July 1, 1961. At the suggestion of association officials, and with the full endorsement and cooperation of its members, any provision for payment of professional fees from Kerr-Mills funds was omitted. Therefore, despite the authority therefor granted by the act of Congress, no money from the Federal Government or the State government under the Kerr-Mills law is used in the payment of professional fees for physicians in South Carolina.

By reason of all the foregoing, we respectfully submit that this association and its members are qualified to speak and are entitled to be heard on the subject of the means of providing hospital, nursing home, or medical care for the citizens of the State.

Now, as to the specific benefits available to persons over 65 under Kerr-Mills:

A. Institutional medical care

1. *Hospitalization.*—(*a*) *Coverage.*—General hospital care is provided an individual who (1) has been certified by the county welfware department as meeting the need and other eligibility requirements, and (2) has been certified by a physician as acutely ill, injured, or has a sight-endangering condition, with hospitalization being essential for treatment. Conditions diagnosed as either tuberculosis or psychosis are excluded, except for a period of 42 days of hospitalization for such conditions. Provisions for out-of-State hospitalization are included, provided the recipient is a resident. Hospitalization will be provided for a recipient for as much as 40 days in any 1 fiscal year.

2. *Nursing care.*—Nursing care in a public medical or private institution licensed by the South Carolina Board of Health is provided under the program. Where possible, an effort is made to limit such care to a period of 3 months, but this is extended in unusual cases involving long-term treatment.

B. Noninstitutional medical care

In addition to the foregoing, the program in South Carolina provides for the following:

1. *Outpatient hospital or clinic medical care service.*—(*a*) *Emergency room service.*—This service will include drugs administered in the emergency room, oxygen, small casts, sutures, dressings, and so forth, administered to emergency cases seen and treated in the emergency room, but not admitted to the hospital.

(*b*) *Organized clinic service.*—This service will include drugs administered in the clinic, oxygen, dressings, cast removal, and so forth, routinely used in the treatment of patients in an organized clinic.

(*c*) *Special diagnostic and therapeutic services.*—In addition to payments for emergency room and clinic services when requested through those departments or on the basis of a direct request from a private physician, the following services will be provided:

(1) Laboratory procedures: This service will include all examinations of urine, blood, sputum, stool and tissue specimens, both gross and microscopic, and metabolism tests.

(2) X-ray and radioisotope procedures: This service relates to diagnostic procedures.

(3) Intravenous solutions: This service relates to the administration of intravenous solutions, regardless of the size of the dose.

(4) Minor surgery: This service includes biopsies, excisions of pigmented nevi, and so forth.

The foregoing services are available to single persons having an annual income not exceeding $1,400, or to a man and wife whose combined annual income does not exceed $2,400. Ownership of a homestead does not disqualify a recipient otherwise eligible. The cash loan or surrender value of an applicant's life insurance on the first $1,000 face value, if single, or $2,000 in case of a man and wife, are exempt from consideration of eligibility or from the requirement that it be applied to payment for care received under the program. Likewise, exempt are the first $500 of savings of an individual, if single, or the first $800 savings of a man and wife living together, and also the value of such personal property items as automobiles, household furnishings, and farm equipment.

According to the records of the department of public welfare, as of February 1961 there were in South Carolina approximately 150,600 people over the age of 65. Of these, there were 34,000 on the public welfare rolls (OAA). Fifty-four percent of the total, or 81,324, received an annual income of less than $1,000, some of whom may have been covered by OASDI. Generally speaking, it is the latter group, therefore, with which the Kerr-Mills program is concerned, although, obviously, considerably more than this number will be included under the higher annual income of $1,400.

Now, let us look briefly at the extent of the service which has been rendered under the program. During the fiscal year ending June 30, 1963, the last full year of operation for which figures are now available, the program paid for hospitalization of 5,670 patients, representing 66,578 patient days. The total amount paid to hospitals for these cases was $1,330,546.37. Nursing home care was provided for 489 patients, representing 12,580 patient days, for which a total of $50,138.33 was paid to nursing homes. In addition, payment was made for service to a total of 3,407 outpatient cases.

Of the total expenditure of $1,409,293.20 for medical assistance during the year July 1962-July 1963, the State of South Carolina paid 20 percent or $281,854.64, and the Federal Government 80 percent or $1,127,438.56.

According to the director of the department of public welfare, the extent and cost of services under the program are increasing steadily. There are now 12,000 on the eligible list for Kerr-Mills benefits, and there are many more who are eligible but have not established eligibility.

The foregoing information demonstrates:

(1) The recognition by South Carolina citizens of their responsibility in the field of medical, nursing, and hospital care for the aged.

(2) Their willingness to cooperate with the Federal Government in providing the needed assistance.

(3) The fact that the benefits are available to the group for whom they are intended—those of modest income, able to provide for their ordinary needs, but unable to bear the burden of serious illness and the cost of institutional care.

It is obvious, we submit, that such a program is vastly preferable to one which, through a substantial increase in social security taxes for everyone, would undertake to provide limited hospital and nursing home care for millions who would prefer to buy their own private insurance coverage from Blue Cross-Blue Shield or other commercial companies, or whose financial circumstances are such that they do not need to provide insurance coverage at all.

FRANK C. OWENS, *President.*

STATEMENT OF THE MISSOURI STATE MEDICAL ASSOCIATION SUBMITTED BY LEONARD T. FURLOW, M.D., PRESIDENT

Re H.R. 11865

The following statement concerning H.R. 11865 is being filed on behalf of approximately 4,000 Missouri physicians who are members of the Missouri State Medical Association.

We hereby record our opposition to the King-Anderson bill being substituted for or added to the House-passed legislation, as well as to the so-called option plan whereby recipients of social security would have the choice of increased cash benefits of a hospitalization program.

Our reasons for opposing the King-Anderson approach to health care for persons aged 65 and over have been stated before. First, this method would pro-

vide benefits regardless of ability to pay. It would not, as does the Kerr-Mills program, operate on the sound basis of providing aid only to those in need.

Second, because all persons aged 65 and over would be eligible for benefits, the cost would not only be prohibitive, but would force working people of today to pay these higher costs in order that assistance be provided to very man and woman over a certain age limit, whether such assistance is needed or not.

Third, such a compulsory plan for the aged under the social security system would, of necessity, place unwarranted control and direction of our Nation's health care in the Federal Government and would, thereby, disrupt the traditional doctor-patient relationship and free choice of physician which has built and maintained a system of health care second to none in the world.

Finally, from our experience and knowledge of the needs of Missouri's elderly, we are convinced that these needs can be taken care of at the State and local levels. The last session of the Missouri General Assembly authorized increased and expanded payments under the Kerr-Mills program. Along with local assistance programs and the steadily growing coverage of persons 65 and over by private health insurance plans, it is apparent that whatever problem there is in providing medical care for the aged in Missouri is being taken care of without a costly Federal program.

We oppose the addition of King-Anderson to H.R. 11865 for the same reasons, with an added emphasis on the cost factor. As Health, Education, and Welfare Department Secretary Celebrezze stated to your committee, the social security wage base would have to be raised from the $5,400 level of the House bill to $6,600 in order to finance a King-Anderson program.

Moreover, placing King-Anderson on top of H.R. 11865 would probably result in a combined social security payroll tax on employers and employees of at least 10 percent. Certainly, it would be impossible to have both the cash increase provided in the Mills bill and King-Anderson without a major increase in either the wage base, the tax rate, or both. It seems clears to us that advocates of social-security-financed health care are determined to enact such a program, regardless of the financial burden it would put on our working men and women, or the danger it would pose to the continuing stability of the social security system itself.

Similarly, we oppose the inclusion of a Federal program as an option to increased cash payments. This would not only lead to confusion and higher costs, but would be a first step toward a completely compulsory King-Anderson program. As an "option," this scheme has the same inherent drawbacks it has always had.

We would, therefore, urge each member of the committee to oppose any amendment in support of King-Anderson, or a similar program, as an addition, substitution, or option to increased cash payments.

We would also ask that you act favorably toward an amendment which would eliminate that part of H.R. 11865 which brings private physicians under social security coverage. Physicians do not generally retire at any certain age; in fact, a majority of doctors in the United States continue to practice after they have reached the 65-year mark. Thus, although the average physician would be required to pay into social security at a maximum rate, many of them would never receive retirement benefits. We believe that a majority of physicians in Missouri and throughout the Nation oppose inclusion, and hope that your committee and the Senate will take these views into account.

Thank you for your consideration and attention.

STATEMENT OF THE NEBRASKA STATE MEDICAL ASSOCIATION SUBMITTED BY THE R. E. GARLINGHOUSE, M.D., PRESIDENT

In opposition to the type of legislation as proposed in the medical-hospital care amendments to H.R. 11865; and compulsory inclusion of physicians under social security

Mr. Chairman and members of the committee, the health care horizon for senior citizens in Nebraska is unclouded, because Nebraskans have shouldered the responsibilities of providing adequate health services to any of their fellow citizens in need.

Working hand in hand with the department of public welfare and the Governor's Commission on Aging, the Nebraska State Medical Association has investigated every phase of health care problems which confronts senior citizens

in Nebraska. During the 1963 session of the unicameral, the NSMA worked with the Nebraska Legislature in securing passage of a fair and broad Kerr-Mills program. The association has labored with dedication alongside voluntary care agencies. From an analysis of the facts available from all sources, including actuarial studies made by the insurance section of the Governor's Conference on Aging,[1] the Nebraska State Medical Association concludes that Nebraskans neither desire nor need the type of legislation as proposed in H.R. 3920, or any similar proposal attached to H.R. 11865. As in the past, the members of the NSMA are also unalterably opposed to any attempt to include physicians under compulsory social security.

The objections of the people of Nebraska, and the Nebraska State Medical Association to King-Anderson type legislation in any form, are threefold.

First, the cost of the proposed legislation is prohibitive and exorbitant. The Nebraska taxes for medicare in 1961 would have been part of the $87.5 million collected in social security, plus an additional $10 million.[2] By 1965, the tax bite would have been $119 million plus $11.2 million to finance the proposed legislation. Since there are only 174,000 persons in Nebraska over age 65, and of that number about 7 percent, or 13,325, have received old-age assistance,[3] the cost to Nebraska taxpayers for each eligible beneficiary would be $804. This figure compares with $277 per eligible beneficiary under the Kerr-Mills bill passed during the 1963 unicameral session.[4]

Second, the senior citizens of Nebraska are adequately cared for and will continue to be adequately cared for through private voluntary health programs or through old-age assistance and medical assistance for the aged administered by Nebraskans who know and understand the needs of their State's residents.

In Nebraska there are about 174,000 people over age 65. Of this number, 7 percent, or 13,325[5], received OAA during 1962. During the biennium 1961–63, Nebraska spent approximately $13 million in the operation of the OAA program to provide all necessary health services to these needy citizens.[6] During the first quarter of 1963 alone, the department of public welfare spent $1,797,425 on OAA in Nebraska. This represented an increase of 2.4 percent over the previous quarter although the caseload dropped 1.6 percent, for an average increase in expenditures of 4.1 percent.[7] Still more has been done. The 1963 session of the unicameral implemented the Kerr-Mills legislation adopted by a majority of the States. L.B. 100, introduced by special legislative permission by 12 senators of both parties and urged by Gov. Frank B. Morrison in his second inaugural address[8] imposed a head tax on every working person in the State between the ages of 21 and 60 to add additional health care for the aged. The bill provides for hospitalization, nursing care, physicians care, dental care, care by an osteopath or chiropractor, a doctor licensed to practice podiatry or optometry, the cost of drugs and medicine, and prosthetic appliances. The only limitation is for persons who have families capable of meeting the necessary medical expenses of the applicant. The Nebraska act prescribes that information regarding applicants for such medical service shall be used only for purposes directly related to the administration of that service. This legislation went into effect in May 1964.

Public assistance programs are less than half the story in Nebraska. Two private care plans alone cover the health emergencies of more than 50,000 Nebraskans over 65 years of age.[9] By July 1, 1965, the insurance section of the Governor's Commission on Aging estimates that 73.5 percent of the people over 65 would have private hospitalization coverage. This section also revealed that at least 166 companies issue insurance policies at age 65 or older. The impact of these figures can be felt when they are compared with the 1960 figure of 12 percent of the over-65's covered by health insurance in Nebraska.

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[1] Report of the Subcommittee on Insurance, Governor's Conference on Aging, Lincoln, Nebr., Aug. 23, 1960.

[2] Annual statistical supplement of the Social Security Bulletin, 1961, table 23. Tax increase for the United States estimated at 11.1 percent per calculations by Economic Research Department.

[3] Population figures drawn from Congressional Record, May 17, 1962, p. 1018; recipients of OAA based on quarterly averages supplied by Department of Public Welfare, State of Nebraska, Quarterly Health Service Statistics, vol. 9, Nos. 1–4, and vol. 10, No. 1.

[4] Lincoln Evening Journal, June 21, 1963.

[5] Op. cit., note 3, pt. B.

[6] Ibid.

[7] Quarterly Health Service Statistics, vol. 10, No. 1, p. 2.

[8] Inaugural address of Gov. Frank B. Morrison, Jan. 3, 1963, p. 15.

[9] Statement, Mutual of Omaha, Aug. 21, 1963; statement, Nebraska Blue Cross-Blue Shield, August 1963.

Nebraskans are rapidly making care facilities readily available to senior citizens. As of 1963, there were 131 hospitals with 11,347 beds. Eleven of these hospitals have geriatric wings which provide 297 beds for chronic illness and 119 beds for skilled nursing services. Private old-age homes are springing up rapidly over the entire State. As an example, the Good Samaritan Village in Hastings has 196 beds for the occupants of the village, with 2 registered nurses on duty, as well as 1 licensed practical nurse.

Third, Nebraskans are constantly reappraising their own health care problems and creating locally controlled and paid for solutions to them. In 1960, the people of the State amended their constitution to create a department of public welfare and to provide for officers of that department.[10] This department has the responsibility of administering the health care programs through welfare. It will administer and evaluate the Kerr-Mills medical program toward necessary expansion in the years to come.[11]

Beneath the framework of public health care programs in Nebraska is the solid foundation of medical assistance. Under the Kerr-Mills program the medical profession and other health vendors will provide services to the needy at a reduced cost as part of their contribution to the program.

The medical profession is proud of the progress made in Nebraska in the health care fields. They are proud of the role they have played in legislative study, in developing adequate laws and in implementing them.

The medical profession in Nebraska, as in the past, is unalterably opposed to the compulsory inclusion of physicians under the social security program, as proposed in H.R. 11865. Their objections are based on the following reasons:

H.R. 11865 proposes to increase social security benefits, the rate, and the taxable wage base to finance it. The costs of social security are not made stationary by any regulatory means or guarantee. The self-employed physician's payment into the social security system would increase from $259 this year to over $300 in 1965. By 1970, he would pay $388.

The objections of the members of the Nebraska State Medical Association also rest on the fact that there lacks a balance between taxes paid and benefits received. Social security taxes are constantly increasing and will ultimately become exorbitant.

Physicians in Nebraska, and over the Nation, can use the amount of their potential social security payments to purchase safer insurance, securities, and investments from private companies. Social security is not insurance, consequently no contract as such is present.

In conclusion, we urge that you direct your attention to our objections to both of these issues which are of vital interest to the people of the State of Nebraska, its physicians, and the Nebraska State Medical Association.

Thank you, gentlemen.

MEDICAL SOCIETY OF THE STATE OF NORTH CAROLINA, SUBMITTED BY EDGAR T. BEDDINGFIELD, JR., M.D.

Mr. Chairman and members of the committee, my name is Edgar T. Beddingfield. I have practiced general medicine in the small coastal plain community of Stantonsburg in eastern North Carolina for 13 years during which time I have been closely involved in observing and meeting the medical service needs of a cross section of the rural population which characterizes our State. As the son of a long-time practicing pharmacist who, with a pharmacist uncle, operated an areawide service drugstore in Clayton, N.C., I grew up to be associated with people in many walks of life—farmers, merchants, textile laborers, business people of all types, the average run of citizen both in private enterprise and government, inasmuch as my childhood home was only 15 miles from the capital of the State. From the vantage of my home community, the drugstore in which I worked as a youth, my educational experience in academics and the professional schools of pharmacy at the University of North Carolina, and in medicine at Harvard (graduated in 1948) on through my residency at Walter Reed Hospital and finally in my general practice, I sense there has been more than a usual opportunity afforded me to observe the wants, needs, and actual health services people desire and gain. This is true, particularly in North Carolina, where I have given study and some leadership, over a good

[10] Cf. L.B. 113, 72d sess., Nebraska Legislature, 1961.
[11] Op. cit., note 4.

number of years, to the problems of medical care and the means by which medical care can and should be best purveyed to the citizens.

Many of the advances of medicine throughout all cultures have been episodical. The same may be said of its hindrances. History is replete with darkened ages of medicine when man's mind has been closed or blinded by bias and prejudices and where leadership has befallen to the less knowledgeable. On the other hand in every movement in which medicine has been bound by ignorance and the feigned artfulness and designing of incapable leadership there have arisen men of courage who could and did throw off the yoke of ignorance and organized hindrances and so, through the centuries, the progress of medicine has gone on particularly forward. Thus, it is that we can now rightly claim that the world has the best scientific medicine of all time and that the arts and skills of purveying it here in America have not been equaled in any previous time or place. Now, let us, in the United States, beware of those proposals which put the proven aside and undertake, with haste, schemes of an unproven nature the counterparts of which in other countries can be cited as failures or inefficient in meeting genuine human medical and health needs, particularly when compared with the American free system of choosing.

With these premises, I wish to direct attention to the proposition now before the committee, the 1964 House amendments to the Social Security Act (H.R. 11865) to which some propose to attach a version of medical care, similar to the so-called King-Anderson bill, H.R. 3920.

In discussing this I do as a representative of the Medical Society of the State of North Carolina and its 3,600 members of which I am an elected councilor of a 1-county district in which capacity I serve on the prime policy body, the executive council of the society and as chairman of the society's committee on legislation. My society and most of its members have studied each of these type measures, beginning with the propositions in the early Murray-Wagner-Dingle bill, through the episode of Forand bill, the first King-Anderson bill and the current King-Anderson proposal (H.R. 3920), lately laid dormant after much review and astute study. I earnestly state that our society and its members oppose any King-Anderson type of modification to this bill. The principal points of our opposition to H.R. 11865 with inclusion of King-Anderson relate to the following:

1. The experienced success of present health care for the aged as provided in existing programs of medical care of the needy aged in our State, combined with the newly enacted Kerr-Mills implementation law, now fully encompasses all of the adequate provisions of the Federal act for the health care of the aged. The new State authority and appropriations do make it possible (despite senseless administrative delay) for the administration of all the major Kerr-Mills priorities of services which are vital to the medical care of the aged. Possible needs beyond those provided in this act are not apparent to physicians in our State nor substantiated by any other group which has seriously studied the matter. And King-Anderson is a very poor substitute in relation to invisioned services required by needy aged.

2. Existing Federal and State laws encompass fully all the known essentials to adequate medical care of the aged and new legislation proposes no other essentials. Moreover, under law these programs may be constantly expanded to meet newer concepts of adequacy and efficiency of the same essentials.

3. The expense proposed if King-Anderson were attached to H.R. 11865 is too great either as provided or ultimately implied to justify its limited schedule of benefits, comparable to those going programs in the State which offer greater benefits to the needy at less expense and which may be expanded when needs and priorities develop beyond present provisions. Yes, improved to meet any imaginable concept related to vital need, medical or economic, under voluntary concepts. To our knowledge, it is much more in reason and justified to spend whatever public funds are necessary to restore a given individual's health (provided he is unable to provide such funds himself) as opposed to the King-Anderson proposal which provides limited help to a given patient irrespective of the patient's economic status or ability to provide his own care.

4. The philosophy contained in any compulsory social security is neither supportive of active medical care programs in operation in the State nor by its taxing features will it increase the capacity of the people in a community to support going programs, private and public, of known and lasting benefit to the needy aged of the State and would, therefore, be contrary to the progress manifestly in effect in our State of caring for all the needs of its citizens, including the identifiable aged needy of our total population among other needy.

You are aware that North Carolina is a youthful people—near a quarter of the population encompassed in its educational system which through constant expansion bids well to enchance the economic and cultural level of all so that we shall anticipate less illiteracy and poverty in coming generations. Our industrial and agricultural systems are expanding and progressively bear evidence of greater know-how and of economy to embrace and forestall the vicissitudes of the future. Our aged population (6.9 percent) is minor in comparison to our youth and much below the national average (9 percent). Our educational and health programs will not tend to spawn ignorance and frailness of human need, but rather develop a teamwork of producers out of our labor and industry to actually disrupt what our Governor has termed the "cycle of poverty."

And, by planning and saving for the needs of late life, intercurrent illness and latent handicap, we shall minimize the needs of the aged. Under these trends we hope by research and practical controls to reduce the incidence of physical, mental, and economic disability attributable to disease processes to the point our older citizens will arrive at the threshold of retirement a more adequate individual, able to cope with the manifest problems of old age and the essential adjustments thereto without the deadening influence of largess by Government and we shall then see a heartening generation of older people prepared for the good years of life. I have the explicit faith that unhampered medical science can and will play a leading part in these exciting events, but it can scarcely do so with the encumbrances of a governmental system such as would characterize the legislation at issue and that which would surely follow its pattern to an all encompassing medical care scheme. It is on these points of issue that I submit this statement to you in opposition to amendments to H.R. 11865 or opposition to King-Anderson per se. It is a proposal falsely claiming its fealty to responsible health care services for our older people. It simply cannot and will not meet needs sufficiently as the current private and public programs can do if allowed to carry on in their proven courses of developing efficiency and adequacy.

I should like to bring into review some of the actions in North Carolina in proof of our concern with these problems and cite to you that we are meeting needs in the area of the aged in our State:

1. As long ago as 1953 the "pooled" hospitalization fund had established the objective of meeting 85 percent of all medical care costs for those in need—hospitalization. By expanded legislation and appropriations in acts of seven biennial sessions of the general assembly this fund encompasses all known types, ages, and cases of needy requiring hospitalization. Administration and funds are adequate to cover care at $20 per diem. In addition to $20 per diem from public funds, certain other public and private supplements thereto now meet the mean per diem costs of care in 172 general, medical, and surgical hospitals throughout the State.

All persons of reasonable and proven economic need have access to this fund. To tax our people for a scheme encompassing segments of citizens without such need is to hinder the very progress we have exemplified in the past decade. The passage of a Kerr-Mills Implementation Act in 1963 assures the continuation of hospitalization for all people in real need and assures adjunctive services which are designed to lessen the future incidence of hospitalization and prolonged care in hospitals such as has characterized some patient requirements in the past and these objectives certainly would never be the result of the type legislation as proposed in a King-Anderson principle. Total combined matching appropriations for hospitalization in 1963–65: $21,700,000.

2. The 1963 Kerr-Mills Act now embraces and is implemented, including aspects of the drug program at the threshold of implementing:

(*a*) Outpatient diagnostic services to award our needy aged with early and adequate detection in hospitals and doctors facilities which will lower the incidence of prolonged disablement and disease and make possible, and feasible, prompt treatment and more ready recovery, perhaps with lessened hospitalization and overall medical costs. This easy and accessible method is prompt and noncontributory which is scarcely feasible under King-Anderson. Total combined matching appropriations 1963–65: $2 million.

(*b*) A vendor payment drug service designed to fit into the outpatient service and posthospital service which will make feasible prompt treatment and medical care of the needy aged for effective initial treatment and continued treatment for diseases and disablements which, when untreated, lead to more serious involvements and services at a greater cost. This type care is scarcely feasible nor provided for under King-Anderson. Total combined matching appropriation for 1963–65: $2 million.

(c) A vendor payment dental service designed to supplement and augment medical services in generating a health, recovery, and rehabilitation program for the needy aged population where serious dental health, edentiality, malnutrition, and loss of pride and morale constitute a hazard to the maintenance of health and recovery from illness. This type program is considered vital in a combined program such as is envisioned for the needy in North Carolina. It would be folly to contemplate this type care under King-Anderson. Total combined matching appropriation for 1963–65: $1,600,000.

(d) Provision and authority for the administration of Kerr-Mills Act at the county level. Assisting the counties appropriated by the State for 1963–64: $100,000.

(e) Authorization for the department of public welfare to establish priorities on any other of the 11 categories of services encompassed in the Federal Kerr-Mills Act of 1960 and to request successive appropriations from the general assembly to implement such priorities. No such provisions are inherent in King-Anderson nor is there prospective opportunity thereunder to plan with particular conciseness for the diversity of needs of older people.

3. We believe that the present growth in our private enterprise system comprised of voluntary insurance, savings, personal resources, and industrial contributions is providing health and medical care to large segments of our population which carries into the era of the aged as they become less productive in our commercial and industrial enterprises.

(a) In 1959 through the Blue Shield of the society a senior citizen service plan of low-cost coverage was implemented. The Blue Cross-Blue Shield package in this instance has been widely accepted by the older population near the threshold of public need and its administration has proven sound. Moreover, a high option Blue Shield service plan for the median income level encompassed by a large segment of the aged group was initiated November 1, 1963, and was markedly purchased by the nonneedy at costs comparable to the long-existing Blue Cross-Blue Shield programs of voluntary coverage. Enrollment and maintenance of enrollment is proof of peoples choice predicted such a short time ago.

(b) It is estimated that some more than 62 percent of the population above 65 years have purchased some type of private health and accident coverage in the State. This may have varied in adequacy in past years, but increasingly this protective health coverage, including major medical, with its principles of free choice appeal to our people. The general assembly of 1963 amended chapter 58 of the general statutes regulating joint actions of insurers and encouraging their combined efforts in offering residents 65 years of age and over and their spouses insurance against financial loss from accident and sickness. There are 240 companies licensed in North Carolina in this area of insurance and the amendment is now being exercised in a program involving many companies writing insurance in the health field and now being offered in a plan of such private insurance to our aged population. This move ment will have the opportunity to become increasingly fruitful.

4. We are markedly pleased to report the enactment by the 1963 general assembly of complete revision of mental health laws of the State which vitally affect the aged population. We have long had full and adequate care for institutionalized mentally ill of all ages, but scarce facilities for early detection, prevention, medical treatment at fulmination and postinstitutional after care. This now becomes a community obligation under the Mental Health Act with one statewide administrative authority. Medicine is now leading the current implementation of those community mental health authorities and facilities bidding well to influence high-level medical mental health care of the aged throughout the State. If one concedes that some over half of all human illness involves nonorganic entities, it becomes obvious that a markedly high percentage of medical problems of the aged do come within the purview of this new program, particularly at the community level, which does obviate the unneeded applicability of the proposal under consideration.

5. We, as tax contributors at the State level, would direct your attention that the four major Veterans' Administration facilities and the statewide medical service so administered in North Carolina as to be applicable to the veteran of any service incident are ruled eligible and are medically served throughout the State, both at the institutional level and by Government purchased private vendor medical care. This encompasses a wide segment of the male veteran aged population in the State which so notably contributed in World

War I and World War II. Add this as a going program of service more adequate and surely superior to services related to the proposal at issue which would obviously establish a duplication of Federal health care programs for these individuals. Private medical manpower in many ways makes this program available at the community level. Why should this service be duplicated in the proposals and fiscal prospects of the matter at issue here?

6. The committee is aware of services under vocational rehabilitation under State-Federal finance. There is increasing evidence of the applicability of these services to the aged handicapped and despite the concept of enforced retirement at age 65 the facts are that most men and women desire, and many do work productively beyond that era. Particularly, is this true of doctors who retire after 70 more nearly "dying in their boots." Medical services are now available to the feasible aged disabled worker who can and wills to be rehabilitated. Many must be because never has social security at retirement done the job of creating the supportive annuities which support life demands and thus many aged people must work; thus rehabilitation with its complement of medical services obviates further provisions of medical service as envisioned in the proposal at issue.

7. In North Carolina, stimulated by medical leadership over a period of 9 years, there has been marked progress throughout the State in diverse associated services which enhance the health maintenance and medical care of the aged, whatever the degree of disease or disability. These are effective and lessen the concern for financial schemes to support the needs of the aged. These are:

(*a*) Considerable progress in developing homemaker manpower and the medical and administrative integration of these services to the needs for care of the aged in his home and community environment in lessening the need for institutional care. This is a growing service technique which needs local application and which is gaining in private support of the essential finance without interference from high levels of government.

(*b*) Nursing home facilities have increased fivefold in 8 years and are characterized by high standards under State licensure in rendering increasingly adequate services to the chronic disablements of the aged and logically financed more and more by private and volunteer funds and savings. These represent wonderful outlets for family and benevolent support and may readily be, and are being, incorporated in our voluntary plans, prepayments, and family finances. Let us not spawn overdevelopment and misuse of these growing services under concepts of social largess but guide, direct, and utilize the development of these institutions for the ultimate general availability and sensible use.

(c) Boarding homes under State licensure supervision have increased and are a vital factor in the domiciled care of the aged in the State. These prevail in proportion to demands for such care, and will increase in numbers and standards if local guidance and supporting devices can be given continued play. These meet real areas of service needs of the aged's home disruptions and come into effect less expensively. Medical care is available and supervision in the local area leads to happier rapport between the family, the aged patient, and the medical service of choice.

(*d*) Statewide cancer services have made an increasing impact upon the aged bearing such involvements. These services are diversified public, voluntary, and private services functioning in many areas related to detection and diagnosis, institutional services, home care services, drugs, and other. Let us not supplant this local, family, community, and professional teamwork in which the aged cancer patient gains interplay with a remote scheme of fiscal largess. It will not serve the cause near so well as the operative services have proven.

(*e*) It should be recognized that the medical profession carries a remarkable service load in all of the enumerated programs cited herein. Whether the aged patient be pecuniarily involved or not he has the choice of the services of a good physician. In the insurance and prepayment plans there may be some level of compensation for the physician, but throughout the programs of voluntary health agencies involving medical services there are not compensations for physicians' services nor are there vendor payments for physicians' services in any public-supported services, whether it be the so-called categories of aids or the publicly supported aged patient services. The physicians have served freely without compensation and will continue to do so based on human needs rather than concepts of largess and uniformity such as is at issue here. The giving of services lends dignity to the medical pro-

fession and its concern as a vendor priority can come later if the need ever be that volume overcomes the balance operative reality.

(*f*) There is a widespread application of professional home nurse services being plied to the aged in the State. Under enactments of the 1963 general assembly public nurses may now serve for fee accruable to a sponsoring nurse agency, whether public or private. This enhanced availability of nursing attention to the aged throughout the State and the home-visiting features of nurse service is operative now and will expand markedly.

8. Let us observe that the King-Anderson proposal or any modification yet offered is entirely "hospital oriented." Considering that hospitalization is the most expensive of all the components of medical care any concerted implementation of a uniform hospital service available under social security will result in our existing programs "withering on the vine." We in North Carolina assert that our youthful State is prepared to go forward with the programs and services we have related above as organized and operative. It is healthy culturally, industrially, technically, intellectually, and locally oriented to these programs and services with full intention and determination to finance, supervise, and administer them effectively and efficiently. We look with great disfavor toward interruptions of these trends and movements now designed for the good of all our people, not just the aged, because there is a political stake in their intercurrent plight, and we want the right to go on about this business with the least interference from afar. Leave us void of any mammoth, burdensome scheme of compulsory Government health insurance and allow us to encourage our generations of youth in the State to face and solve the aged problem without the inequitable tax burden on our young family-working population to pay largess to the poor and nonpoor. Most of our young working families are encompassed in that group at or under $5,400 income. They will be forced to pay $36 million more taxes if the King-Anderson proposal is enacted and you should know we think this will diminish the capacity of our people to support those good programs which we have underway.

We are convinced that the need for such a program as proposed in King-Anderson has been vastly exaggerated; that the composite group of programs as has been evolved in North Carolina can and will meet any existing problem; and, that any medical care proposal under discussion as amendment or substitute for H.R. 11865 is, therefore, not needed and would be prohibitive in cost and in that it could not avoid gradual lowering of health care standards by virtue of marked Government interference and controls. Therefore, we respectfully solicit your considerations to the facts presented in this statement and urge that no King-Anderson-type legislation under consideration be given a favorable report.

MEDICAL ASSOCIATION OF GEORGIA, SUBMITTED BY J. G. MCDANIEL, M.D., PRESIDENT

The Medical Association of Georgia, founded in 1849 by the physicians of our State, is a nonprofit, incorporated, professional association. It subscribes to the concept that service for the betterment of the health of our people is the highest possible motive for existence as an organization. At the present time it represents some 3,200 physicians, or more than 96 percent of the total physician population of the State and is comprised of 78 county medical societies.

The governing body of the association is its house of delegates which meets each year to decide on questions of great importance to the medical profession and to the general public which it serves. Each county medical society in the State is represented in the house of delegates on the basis of 1 delegate for each 25 physician members or fraction thereof.

The Medical Association of Georgia is and has been for years, engaged in myriad activities all calculated to support our primary purpose which is to "promote the art and science of medicine and the betterment of public health."

PROGRESS IN MENTAL HEALTH; VOLUNTARY FEE REDUCTION FOR OLDER PATIENTS; GAINS IN PRIVATE HEALTH INSURANCE

Over the years, our association has played an important and effective role in shaping the total health picture in Georgia.

To cite an example of recent years, the Medical Association of Georgia, at the request of the Governor, conducted an exhaustive study of State mental health facilities and programs which has resulted in manifold improvements. As a direct outgrowth of this association activity, numerous items of new legislation

were introduced and adopted by the General Assembly of Georgia. As evidence of the far-reaching effect of our study and recommendations for improved mental health programs, we point with justifiable pride to the State's new $9 million intensive treatment center (under construction) for the rehabilitation of persons suffering from mental illness.

At the State mental hospital at Milledgeville, Ga., there are more than 12,000 patients receiving treatment and domiciliary care. Of this number, approximately 3,000, or roughly 25 percent, are age 65 and over. This is cited as a case in point of Georgia's determination to respond to the health care needs of her elderly citizens.

As an indication of the awareness of the physicians in Georgia that some of our older citizens, do in fact, have a problem meeting the cost of needed medical care, permit me to relate an action of the Fulton County Medical Society (Atlanta area) which comprises a third of the total membership of our association.

Several months ago, in response to a poll conducted by the Fulton County Medical Society, the physicians of the Atlanta area went on record approving a voluntary reduction of normal fees by 50 percent for those patients age 65 and over who could demonstrate to their physician hardship in meeting the cost of medical care. Fee reduction is no new step for physicians in Georgia. It does, however, indicate an extraordinary move by a large group to accommodate their patients in a manner that would cause embarrassment to no one. The fact that doctors have always been willing to administer to the sick regardless of their ability to pay is beside the point. What is important here is that this represents an organized recognition of a problem, and an organized effort to meet the problem squarely for those persons who are in need.

Another area vital to the health and welfare of our people, in which the Medical Association of Georgia has played a commanding role, is that of voluntary prepaid health insurance plans. Twelve years ago the medical association drafted a comprehensive set of standards uniquely applicable to persons of low income. These standards included participating physicians' services and written guarantees of full doctor bill coverage for people in specified income limits. This is known as the Georgia plan and at the present time more than 30 major insurance carriers are writing health insurance which embraces these broad standards.

As an active participating member of the Georgia Health Insurance Council, the Medical Association of Georgia has been a leader in the promotion of low-cost voluntary health insurance. A result of the wide acceptance accorded these promotional efforts is that there are now more than 50 insurance companies selling "over age 65" plans in Georgia. These are attainable on both a group and individual basis.

The rate of growth of health insurance in Georgia has been both dramatic and reassuring to everyone interested in health care for older citizens. Between the years 1951 and 1959 the number of people in Georgia protected by health insurance grew by the astounding figure of 116 percent. This represented 60 percent of the total population of the State. By the end of 1962 this figure had increased to 70 percent of the total population. In absolute terms, as of the end of the year 1962 there were 2,814,000 Georgians carrying protective health insurance.

All of this points unmistakably to the fact there are available in Georgia vast number of health insurance plans being sold at reasonably monthly premiums which the majority of the people can buy and are continuing to buy at an impressive rate.

KERR-MILLS IMPLEMENTATION IN GEORGIA

The Medical Association of Georgia and its component county medical societies have been equally active in the promulgation and implementation of programs in the categories of rural health, maternal and infant health and welfare, rehabilitation services, general immunization, polio clinics, sports injury clinics, and others too numerous to list.

Of perhaps the greatest concern to the members of this committee is the assistance given and role played by our association in both the drafting and promotion of legislation which permitted the State of Georgia to participate in the benefits of Public Law 86-778, the Kerr-Mills law. Immediately following enactment of Public Law 86-778 by the Congress in 1960, the Medical Association of Georgia formally requested the Honorable Ernest Vandiver, then Governor of Georgia, to appoint a study commission with the instructed purpose of drafting enabling legislation pursuant to Public Law 86-778. Our request followed closely a similar appeal by a member of this committee, the Honorable Herman

E. Talmadge. Representatives of our association began at once a series of conferences with the Governor's representatives from the State senate and the State house of representatives. Their purpose was to perfect legislation which could be presented at the following session of the general assembly.

It is of more than passing importance to note here that the Governor's representative from the State senate was the Honorable Carl E. Sanders, now Governor of the State of Georgia. Mr. Sanders ultimately became the Senate sponsor of the Medical Assistance for the Aged Act and together with the Medical Association of Georgia campaigned actively in support of its passage at the 1961 session of the legislature.

From a legislative standpoint it should be noted that the Georgia law is so all inclusive as to permit virtually unlimited expansion thus obviating the necessity for additional legislation. In short, Georgia has in its code the statutory authority needed to expand its Kerr-Mills implementation program as changing conditions require.

As for the administration of the Kerr-Mills program, two factors merit special mention here. First, the doctors of Georgia are participating in this program without cost whatever to the program. Not so much as $1 has been paid for medical or doctors' fees since the inception of this program 2 and a half years ago. We feel that this demonstrates, stronger than mere words, the determination of Georgia doctors to keep the program on a sound fiscal basis resulting in maximum health care value for each Kerr-Mills dollar spent in Georgia. Secondly, the Medical Association of Georgia serves as coadministrator of this program, with the State welfare department (department of family and children services), the single State agency recognized by the Department of Health, Education, and Welfare for the administration of this program.

We feel that these factors alone demonstrate beyond question our determination to make the Kerr-Mills program a successful undertaking by the State of Georgia. It likewise demonstrates our prevailing belief in the Kerr-Mills program as the broadest, most sensible and least expensive means of providing hospital, medical and nursing home care for those aging citizens in actual need of assistance.

The Kerr-Mills program in Georgia is a working, successful, and popular program by any measurable standard. It has been well received by the hospitals, the nursing homes, the people, and the physicians. It gives evidence, clear and positive, of the total workability of a program rooted in local determination. And above all else, it underscores the desirability of having the cooperation and enthusiastic acceptance of hospitals, nursing homes, and physicians, around whom any hopsital, nursing home, or medical-care program, State or Federal, must revolve.

The 1960 decennial census in Georgia revealed an over-age-65 population of some 290,000 persons, representing 7.4 percent of the total State population. Of this group approximately 100,000 persons, or roughly one out of every three is the beneficiary of old-age assistance. Pursuant to Georgia's Medical Assistance for The Aged Act, 100 percent of the people in this category are eligible for maximum benefits as follows:

(1) All needed nursing home care up to 365 days a year, year in and year out;

(2) All needed hospitalization to the extent that 60 days per year is guaranteed (where medically indicated) under the State program, and such additional needed inpatient care is furnished by the hospitals designated as participating hospitals under this program; and

(3) All needed physician care is furnished without cost to the patient or to the State by the physicians of Georgia.

Categorically then, Mr. Chairman, we can state that one-third of our total over-age-65 population is being provided all the nursing home care needed, all the hopsital care needed, and all the physician care needed.

COST COMPARISON OF KING-ANDERSON AND KERR-MILLS IN GEORGIA

For a better idea of the magnitude of the Georgia Kerr-Mills program and to gain a better understanding of how well it is serving the needs of our aging population, permit us to look at some of the statistical data as concerns this program.

During the month of June 1963, at a cost of $400,119.06, this program provided 97,347 days of covered nursing home care for eligible recipients in Georgia.

During the first 6 months of the same year, 548,164 days of covered nursing home care was provided under this program.

Turning to the area of hospitalization we get a picture no less impressive for both the number of actual patients and the number of days of hospital care financed by this program. During the months January through June 1963, 11,009 beneficiaries, or approximately 10 percent of the entire eligible group, were hospitalized for a total of 90,603 days of covered hospital care.

For the sake of comparison permit us to examine closely the total cost of Georgia's Kerr-Mills program for the month of June 1963, against the calculated cost of a King-Anderson type program financed under social security for a similar 30-day period. In Georgia the Kerr-Mills program was financed in its entirety for the month of June 1963, at a cost of $606,397.74. Under the King-Anderson bill, should it be enacted, and based on the cost estimates of the administration, the residents of Georgia would pay an additional $23.6 million in social security taxes and general revenue taxes. These figures are calculated from average earnings per worker in Georgia as reported in the 1961 annual statistical supplement of the Social Security Bulletin. In other words, the enactment of the King-Anderson bill would drain, from the beginning, additional taxes from Georgia at a rate of $23,600,000 per year. On a monthly average basis, therefore, the cost of a health care program under King-Anderson would run at approximately $2 million as compared with less than two-thirds of $1 million for the program now in operation.

Mr. Chairman, we feel, as I am sure you and the members of this committee feel, that the expenditure of public moneys carries with it a grave responsibility to insist that every dollar be spent wisely, prudently and consistent with high quality and maximum productivity. I cannot overemphasis that Georgia's health care for the aged program under the Kerr-Mills law is a quality hospital and nursing home care program, efficiently administered by a dedicated, fiscally responsible State agency.

On the other hand, we suggest that it would be exceedingly difficult, if not impossible, to manage from Washington a sweeping health care program for some 19 million persons, scattered throughout the 50 States, and still give due and proper attention to efficiency, quality of services, and economy of operation.

We should like to make it clear that our opposition to a system of Federal health care is not limited to the King-Anderson proposal alone. Our opposition addresses itself to the broad area of financing medical care through the social security mechanism. As such we are equally opposed to so-called option plans which offer cash benefits and/or hospital insurance policies to all social security beneficiaries regardless of need. Such option plans have been discussed in the context of a compromise proposal. The only thing they seek to compromise, however, are the details and not the basic principle which is social security financing. This has been, is and remains our fundamental objection.

OTHER STATE AND FEDERAL PROGRAMS WHICH MINIMIZE NEED FOR KING-ANDERSON

In addition to Georgia's Kerr-Mills implementation program, there are numerous State and Federal programs giving either insurance protection during and after retirement from active work, or direct hospital benefits to great numbers of Georgia people. I am sure that the members of the committee are well aware of the postretirement hospital insurance benefits available to civil service employees under the provisions of Public Law 382 of the 86th Congress.

You are equally aware of the vast scope of hospital and medical benefits available to veterans of the armed services, which incidentally comprise more than 10 percent of the total population of the State of Georgia. The point in listing these figures, Mr. Chairman, is to show that a majority of these people, if they choose, can be well protected during their retirement years through the mechanism of health insurance of direct hospital benefits in some cases.

SUMMATION

We are aware, Mr. Chairman, that cold statistics tell only a part of the story. Of far more importance than statistical data is the fact that we know that the majority of the aged population in Georgia is neither destitute nor suffering from serious illness as some proponents of social security medicine have charged. Additionally, in Georgia, as a matter of principle and historical precedent, physi-

cians have always honored their professional obligation to give medical assistance whenever and wherever it is sought. Payment for services is, always has been, and will continue to be of secondary importance.

We believe the record is clear in Georgia. Working through their county medical societies and through their State association, the doctors in Georgia have demonstrated repeatedly an inordinate determination to cooperate in any program that will provide a higher level of health care for the aged and for all ages.

I wish to thank the members of the committee for the opportunity to present our views on this matter for inclusion in transcript of these hearings. In conclusion, permit me to reiterate the strongly held conviction of the doctors of Georgia that to enact this legislation and lavish, needlessly, the fruits of massive welfarism upon the people, would be a tragic step of virtually irreversible proportions.

STATEMENT OF THE IOWA MEDICAL SOCIETY CONCERNING H.R. 11865, 88TH CONGRESS, SUBMITTED BY OTIS D. WOLFE, M.D., PRESIDENT

Social security legislation (H.R. 11865) which has passed the House of Representatives and is now under consideration by the Senate Finance Committee contains a provision to make mandatory physician participation in the social security program. The Iowa Medical Society is gravely concerned about this latest attempt to legislate compulsory inclusion of physicians in the social security system and wishes to formally express opposition to this provision.

The Iowa Medical Society and the American Medical Association have repeatedly rejected compulsory inclusion of physicians under social security for several important and valid reasons.

1. Physicians have often voiced their individual and collective objection to such inclusion.

2. Physicians seldom retire at age 65; in fact, the American public could ill afford to have such a large percentage of physicians leave active practice at that age. A serious doctor shortage would result.

3. Physicians are now able to establish retirement plans which afford certain limited tax relief. Until recent action by Congress this was not possible. Physicians would rather provide and arrange for retirement voluntarily through the private free enterprise system.

For these and other reasons, the Iowa Medical Society respectfully requests the Senate Finance Committee to delete from the social security legislation now before it the compulsory participation by physicians.

HEALTH CARE FOR THE AGED FINANCED BY SOCIAL SECURITY

Although not a part of the House-passed bill (H.R. 11865), we are aware that the Senate Finance Committee is receiving testimony with regard to the provision of health care for the aged through social security financing.

The Iowa Medical Society is on record in opposition to such legislation. Iowa does not now have an obvious need to supplement its programs for providing health care to the near-needy aged. Its legislature in 1963, at the behest of the Iowa Medical Society and similar groups of public-spirited citizens, appropriated money for a Kerr-Mills program so that the numbers of the near-needy who haven't previously been helped in securing health care, and the extent of their needs, might be accurately determined.

Statistically, the situation is approximately as follows:

Iowans 65 or more years of age [1]	317,974
OAA recipients in Iowa as of Jan. 1, 1964	30,000
Over-65 inmates of Iowa institutions [1]	14,460
World War I veterans eligible or about to be eligible for VA care (average age 65.8 years) [1]	49,466
Well-to-do persons 65 or over (estimate)	30,000
Iowans over 65 covered by voluntary health insurance (estimate) [2]	173,934
Total	297,860
Total	20,114

[1] Source: 1960 census.
[2] As of Jan. 1, 1962.

These are not precise figures in all instances, and they were not all gathered at precisely the same time, but they constitute reasonable approximations. The 1960 Census of Population (PC (1) 17D) shows that there were 317,974 persons 65 or more years of age in Iowa. That number has doubtless grown somewhat in the succeeding years, but it remains somewhere nearly accurate. The Health Insurance Institute of America estimates that on January 1, 1962, there were 54.7 percent of over-65 Iowans who held health insurance, which indicates that at least 173,934 individuals were caring for themselves by that means. Several other groups are quite fully provided for. There were 14,460 inmates over 65 years of age in Iowa institutions, according to the 1960 census. World War I veterans numbering 49,466 were residents of Iowa when the 1960 census was taken, and their average age at that time was 65.8 years. The total is slightly smaller now, of course, but their average age must be approximately 68.8 years, and by signing an application form they can secure complete health care without cost at Veterans' Administration facilities. Then a considerable number of the elderly—estimated to be as large as the number of OAA recipients—are sufficiently well off so they can pay their health care bills without difficulty as they incur them.

The remaining 20,114 elderly Iowans, it should be emphasized, have been taken care of quite satisfactorily in the past, at public expense if their own resources were inadequate. Polk County, Iowa, in which Des Moines is located, has a county hospital where the near-needy as well as the indigent are provided surgery and medical and hospital services free of charge, and at county, community, and private hospitals throughout the rest of the State, varying numbers of patients are given necessary care free of charge, though they don't all qualify for old-age assistance. All physicians in private practice, of course, are accustomed to cut their charges or to submit no bills for the care of the economically marginal ones of their patients, regardless of age.

Like many other States, Iowa operates a public hospital in connection with the SUI College of Medicine, in Iowa City, and patients are sent there from throughout the State for surgery and/or medical care, either outpatient or inpatient, partially at State expense and partially at the expense of their respective county governments. The administrator of university hospitals, Iowa City, reports that 15,668 such patients were admitted there between July 1, 1961, and June 30, 1962, and he estimates that at least 50 percent of them were 65 or more years of age. There are no comprehensive records that show how many were relief recipients, in the generally understood meaning of the term, and how many were in the near-needy category.

Some figures regarding nursing homes in Iowa may help to show the concern that our people are showing for their elderly fellow citizens. Recent authoritative reports indicate that the State is rapidly becoming adequately supplied with such facilities. In 427 existing homes (all but 54 of them proprietary), there are 11,953 beds. Eighty-three of them (41 proprietary and 42 nonprofit), containing 3,915 beds, have been built since 1960, and 60 more of them (39 proprietary and 21 nonprofit), to contain 3,757 additional beds, are now in the planning stage. These institutions provide or will provide, appreciable amounts of health care to the aged, and in roughly a third of the cases can be expected to subsidize its cost to a considerable extent at the sponsoring church's or fraternal organization's expense.

THE IOWA KERR-MILLS PROGRAM

The Kerr-Mills program which was started in Iowa on December 1, 1963, will certainly provide for any currently unmet needs of the near-needy elderly.

1. The General Assembly of Iowa, last spring, appropriated $1,680,000 as the State's contribution to the program for each of the next 2 years. These sums together with Federal matching funds, will provide about $4 million per year. In addition, the assembly's interim committee was authorized to release up to $320,000 per year of additional State money, in case the original appropriation proves insufficient.

2. To be eligible for medical aid to the aged, an Iowan may have an income, after deduction of medical expenses, up to $1,500 per year if single, or up to $2,200 per year combined with that of his or her spouse. A single person may have assets up to $2,000, and a couple may have assets up to $3,000, exclusive of a home and an automobile.

The 1960 census (PC–(1)17D) showed the median annual income of Iowa families with heads 65 years of age or older to be $2,796. The median annual income for single persons in that age group wasn't clearly stated, but since

Iowa ranked 36th among the States as regards incomes of the elderly, the figure can be presumed as not in excess of $1,050 per year, which was the national median for such people.

Thus it is apparent that MAA will be available to about half of the elderly people of Iowa who are not already receiving health services under the old-age assistance, aid-to-the-blind, or aid-to-the-disabled programs.

3. The program will furnish any or all of the following, after the eligible recipient has paid or obligated himself or herself to pay $50 for health care during the current calendar year:

Office, clinic, or hospital care rendered by licensed doctors of medicine, osteopaths, chiropractors, podiatrists, dentists, optometrists, and nurses.

Hospitalization.

Nursing home care, limited to 180 days immediately following hospitalization.

Drugs.

Laboratory services.

Supplies authorized by any of the above-named practitioners, within the scope of his or her practice. These include prosthetic appliances of all sorts.

4. The Iowa Medical Society proposed and the 1963 General Assembly of Iowa enthusiastically accepted the idea that during the initial 2 years of MAA, statistics should be collected to provide a basis for converting the program into a State-Federal subsidy for the private health insurance policies of individual MAA-eligible persons. The physicians and the legislators agreed that such an arrangement would best preserve the privacy and dignity of the aid recipients, and would be most nearly consistent with the principles underlying the American free enterprise system.

From what has been said in this statement, it should be obvious that Iowa—the State with proportionately the greatest number of elderly citizens—has been doing a great deal to assure sufficient health care for all such people, and is embarked on a program which will certainly remedy any previously existing deficiencies. Further, it should be obvious that the passage of King-Anderson-type legislation would be altogether superfluous, as far as our State is concerned, quite apart from the fact that it would be enormously burdensome from the standpoint of social security taxation, and wasteful in providing assistance to many people who are economically self-sufficient.

(Whereupon, at 1:05 p.m., the committee recessed to reconvene at 3 p.m., the same day.)

AFTERNOON SESSION

Senator GORE. The committee will be in order.

The first witness is Mr. H. Lewis Rietz.

STATEMENT OF H. LEWIS RIETZ, EXECUTIVE VICE PRESIDENT, GREAT SOUTHERN LIFE INSURANCE CO., HOUSTON, TEX., APPEARING ON BEHALF OF AMERICAN LIFE CONVENTION, THE HEALTH INSURANCE ASSOCIATION OF AMERICA, THE LIFE INSURANCE ASSOCIATION OF AMERICA, AND THE LIFE INSURERS CONFERENCE; ACCOMPANIED BY J. F. FOLLMAN, JR., DIRECTOR OF INFORMATION AND RESEARCH, AND DAVID ROBBINS, ASSISTANT DIRECTOR OF STATISTICAL RESEARCH, HEALTH INSURANCE ASSOCIATION OF AMERICA

Mr. RIETZ. My name is H. Lewis Rietz. I am executive vice president of the Great Southern Life Insurance Co. of Houston, Tex. I appear today in behalf of the American Life Convention, the Health Insurance Association of America, the Life Insurance Association of America, and the Life Insurers Conference. These associations in-

clude in their membership over 500 insurance companies having in force approximately 90 percent of the voluntary health insurance underwritten by insurance companies.

My purpose today is to register our opposition to the proposed amendments to H.R. 11865 relating to health care and all similar proposals. They are unnecessary and undesirable in the light of the existing magnitude and continuing growth of voluntary health insurance for the majority of the aged, coupled with the evolution of the present governmental programs particularly for old-age assistance (OAA) recipients and those who become beneficiaries under medical assistance for the aged (MAA).

These facts, together with the heavy cost of the proposed compulsory program, are compelling reasons for your committee to reject such amendments.

In testifying before the Committee on Ways and Means of the House of Representatives on November 22, 1963, we concluded that:

> The established voluntary health insurance system for the majority, with public and private programs to meet the needs of limited segments of our aged population, encourages individual responsibility important in our social and economic system. Hence, the present pattern should be maintained with the existing public programs evolving only as experience indicates the existence of a substantial unmet need that cannot be fulfilled by the voluntary health insurance system.

We are convinced this conclusion is sound and in the best interests of all elements in our society.

Within the framework of our society and our economic system we strongly support and devote our best efforts to providing a sound means of financing adequate health care for all segments of our society including the aged who are not wards of the State or welfare recipients.

THE GROWTH OF PRIVATE HEALTH INSURANCE FOR THE AGED

We have estimated that 60 percent [1] of the noninstitutionalized aged populations were covered by some form of voluntary health insurance at the end of 1962.[2] The U.S. national health survey estimated that at that time 54 percent were covered.[3] A study by the Social Security Administration estimated the proportion covered at that time to be 51 percent of the total population including the institutionalized aged.[4] This latter study also found that—

> of the aged units that were in a short-stay hospital at any time in 1962, 68 percent of the couples and about 55 percent of the nonmarried said they had some kind of health insurance.[5]

These figures obtained from different sources are of the same magnitude as our coverage estimates. These studies, when related to earlier studies,[6] reveal that the number of people age 65 and over with health insurance protection has about tripled during the decade 1952–62, and

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[1] The majority report of the Subcommittee on Health of the Elderly of the U.S. Senate Special Committee on Aging has attacked the integrity of this estimate. Their criticism is unwarranted and unfounded. The data were gathered in accordance with accepted scientific methodology having to do with statistical collections in good faith with no other objective than to obtain the facts of a situation as of a given date. This is substantiated by data, reports, letters, exhibits filed with the subcommittee and borne out by testimony of both public and Government witnesses.

[2] An estimate of the extent of private health insurance coverage of the aged as of Dec. 31, 1962, Health Insurance Association of America, July 1963.

[3] "Medical Care, Health Status, Family Income, United States," series 10, No. 9, Public Health Service, HEW, May 1964.

[4] Social Security Bulletin, July 1964.

[5] Ibid.

[6] Bureau Report No. 18, Social Security Administration, April 1953.

the proportion of the older population covered has doubled during th same period. This is evidence of remarkable growth and of publi confidence in voluntary health insurance and its ability to provid health care benefits for the vast majority of the aged, nonwelfar recipients.

Senator GORE. How many did you say are covered now?

Mr. RIETZ. About 10 3/10 million.

Senator GORE. Thank you.

Mr. RIETZ. With 60 percent of the aged population covered by some form of private health insurance at the end of 1962, with an additional 12 percent [7] who are recipients of old-age assistance and hence entitled to medical care without cost, and with others eligible for benefits under the medical assistance for the aged program, as veterans of the Armed Forces, as members of health care professions, or because of affiliations with lodges or religious groups, it is apparent that for over three-fourths of the aged, provision has been made for payment of some or all of their health care costs.

THE COST OF ADDING HEALTH CARE BENEFITS TO THE OASDI SYSTEM

Important in any consideration of adding health care benefits to the social security system are the present and future cost implications which are of serious magnitude even for limited benefit programs of the King-Anderson type.

In July 1961, we presented estimates to the House Ways and Means Committee that H.R. 4222, the King bill of the 87th Congress, would involve a level cost of 1.73 percent of taxable wages, while the administration estimate was 0.66 percent.

In November 1963, we estimated to the House Ways and Means Committee that H.R. 3920, the King bill of the 88th Congress, would involve a level cost of 1.71 percent of taxable wages.[8] By this date, the administration had not only raised its level cost estimate to 0.68 percent but they stated that the taxable wage base of $5,200 and the dollar amounts of the deductible would have to be periodically adjusted upward as average earnings levels and average hospital costs rise above the levels of 1961. Both of these proposals were to be financed by a total tax rate of 0.5 percent together with an increase in the taxable wage base from $4,800 to $5,200. The administration estimated that 0.18 percent of the level cost would come from a transfer of surplus funds from OASDI, which surplus funds would result from the increase in the taxable wage base.

In connection with the amendments now under consideration, the administration has once more revised their cost estimates. The administration now states that the level cost of this amendment will be 0.85 percent and the amendment provides a tax rate of 0.8 percent on a $5,400 taxable wage base. Since under H.R. 11865 there will be no surplus arising under OASDI for transfer to the health care fund as a result of this amendment, the level cost and the tax rate should be identical. Further this 0.85-percent tax rate is based on continuation of underlying assumptions in connection with which the administra-

[7] Social security bulletin, April 1963 reports 14 percent of the aged were OAA recipients in 1962. Allowing for OAA programs administered in 2 States by Blue Cross covering approximately 275,000 recipients, this figure is adjusted to about 12 percent.

[8] This cost estimate was lower than for H.R. 4222 due to the more restricted benefit provisions for nursing home care contained in H.R. 3920.

tion admits "an unfavorable cost result is shown when total earnings levels rise unless the provisions of the system are kept up to date (insofar as the maximum taxable earnings base and the dollar amounts of the deductibles are concerned)." [9]

The administration's level cost estimate of 0.85 percent for the Gore amendment to H.R. 11865 is based on 1963 average earnings levels, estimated 1965 hospital costs with projected increases in the hospital costs to 1971, and a $5,400 initial taxable wage base. It relies upon the questionable assumption that hospitalization costs will increase after 1971 at the same rate as any increase in earnings levels, whereas the increase in hospital costs have outstripped the increase in earnings levels through 1963. Thus, again the administration's cost estimate contemplates regular increases in the taxable wage base and the deductible as average earnings levels increase beyond the levels of 1963.

Any continued increase in hospital costs at rates greater than the increase in the total earnings level would compound this problem. Any implication that the taxable earnings base for the OASDI system is to be strongly influenced by future hospital costs raises questions of a most serious nature. Hence, we believe the administration's reliance on periodic updating of the taxable wage base and the deductibles to justify their level cost estimate and the proposed 0.8-percent tax rate (which we are convinced is inadequate) would so fundamentally affect the whole social security structure that this approach should be discarded.

We are convinced that any cost estimates of a health care program should reveal its real cost independent of the broad ramifications of "an unfavorable cost result" arising in the absence of future changes in such a fundamental factor as the taxable wage base. In HEW actuarial study No. 53, and for other purposes, the administration has indicated the expectation of an annual 3-percent increase in average earnings levels. Using this annual rate of increase in average earnings levels, we would emphasize that the administration's present cost estimate of 0.85 percent, which is based on 1963 wage levels, would require an increase in the taxable wage base to $5,900 as early as 1966, the first year that full benefits would be payable under the amendment. Further increases in the wage base would be necessary thereafter to maintain the administration's level cost estimate of 0.85 percent. Thus, these assumptions would pass the buck to future Congresses to face the evolving costs of the promised hospital service benefits.

From lengthy consideration and continued study we conclude that even under the administration's assumptions, the level cost will be 1.66 percent or about two times the administration's level cost estimate. This cost is based on an initial $5,400 taxable wage base but with a 1966 average wage and hospital cost level and using the administration's underlying assumption of a 3-percent average annual increase in earnings.

If earnings increase 3 percent per annum, and hospital costs increase 5 percent per annum to 1968, 4 percent per annum from 1969–78, and 3 percent thereafter, and if the $5,400 taxable wage base was maintained until 1980, the level cost, and hence the tax rate required from the proposed effective date of benefits, would be about 2.13 percent.

[9] "Actuarial Cost Estimates for Hospital Insurance Bill, Actuarial Study No. 57." HEW, July 1963.

Expressed in dollars, we are convinced that the cost of the Gore amendment, in 1966, will be at least $2.8 billion. By 1990, we are convinced the costs will reach at least $6.8 billion per year. These figures make no allowance for future benefit increases.

Even more staggering are the costs inherent in liberalizations of benefits which many advocates of these proposals view as certain once the Government benefits of this type are established.[10] The main reasons for the significant differences in costs between our estimates and those of the administration are as follows:

1. We concur with the opinion of most hospital authorities and medical economists, that hospital per diem costs will continue to rise faster than average wages for the foreseeable future. The administration has assumed future increases in hospital costs after 1971 to be the same as increases in the general wage level.

2. We have utilized actual hospital charge statistics published by the American Hospital Association. The administration has assumed that the aged beneficiaries under this program will be granted lower hospital per diem costs than the general public. The assumption of a lower than average charge concerns us since it raises serious implications in hospital finances because any preferential costs for so large a segment of the population must be subsidized, presumably through increased charges to other patients, including those with private health insurance.

3. We rely on hospital utilization rates based on actual claim records of insured persons. This rate is considerably higher than the administration's estimate of such utilization which is based largely upon unsubstantiated results from a 1957 household interview survey of a limited sample of the aged population.

4. We do not believe that the administration has been realistic as to the ultimate cost for the skilled nursing home benefits which we are convinced will cost many times the amount of their estimate.

As an appendix to this statement, we have filed a comprehensive actuarial memorandum setting forth the methodology employed in developing our level cost estimates. The appendix also contains an analysis of the dollar costs of providing benefits under the Gore amendment to certain of the aged who are not OASDI eligibles. These benefits would be financed from general revenues. For the same fundamental reasons our cost estimates for these benefits are in excess of the Administration's corresponding estimates by about the same proportion as indicated in the preceding paragraphs. We urge your careful consideration of this appendix.

The cost estimates presented in this statement and those of the Administration have undertaken to price only the benefits provided under the amendment now under discussion. We would point out that the general impression which has been created over a period of time is that the King-Anderson bill which is embodied in the Gore amendment to H.R. 11865 would, in the future, provide benefits for almost

[10] On Jan. 13, 1961, former Congressman Forand was quoted by the Chicago Daily News as having said: "If we can break through and get our foot inside the door then we can expand the program after that." In May 1962 Walter Reuther, vice president of the AFL–CIO, is reported to have said (Congressional Record, May 23, 1962, p. A3854): "Those who share my point of view that the present proposal—the King-Anderson bill—is not adequate in certain areas, would want to continue their efforts to get amendments in the future to make it more adequate. Nothing is static. Nohing is fixed. Therefore, if we could get the principle established, we want to build on that principle, just as we built on the social security principle."

all persons over age 65 whether or not OASDI eligibles. This is a mistaken assumption because of the cutoff date. The Administration projects a total of about 2½ million such aged in 1990. With the cutoff date, only about 200,000, or less than 10 percent of this substantial group would be eligible for the now proposed benefits.

While not considered in either the Administration's or in our 1.66 percent cost estimates, we did include in our memorandum cost estimates for the non-OASDI eligibles who would be afforded benefits under these proposals. If all persons age 65 and over are to be entitled to the proposed benefits in the future, it would be necessary to amend this bill and recompute the cost. Based on the Administration's estimates that there will remain 2.5 million aged persons not eligible under this amendment in 1990, these costs after 1967 would be most significant and increasing to approximately three-fourths billion dollars per annum by 1990 as a charge against general revenue.

Under present law, social security taxes are scheduled to rise to a combined employer-employee tax rate of 9¼ percent of the first $4,800 of taxable income by 1968. Under H.R. 11865, as it passed the House, the ultimate tax rate would reach 9.6 percent of the first $5,400 of taxable income in 1971. Based on the Administration's estimate of the cost of the hospital and nursing home benefits contained in the Gore amendment to H.R. 11865, the total cost for social security in 1971 will be 10.4 percent of the first $5,400 of payroll. However, on the basis of our cost estimates, the combined employee-employer tax rate will exceed 12 percent in 1971.

AVAILABILITY OF PRIVATE HEALTH INSURANCE FOR THE ELDERLY

The whole concept of prepayment for health care costs is a new development in our social and economic system having had its origin only a little over 30 years ago. By 1940, only 8 percent of the population had any provision for prepayment of health care costs. Public acceptance of the desirability of prepayment came in a cycle of inflation in all living costs which together with the rapid development of medical and surgical techniques and procedures produced medical care costs that increased far more rapidly than costs generally. The voluntary prepayment system responded with larger benefit limits, broader coverages, as well as in developing techniques to afford coverages to persons generally not eligible under the underwriting standards and marketing systems theretofore developed. Thus, concentrated efforts were directed to fulfilling the needs of the aged and of those with existing impairments.

For the aged, a real breakthrough came as recently as 1957, from a single company experiment in a single State—Iowa—with a mass enrollment technique. Another substantial breakthrough occurred when a group of companies first offered high limit major medical benefits on a mass enrollment basis through the implementation of the Connecticut 65 program in the fall of 1961.

Today, in addition to earlier forms, the aged have available insurance company coverages which have substantially all been developed in less than 10 years.

(*a*) Individual company mass enrollment programs affording coverage irrespective of condition of health.[11]

(*b*) Voluntary associations of insurance companies offering coverage regardless of condition of health on a statewide mass enrollment basis. These are the programs which began in Connecticut in 1961; in Massachusetts and New York in 1962; in Texas in 1963; and this year in California, North Carolina, and Virgina. A similar program has been developed for early implementation in Ohio and enabling legislation has been enacted in Maine, Michigan, Mississippi, Nevada, New Hampshire, New Mexico, Orgeon, and Washington.

(*c*) Group insurance plans for those who remain as active employees beyond age 65.

(*d*) Continuance of group insurance coverage to retirees under private industry, Federal, State, and local government employee benefit plans.

(e) Conversion of group coverages at retirement.

(f) Coverage under group contracts issued to associations of retired persons such as the American Association of Retired Persons and retired civil servants, including retired Federal employees.

(*g*) Continuance of individual coverages, many of which are guaranteed renewable for life. At least 175 insurance companies make available such coverages, and of these at least 126 will renew the coverage for life, at least 72 being guaranteed renewable for life.[12]

(h) Purchase of individual or family policies after age 65.

(i) Individual policies which become paid up at age 65.

In addition, of course, there are the coverages available through Blue Cross-Blue Shield plans and other types of private prepayment plans.

It is evident from the foregoing that private health insurance is generally available for the present or future aged who desire such protection. The several approaches taken demonstrate the flexibility of private insurance and the variety of choices available.

The Department of Health, Education, and Welfare reports that 2¾ million aged persons are in active employment.[13] With the widespread existence of group insurance plans for active employees, many of these employed aged and their dependents would have group insurance coverages. This together with the rapid extension of retiree benefits under group plans means that substantial numbers of the aged are insured under group plans where the employer frequently pays a part or all of the cost.

With so much of the development in long-term, guaranteed renewable coverages, extension of group benefits to retirees, and other inno-

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[11] In testimony before the House Ways and Means Committee in November 1963, the HIAA indicated that, during a 5-year period, more than 2 million senior citizens had been enrolled under mass enrollment programs. The HIAA did not testify, as has been alleged in the majority report of the Senate Subcommittee on Health of the Elderly, that the foregoing total was covered at a given point of time. Furthermore, these enrollment figures did not enter into the HIAA estimate of the total number of aged persons covered, this estimate having been based upon a survey of the number of aged covered by insurance companies on Dec. 31, 1962.

[12] "An Estimate of the Extent of Private Health Insurance Coverage of the Aged as of Dec. 31, 1962," Health Insurance Association of America, July 1963 and earlier studies.

[13] Merriam, Ida C., Director of Division of Research and Statistics, Social Security Administration, before Senate Subcommittee on Health of the Elderly, Apr. 27, 1964.

vations during the last 10 years, many of the present aged had no opportunity during their active working careers to obtain coverage continuing into retirement. Hence, the existence of current coverage with respect to over half the aged population is a real achievement. Persons moving into retirement now and in the future will have benefits of substantial magnitude from both individual policies and retiree group insurance that were not available to the present aged.

Health insurance can and does fulfill its fundamental function by offering a wide variety of benefit patterns and benefit amounts. Their adequacy in any individual case can only be measured in terms of need in relation to all available resources or means, including current income, assets, benefits deriving from such entitlements as veterans status, employment status, or membership in religious, social or lodge organizations. Furthermore, health care costs and the availability of facilities for care vary extensively among communities and geographic areas. Since the relationship of these elements differs in individual cases, it is difficult, if not impossible, to generalize as to the adequacy of existing health insurance coverages. In any event, adequacy cannot be judged on the basis of a single health insurance policy in force in any one company since we estimate that about 1.3 million of the aged have health insurance benefits from more than one source.

In mid-1961, about a fifth of the older people insured by insurance companies were covered by major medical policies. By the end of 1962, this proportion had increased to a fourth.[14] Major medical policies are especially designed to help offset the more serious medical expenses, whether occasioned in or out of the hospital, resulting from severe or prolonged illness or injury. Such coverages generally provide up to 75 or 80 percent of expenditures for hospital care, surgery, physician services, nursing care, drugs, and frequently skilled nursing home care; after an appropriate deductible and with the aggregate benefit as high as $10,000. Since the end of 1962, there have been extensions of the State 65 plans mentioned earlier and other major medical plans offered to the aged by individual companies and it is therefore reasonable to assume that the extent to which senior citizens have major medical benefits has increased since the end of 1962.

THE JAVITS AMENDMENT

That portion of the amendment, parts A through C, providing inpatient hospital, skilled nursing home, and home health care, irrespective of any need and financed through increased payroll taxes, involves the fundamental objections that are inherent in the Gore amendment. Part D of the amendment which would provide "complementary private health insurance for individuals aged 65 or over" would not accomplish its purpose and is as undesirable as the proposed compulsory program. This part raises serious legal and administrative questions which were the subject of a memorandum of comments concerning S. 2431 submitted in response to certain questions raised by the chairman of the Ways and Means Committee (p. 1281, pt. 3 of the hearings on H.R. 3920, January 1964). A copy of this memorandum is attached.

Even if the proposal in part D were feasible, the cost of benefits could not be lower than the cost of corresponding benefits provided outside the purview of part D, since the pooling process proposed will

[14] Op. cit. Footnote No. 12.

not reduce such costs below cost levels which can be achieved in other ways.

Provision of supplementary benefits is not the most economical method of providing coverage. Administrative costs per policy do not vary in direct proportion to the amount of benefits and premium paid. To write a small policy supplementary to a Government coverage would entail administrative expenses at the same level as required to provide the entire coverage.

ROLE OF GOVERNMENT

Much of the growth of voluntary health insurance among the aged has come during an era of substantial improvement in both the income and the resources of the aged. Private pension plan payments have increased rapidly. The liquid-asset position has improved materially. OASDI has provided an increasing flow of income payments to the aged. Hence, we believe that sound growth in both numbers covered and benefit adequacy will materialize if we are free to devote efforts to this result.

In a dynamic economy of opportunity and free choice, we must recognize that there will always be some individuals who through personal misfortune or otherwise will require assistance to meet their living requirements, including their medical care needs.

A sound structure for assisting such groups already exists in the Federal-State assistance programs administered at the State and local level and coordinated with existing health care facilities in the area.

Real progress has been made in establishing such programs. The OAA program has, on the whole, solved most of the acute problems facing the indigent aged in their need for food, clothing, and shelter as well as medical care.

The progress in implementation of the newer MAA program, still in the developmental stages, compares favorably with that of other and earlier Federal-State programs.

In addition, the programs established by Government at all levels, to say nothing of the important services provided by voluntary agencies, play a significant role with respect to the payment for health care of certain of the population age 65 and over.[15]

Conclusion

The established voluntary health insurance system for the majority, with public and private programs to meet the needs of limited segments of our aged population, encourages individual responsibility important in our social and economic system. Hence, the present pattern should be maintained with the existing public programs evolving only as experience indicates the existence of a substantial unmet need that cannot be fulfilled by the voluntary health insurance system.

Within the necessary time limitations, it has been impossible to discuss all of the adverse consequences that would result from the enactment of these proposals. Hence, we have limited our presentation primarily to factual information and statistics which alone, in our opinion, constitute adequate reasons for your committee to reject

[15] U.S. Department of HEW, Research and Statistics Note No. 3, 1963.

this proposal. We appreciate this opportunity to present our views on this matter.

(The comments concerning S. 2431, and appendix follow:)

COMMENTS CONCERNING S. 2431

Responses to questions asked in letter of January 27, 1964, which the Honorable Wilbur D. Mills, chairman of the Ways and Means Committee addressed to Mr. H. Lewis Rietz, executive vice president of the Great Southern Life Insurance Co., to request his opinion and, if possible, the position of the American Life Convention, the Health Insurance Association of America, the Life Insurance Association of America, and the Life Insurers Conference on S. 2431, legislation introduced by Senator Javits, to implement the report of the National Committee on Health Care for the Aged. The questions asked by Chairman Mills, and the comments prepared in response thereto, are as follows:

I. "Would the proposed legislation be consistent with present legislation which sets forth the role of the Federal Government in respect to the regulation of insurance?"

While the ambiguity of the bill, and its silence on several key points, makes it difficult to determine the extent of the inconsistency of such bill with the McCarran Act (Public Law 15, 59 Stat. 33 [1945]), there can be no doubt whatsoever of the existence of such inconsistency.

This conclusion rests upon several factors.

First, the central purpose of the McCarran Act is to preserve to the States the power to regulate and tax the business of insurance, the *Southeastern Underwriters* decision to the contrary notwithstanding. S. 2431 would withdraw an ill-defined but important segment of such regulatory and taxing power from the States.

Second, the bill is ambiguous as to whether the intent is to provide total exemption from State regulation, or to superimpose a broad pattern of Federal regulation upon the existing structure of State regulation with respect to the insurance policies authorized by title V.

If, with respect to title V, the intent of the bill is to substitute exclusive Federal regulation for all areas of State regulation, the bill is silent on so many subjects (see the illustrations under question II) as to amount to a wholesale delegation of legislative authority to the Secretray.

If, on the other hand, the intent of the bill is to create dual Federal and State regulation over matters covered in title V, with State insurance laws applicable where title V is silent, then the respective areas of Federal and State jurisdiction are so inadequately delineated as to assure significant jurisdictional conflicts.

Under either hypothesis, the fundamental inconsistency between title V and the McCarran Act is apparent. Furthermore, the standard provided by section 507 is that each carrier shall be subject to the exclusive regulation of the Secretary "with respect to so much of its business operations as is concerned exclusively with offering for sale, selling, and administering, the standard policy or alternative policies. * * *" The operations of an insurance company are so interrelated that it would be virtually impossible to divide its "business operations" into those "concerned exclusively" with the policies authorized by title V and the remainder of such operations. The same executive, actuarial, sales underwriting, statistical, legal, claims, and administrative personnel within any given insurance company would be concerned in part with the policies authorized by title V, in part with other policies, and in part with matters concerning the company's overall affairs.

II. "Would this provision have a tendency to undermine State regulation of insurance?"

Just as it is virtually impossible to separate those operations of an insurer which are concerned exclusively with policies authorized by title V from those which are not, so also those portions of regulations contained in title V cannot be divorced from the interrelated functions of State regulation not mentioned in title V. For example:

First, S. 2431 would require the preparation and promulgation of a Federal insurance code to fill the omissions of the bill. In several respects S. 2431 would expressly override or authorize the Secretary to override State statutory and regulatory policy. For example, section 503(c)(3) authorizes the Secretary, not the State insurance department, to determine whether an alternate policy

"will represent to the subscriber thereof a dollar value which is not less than that represented by the standard policy. * * *" Similarly, section 503(c)(5) authorizes the Secretary and the Advisory Council to approve expense limitations. Furthermore, section 503(e) authorizes insurers to earn a "fair profit" upon supplementary health insurance policies. There is certainly no assurance that such standards would be consistent with State statutory provisions that require policies to be self-supporting, that limit administrative expenses, and that forbid benefits unreasonable in relation to the premium charged.

Second, the bill is silent with respect to such fundamental regulatory areas as: qualification and licensing of agents and brokers for the sale of title V policies; capital, reserves, surplus, and other fiscal regulation; the review and approval of policy forms by the States; the applicability or inapplicability of the uniform individual accident and sickness policy provisions law; jurisdiction, service of process, venue, procedure, and other incidents of litigation concerning title V policies; reinsurance; the applicability or inapplicability of the Uniform Fair Trade Practices Act; the relationship between an insurer's activities under title V and such forms of State supervision as the licensing of companies by the individual States, as well as the annual statement and State insurance department examination requirements.

Third, section 503(c)(6) provides that "the Association, in cooperation with the Advisory Council and with the approval of the Secretary, shall devise programs designed to enable persons who have not attained age 65 and are still employed to purchase the insurance provided by the standard policy or an alternative policy on a prepaid basis." Conceding the ambiguity of this provision, it could be interpreted to extend the exemption from State regulation, and the commensurate growth of Federal regulation, to employees below age 65 for insurance covering their active years as well as their retirement period. Such a construction of this provision, coupled with the nonprofit and tax exempted character of title V policies, would quickly drive voluntary health insurance out of the market, destory State regulation of health insurance, and substitute a Federal program of governmental insurance for all ages.

III. "What Federal and State antitrust legislation would be affected by this proposal?"

All State antitrust legislation applicable to insurance companies would be rendered totally ineffective insofar as concerns the business operations having to do with the sale of standard or alternative policies.

Substantially all of the States have antitrust statutes, which in most cases are very similar to the Federal antitrust statutes. In addition, shortly after the enactment of the McCarran Act, many States, following the invitation extended by Congress in that act, enacted State fair trade practices acts (patterned after the Federal Trade Commission Act) and State Clayton acts (patterned after the Federal Clayton Act). All of these State statutes would be made inapplicable to this particular line of business.

The Federal antitrust laws would also be made inapplicable to these insurance operations. It is true, of course, that the McCarran Act provides that the antitrust laws are to apply to insurance only to the extent that such business is not regulated by State law. Thus, the Federal antitrust laws currently are not applicable to many areas of insurance by reason of the fact that the States regulate in those areas. At the same time, the Federal antitrust laws do apply to insurance where there are no State regulatory laws. Additionally, the McCarran Act expressly provides that the Sherman Act is in all events to remain applicable to any act of boycott, coercion, or intimidation. Thus, in these two areas the Federal antitrust laws presently apply to insurance. S. 2431 would expressly render the Federal antitrust laws inapplicable to insurance companies in these two areas in the case of the "standard" and "alternative" policies. The total effect would be that insofar as concerns insurance company business operations relating exclusively to the policies covered by this bill, the Federal antitrust laws would be totally inapplicable.

IV. "Would there be a blanket exemption and what policy problems are raised in this area?"

There clearly would be a blanket exemption from both the Federal and the State antitrust laws as they might apply to the sale of the standard or alternative policies covered by S. 2431.

One serious policy problem that would arise from this bill is the possibility of confusion between those activities which are exempted and other activities of the insurance business which presently are subject to the antitrust laws despite the McCarran Act. Section 507(a) of the bill would provide that the

association and each carrier member would be exempted from both Federal and State antitrust laws "with respect to so much of its business operations as it is concerned exclusively with offering for sale, selling, and administering the standard policy or alternative policies." Clearly, this is general and somewhat ambiguous language, and it seems most doubtful that it could be made sufficiently explicit.

The insurance companies engaged in this type of business manifestly would at the same time be engaged in many other types of insurance business. It would be most difficult to separate these other types of operations from operations "concerned exclusively * * * with the standard policy or alternative policies." Thus, there would always be a grave danger that the antitrust exemptions granted by this bill, and intended to be confined to these policies, would operate so as to extend antitrust exemptions to insurance companies in areas beyond those intended.

V. "Are there, in your opinion, any constitutional or policy questions as to the Federal exemption of State premium taxes?"

The proposed exemption of title V policies from State premium taxes, and indeed State income taxes, raises serious constitutional questions.

We would concede that the Congress may constitutionally enact legislation exempting the contracts or activities of a Federal instrumentality from State taxation provided the creation of such Federal instrumentality is itself within the power of the Congress. Fundamentally, therefore, the question here may well be whether the association is in fact an instrumentality of the Federal Government with the insurance company members merely acting as agents.

A study of the various provisions of the bill leaves great doubt that this is in fact the case. It is true that under the provisions of the bill the premiums on the policies sold by the insurance carrier will ultimately be placed in a common fund established by the "Association." It is also true that according to the bill the assets of the reserve fund will be "the property of the Association," and that the expenses of the Association will be paid from monies in the fund. Furthermore, the bill would provide that all benefits "payable on account of such policies" are to be paid from the reserve fund. Finally, various provisions of the bill indicate that the management of the "Association" is to consist of individuals appointed by the Federal Government. To this extent, the provisions of the bill suggest that the "Association" is an instrumentality of the Federal Government.

But there are other provisions in the bill which suggest to the contrary. For example, under section 502(a) of the bill, it is expressly provided that the contract is one "entered into between a carrier and another person whereby the carrier, in consideration of the payment to it of a periodic premium, undertakes to provide, pay for, or reimburse the cost of, health services for the individual * * *." This provision states that the carrier is the issuer of the policy, that the contract is between the carrier and the insured, and that the carrier undertakes full liability under the policy. Also section 502(c) expressly states that the premium on the policy is the consideration "charged by a carrier for coverage by a health insurance policy offered by the carrier."

These provisions would seem to make it clear beyond doubt that the insurance companies are the issuers of the policies and the entities which assume all liabilities under the policy. Under this interpretation the "Association" is nothing more than the vehicle for bringing together those insurance companies which want to join in the program. To this extent, therefore, the bill would seem to be one which exempts the member insurance companies from State taxation, and not a bill which merely exempts a Government instrumentality from such taxation.

This interpretation is buttressed by consideration of the provisions of the bill dealing with the alternative policies, as distinguished from the standard policies. Section 503(c)(3) provides that the "Association" shall develop health insurance standards for the purpose "of enabling its members * * * to devise and offer for sale one or more health insurance policies each of which may serve as an alternative to the standard policy." This language is to be compared with the language of section 503(c)(1) which states that the "Association" shall "devise * * * and offer for sale through its members, a health insurance policy* * *." Thus, in the case of standard policies section 503(c)(1) seeks to speak in terms of selling through members, whereas in the case of alternative policies section 503(c)(3) speaks in terms of the member carriers offering the policies themselves. This is a technical comparison, but it suggests efforts on the part of the draftsmen to make what is in fact not a Federal instrumentality appear to be one merely for the sake of avoiding constitutional attack.

In short, the proponents of S. 2431 may either create a Federal instrumentality under title V and thereby provide a basis for congressional authority to immunize title V policies and activities from State premium and income taxes, or they may create a joint private-public cooperative endeavor and thereby achieve the political advantages of such an association with the institution of voluntary health insurance, but not both.

Irrespective of the decision by the proponents of S. 2431 to modify their bill to achieve tax immunity by the creation of a Federal instrumentality, the wisdom of the exercise of such power is dubious indeed. Obviously the States, as well as the Federal Government, must be able to tax in order to perform their proper functions. Only a very small part—probably around 5 percent—of State premium taxes are used for support of the State insurance departments. The remainder is used by the States for general purposes and clearly constitutes an important source of revenue. While the volume of the contracts in question here would probably represent only a small part of the total insurance contracts subject to premium taxation, nevertheless the principle is the same. It cannot be denied that the bill in question represents a direct interference with the States' sovereign power. It seems a dangerous precedent even in this limited instance to permit the Federal Government to interfere with State power to tax.

VI. "Finally, I would like your opinion on whether this legislation would establish a workable and effective scheme which private health insurers will enter into?"

This question may be answered categorically and unequivocally in the negative.

The spectacular growth of voluntary health insurance has been in large part a consequence of the wisdom of Congress in preserving the system of State regulation by enactment of the McCarran Act. As has been indicated in earlier portions of this memorandum, the enactment of title V would be inconsistent with the policy of the McCarran Act and would significantly undermine the system of State regulation. Title V would not establish "a workable and effective scheme" for a series of additional reasons, of which the following three are illustrative.

First, S. 2431 would create jurisdictional confusion and regulatory uncertainty by reason of the ill-defined division of authority between State and Federal regulation.

Second, S. 2431 contains no provision either as to the source of the funds necessary to launch the proposed program or, more significantly, the source of the funds to pay claims and administrative expenses in the event that the proposed premium proves to be inadequate. In such situations, the Secretary might decide that it was more logical to infer that the additional funds should come from the participating carriers than from the Treasury of the United States. Indeed, the latter alternative would require a separate act of Congress.

Third, S. 2431 provides for the issuance of title V policies by private insurers on a "nonprofit" basis. This factor, coupled with the one described in the preceding point, would place the board of directors of an insurance company in the position of making its surplus available for deficiency assessments for title V purposes while receiving no contribution to such surplus from title V policies. Furthermore, the necessity for a deficiency assessment, and the consequent invasion of the insurance company's surplus, would be in significant part dependent upon the investment and administration of the title V reserve fund, in which such decisions the insurer would have no part.

Under such circumstances, participation by an insurance company would be so clearly contrary to the best interests to their stockholders and/or policyholders, and indeed such a threat to the solvency of the insurer, as to create possible personal liability on the part of the directors.

VII. "Moreover, Senator Javits stated at the hearings that such policies, which presumably would cover one-third of the health costs of aged individuals, would be sold for $2 a week. Other witnesses testified, however, that such protection would cost twice as much."

As to whether the "standard" private health policy, to provide benefits supplementary to the hospital and hospital-related benefits under the social security system, can be provided for an estimated $2 a week as represented, a great deal obviously depends on the scope of such supplementary benefits. The terms of title V do not specify the level of supplementary benefits with enough exactness to determine their actuarial cost; instead, section 502 speaks of payment of

"part or all of most charges for or toward physicians' services," and of payment, "in accordance with an unspecified schedule, for or toward the costs of surgery."

These descriptions are too indefinite to form the basis of specific cost estimates. If section 502 were revised to include the usual schedule and other provisions contained in most policies providing reasonably adequate coverage for doctor visits, surgery, and diagnostic X-ray and laboratory expenses, the estimated cost would be about $10 to $12 per month, depending upon the maximum schedule and maximum number of visits decided upon.

In no event would this cost be lower than the cost of corresponding benefits provided outside of the purview of title V since the pooling process inherent in placing all such coverages, under the auspices of the national association authorized by section 503, will not reduce such costs below cost levels which can be achieved in other ways.

APPENDIX IN CONNECTION WITH STATEMENT ON H.R. 11865 AND AMENDMENTS

(By H. Lewis Rietz for American Life Convention, Health Insurance Association of America, Life Insurance Association of America, Life Insurers Conference, August 13, 1964)

ESTIMATE OF THE EARLY YEAR AND LONG-RANGE COST OF BENEFITS UNDER THE GORE AMENDMENT TO H.R. 11865

This analysis of the cost of benefits under the Gore amendment to H.R. 11865 has been prepared from data generally available from insurers. The techniques employed are those used by actuaries in determining the cost of benfits under medical insurance plans. The analysis establishes that the bill's proposed tax rate of 0.8 percent of a $5,400 payroll (as well as HEW's estimated level premium requirement of 0.85 percent) will be totally inadequate to cover the benefit costs for OASDI eligibles. The HIAA estimates the necessary tax rate to be at least twice as great. HEW's estimate of costs for the aged not eligible for OASDI benefits is, likewise, too low.

It is to be noted the HEW's estimated level premium is based on the assumption that earnings will not rise above 1963 levels, or that, if they do, the earnings base of $5,400 and the deductible of $10 per day will be increased proportionately by the Congress. However, earnings can be expected to continue to rise. If earnings rise at 3 percent per year, the rate used by the Social Security Administration in actuarial study No. 53, August 1961, then in 1966 (the first year of full benefits), the HEW's level cost estimate of 0.85 percent will not even be consistent with the assumptions of HEW unless the taxable wage base is raised to $5,900 instead of $5,400 by 1966. (Alternatively, a rise in the tax rate above 0.8 percent could provide temporarily for the necessary increase in revenue.) Additionally, it would be necessary for the $10 per day deductible to be increased to $11.60 per day in order to maintain the system in balance. The HEW estimate also assumes that Congress will continue to keep the program "current" by further regular increases in the taxable payroll and in the $10 deductible as earnings continue to rise after 1966.[1]

The Gore amendment to H.R. 11865 (hereinafter referred to as the amendment) provides that all persons 65 years of age ar older, whether eligible for OASDI benefits or not shall be entitled to receive the benefits noted below. For OASDI eligibles, the benefits would be paid from OASDI funds. For those not eligible for OASDI the benefits would be paid from general revenue.

Benefits under the Gore amendment

(*a*) Up to 90 days of inpatient hospital services in semiprivate accommodations subject to a deductible of $10 for each of the first 9 days of confinement, with a miminimum deduction of $20 per benefit period; or up to 180 days of inpatient hospital services in semiprivate accommodations subject to a deductible of 2½ times the average per diem rate for such services; or up to 45 days of inpatient hospital services in semiprivate accommodations with no deductible.

(*b*) Up to 180 days of care in a skilled nursing facility affiliated with a hospital, upon transfer to the nursing facility after treatment as an inpatient in the hospital.

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[1] See actuarial study No. 57, HEW, July 1963, and statements by R. J. Myers, Chief Actuary, Social Security Administration, before Senate Finance Committee, Aug. 7, 1964.

(c) Outpatient hospital diagnostic services subject to $20 deductible during any 30-day period.

(d) Up to 240 home health service visits during a calendar year. Such services consist of intermittent nursing care, physical, occupational, or speech therapy, medical social services, medical supplies (other than drugs and biologicals), and the intermittent services of a home health aid.

Estimated costs

The actuarial bases for the association's cost estimates are presented in detail on the following pages. Shown separately are estimates for 1966 (the first full year for which all benefits will be available), and for subsequent years. The results of the calculation of the "level premium" cost of benefits is also included. A summary of these cost estimates indicates the following:

(1) Benefits provided under the amendment would cost $2,772 million in 1966.

(2) By 1990, the 25th year of the proposed program, the association estimates that the annual cost for OASDI eligibles will reach $6,796 million (even with no further rise in earnings levels beyond 1966).

(3) The "level premium" cost of the amendment per HEW estimates would be 0.85 percent.[2] On a similar basis, but with earnings frozen at the 1966 level (the first year of full benefits), the association's estimate of this "level premium" is 1.66 percent. On the other hand, this estimate is increased to 2.13 percent should the earnings base of $5,400 and the $10 per day deductible not be increased in proportion to the assumed increased earnings of 3 percent per year through 1980.

(4) Under present law, social security taxes are scheduled to rise to a combined employer-employee tax rate of 9¼ percent of the first $4,800 of taxable income by 1968. Employees earning the maximum together with their employer, will pay a combined $444 per year. With the addition of benefits in H.R. 11865 plus the Gore amendment the tax rate will be 10.4 percent and, based on a $5,400 taxable payroll, according to the bill, the amount will have to be increased to $562 per year. Based on the association's estimate of the cost of health care benefits, and without any transfer of gains from the OASDI system, the combined amount will be $651 per year—47 percent more than the scheduled amount for present benefits and 108 percent more than the combined amount paid currently.

(5) For the non-OASDI aged (excluding railroad retirees) the association estimates a cost of $592 million in 1966 although a portion of this cost will be offset by current Federal spending under the OAA and MAA programs. By 1990, the association estimates that the annual expenditure for this group will be $704 million if all of the persons not eligible for OASDI benefits at that time are covered under the program. However, if eligibility for benefits is limited as provided by the amendment as now written, then some 2½ million persons in 1990 will not be eligible for benefits and there will be only a very small cost for a residual group of persons who are eligible for benefits in accordance with the amendment.

It is to be noted that these estimates of cost, as with all such estimates, are subject to some limited degree of variation either above or below the level estimated herein. The element contributing the greatest amount to the total cost, however—namely, the cost of hospitalization—is subject to the least percentage variation.

ESTIMATED COST IN 1966 FOR OASDI ELIGIBLES

Cost of inpatient hospital services

The association has presented documented calculations of the estimated cost of prior governmental proposals to provide health care benefits to the aged.[3] These calculations, based upon a thorough survey of available insured lives data, indicated an annual rate of hospitalization of 180 persons per 1,000 and an average duration of hospitalization of 18.9 days as appropriate for evaluating the cost of hospitalization for the OASDI population. The product of these two factors equals an expected average of 3.4 days of hospitalization stay per OASDI eligible per year. These data are for a plan with a 90-day maximum.

[2] The level premium calculation is based upon a 1963 earnings level and on the assumption that the taxable wage base will be increased to at least equal increases in the earnings level per methodology employed by the Social Security Administration, HEW.

With the introduction of the amendment, all of the material previously analyzed[3] was reviewed and, in addition, more recent data which had become available was studied. The new sources[4,5,6] confirmed the hospital utilization rates previously used by the association as appropriate for the valuation of the current legislative proposals. See attached appendix tables (these data had over a quarter million life-years exposure).

The development of hospital utilization rates by a review of actual claim and exposure records available from insurance companies, Blue Cross plans, and Canadian provincial plans provides a reliable basis for the health insurance actuary to measure hospitalization costs. HEW, on the other hand, based its estimate of hospital usage on the unverified results of general population survey data—primarily a household interview survey conducted in 1957 among 5,365 of the then 14 million OASDI beneficiaries.[7] Surveys such as the type conducted by HEW suffer from intentional underreporting of "embarrassing" ailments by the aged and the unavailability of data for deceased lives. After "adjusting" such data for underreporting due to the inability to obtain information on deceased lives, the Department arrived at an initial hospital utilization rate of only 2.68 days per OASDI eligible or 20 percent below the 3.4 days mentioned above.

According to the American Hospital Association, the average per diem cost (including the cost of room and board as well as ancillary services) in non-Federal short-term general hospitals in 1963 was $38.91.[8] As indicated in the table below, this average per diem cost has risen in recent years at an average annual increase in excess of 7 percent.

	Average cost per patient-day [1]		*Average cost per patient-day* [1]
1946	$9.39	1959	30.19
1950	15.62	1960	32.23
1955	23.12	1961	34.98
1957	26.02	1962	36.83
1958	28.27	1963	38.91

[1] See footnote 8.

Assuming that per diem costs increase by only 5 percent during 1964 to 1966, the per diem cost will reach $44.75 in 1966. HEW has estimated that the hospital per diem for the aged will be considerably less. HEW does so by using a smaller rate of increase in hospital per diem between 1963 and 1966, and by using a smaller than average daily cost for the aged. HEW maintains that special service charges per day will be lower because persons over 65 have longer than average hospital stays. This approach would be more correct if all ages had the same special service charges. In actual fact, the aged experience considerably higher special services charges.[9] Further, HEW has assumed that OASDI beneficiaries under the program will pay less than full charges for a day in hospital. If the program were to reimburse hospitals at a rate less than their full charges, the already serious financing problems of hospitals would be increased and an unfair and discriminatory burden would be placed upon paying patients under age 65 from whom hospitals would be forced to secure additional revenue. Furthermore, although HEW has admitted that hospital costs are likely to increase somewhat more rapidly than the general earnings level in the next few year, they have assumed that such differential will, over the long run, be counterbalanced by hospital costs rising less rapidly than the general earnings level.[10] It is difficult to see how this can occur.

Application of the utilization and per diem cost factors, discussed on the foregoing pages, to the eligible OASDI population, yields the annual cost of hospitalization for 1966—for a plan with a 90-day maximum and no deductible. The calculation is shown in the following table.

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[3] Testimony of H. Lewis Rietz re H.R. 4222 and H.R. 3920 before Ways and Means Committee, app. A, July 31, 1961, and app., Nov. 22, 1963.
[4] Annual report of the Saskatchewan Hospital Services Plan, 1961 and 1962.
[5] Manitoba Hospital Commission morbidity study, 1961.
[6] Erdenberger, Richard W., Transactions of the Society of Actuaries, pp. D416–D417, vol. XIV, March 1963.
[7] Actuarial study 52, HEW, July 1961, and actuarial study 57, HEW, July 1963.
[8] Hospitals, August 1964, American Hospital Association.
[9] "An Investigation of Group Major Medical Expense Insurance Experience," Gingery and Mellman, Transactions of the Society of Actuaries, vol. XIII, p. 522, 1961.
[10] See "Actuarial Study No. 57," HEW, July 1963.

Age	Eligible OASDI population, 1966 [1] (in millions)	Days per person per year [2]	Hospital costs (in millions) [3]
65 to 69	6.2	2.60	$721
70 to 74	4.6	3.10	638
75 to 79	3.1	3.90	541
80 and over	2.1	6.00	564
Total	16.0	3.45	2,464

[1] From Division of the Actuary, HEW, by telephone, August 1964.
[2] Composite rate derived from actual claim records as published in sources noted in references 1 to 4 Examples of some of the data reviewed are shown in appendix table I.
[3] Based upon an average hospital per diem of $44.75 as noted in the foregoing pages of this memorandum. This is a conservative projection of official cost data of the American Hospital Association.

With no deductible, the average cost for hospitalization per aged OASDI eligible in 1966 will be $154. As to the deductible, most persons age 65 or more who are hospitalized remain at least 9 days, in which case the deductible (under the 90-day plan) is $90. However, since some persons stay in the hospital less than 9 days, the deductible for this relatively smaller group will be less than $90. Based on unpublished data available from several large insurance companies, and a review of recent published experience from the British Columbia Hospital Plan,[11] it has been determined that the average deductible will be $75. With an admission rate of 180 per 1,000 among the OASDI aged eligible population, this would result in a cost reduction of $13.50 per person (i.e., 180× $75). Thus, the net cost per person per year under this plan, for hospitalization, should be about $140.50 (i.e., $154 less $13.50).

It is to be noted that the foregoing estimate does not take cognizance of the fact that the deductible may be applied only once during a benefit period. To the extent that OASDI eligibles are readmitted for additional hospitalization during the same benefit period, the costs would be further increased since the deductible is not applicable.

It will be noted that the association has determined that the deductible in the 90-day plan will reduce hospitalization costs by about 9 percent. HEW, on the other hand, has estimated that the deductible would reduce hospitalization costs by about 15 percent.[12] In other words, it estimates that the deductible would have almost twice the effect. As in the instance of hospital utilization, HEW based this estimate on the unverified results of household interviews of a sample of the general population. For this study, the sample included only 3,000 aged persons.[13]

The association has conducted a careful review to determine if the other two options for hospitalization benefits under the amendment are actuarially equivalent to the 90-day plan. If they were actuarially equivalent, there would be no difference in the cost of the program for the three options.

The determination of whether or not the options are actuarially equivalent depends upon the use of what is known as a "continuance table." In this analysis, use was made of a continuance table based upon 1960 British Columbia data. This review indicates that the options are not actuarially equivalent. In the absence of antiselection, that is, a tendency of the beneficiaries to select the benefits best suited to their needs, the review shows that the 45-day benefit with no deductible is worth 2.6 percent more, on the average, to a beneficiary than is the 90-day option. It has likewise been determined that the 180-day benefit with a deductible equal to 2½ times the average per diem hospital cost is worth 2.7 percent more, on the average, than the 90-day option.

Since the 45-day option provides "first-dollar coverage," it is to be expected that this option will be the most popular among beneficiaries. If it is assumed that 70 percent of beneficiaries elect the 45-day option, 10 percent take the 90-day option, and the remaining 20 percent elect the 180-day option, all elections being without any particular regard to the needs of the beneficiaries (that is without antiselection), then the estimate of $140.50 noted above would have to be increased by 2.4 percent.

[11] Annual report of British Columbia Hospital Plan, 1959. This experience was based upon 28,000 claims distributed by duration.
[12] See footnote 7.
[13] U.S. national health survey, series B–7, December 1958, table 14.

It should be noted, however, that over 17½ million persons now age 65 or older will have ample opportunity to elect their option. It is clear, therefore, that it would be too optimistic to assume that there will be no antiselection. Beneficiaries who suffer from chronic ailments will have a natural tendency to elect the 180-day option, while persons who do not anticipate the need for long hospital stays will be attracted by the 45-day option with no deductible. Antiselection then could result in a larger number than would normally be expected of long-term claims under the 180-day option, with a decrease in the number of short-term cases. Under the 45-day option a larger than normal number of short-term claims would appear.

It is estimated that antiselection of this sort would raise the initial cost of hospitalization benefits under the amendment by at least an additional 2.5 percent. This additional cost due to antiselection would diminish in future years, as beneficiaries who are not yet now 65 or over would have to elect their option sufficiently far in advance to minimize antiselection.

In summary, it is expected that the hospital care portions of the amendment will cost about 5 percent more than the aforecited net cost per person per year of $140.50 or $148 initially. In later years, the effect of antiselection and the actuarial nonequivalence of the three options will result in a 2.4-percent increase over hospitalization costs in those years.

Cost of outpatient hospital services and home care services

The association has presented estimates of the cost of outpatient and home care benefits as proposed by the amendment.[14] They are similar to those contained in H.R. 4222 of the 87th Congress and H.R. 3920 of the 88th Congress. Based on the most reliable data available, those estimates indicated that the benefit for out patient hospital diagnostic services will cost $4 per person per year in 1966. For home health services, the estimated cost will be $6 per person per year.

Cost of skilled nursing home services

A recent nationwide survey indicates that there were 24,114 skilled nursing home beds in facilities affiliated with hospitals in 1962.[15] The same study indicated that there were an additional 2,886 such beds under construction or in active planning for use in the near future.

By the end of 1966 additional facilities affiliated with hospitals will be constructed and many skilled nursing care facilities not currently affiliated with general hospitals could develop affiliation agreements in order to qualify under the amendment. The additional beds produced by these activities are estimated at 33,730 or 10 percent of the 337,300 skilled nursing beds in skilled nursing facilities as of 1962.[16]

A combination of the skilled nursing beds now eligible with those which will become eligible by the end of 1966 produces a total of 60,730 such beds. Since these beds will undoubtedly be made available, primarily, to the aged and since the supply will be insufficient, there will be a high occupancy rate. If an occupancy rate of 90 percent is assumed, the average daily census in such facilities would be 54,660. This would be equivalent to 19,951,000 total days of care per year.

In 1962, the average charges made by nursing homes covered under the insurance plan for Federal employees was $9.79.[17] The corresponding average under the Connecticut 65 nursing home coverage was $12.26.[17] Because of the similarity between the cost factors for nursing homes and those for hospitals, the cost can be expected to increase at least 5 percent per year in a manner similar to hospital costs. Also, it would seem reasonable that per diem cost for nursing facilities meeting the definition in the amendment would be higher than the average present-day charges made by nursing homes recognized under the plan for retired Federal employees. The average per diem cost in nursing homes in 1966 is, therefore, estimated at $12.

Various surveys indicate that, on any single day, about 30 to 40 percent of nursing home patients have been confined for less than 6 months. However, these surveys have included all nursing homes, and many of the patients in these homes were receiving only custodial, personal, and shelter care rather than

[14] See footnote 3.
[15] Medical Care Research Center, St. Louis, Mo., 1962.
[16] "Nursing Homes and Related Facilities," HEW, February 1963.
[17] "Experience of First Policy Year Under Connecticut 65," as distributed to participating insurance companies, May 1963; and letter from Aetna Life Insurance Co., May 1963.

skilled nursing care. It would seem reasonable that the proportion of patients on any given day who would have been confined for less than 6 months could easily be as high as 60 percent where all patients are receiving only skilled nursing care. It should be noted that if the amendment passes, the operators of these facilities would be under considerable financial pressure to avoid patients who did not need skilled nursing care because of the availability of Federal financing for patients who do require skilled nursing care. If a 60-percent assumption is used, the total annual days of care which would be payable under the amendment would be at least 11,971,000.

At a cost of $12 per day, the foregoing 11,971,000 days of care would involve an expenditure of $143,650,000 in 1966. This amount would, of course, be for all the aged eligible under the amendment. For the 16 million eligible OASDI aged, the cost would be 78 percent of this amount,[18] or $112,047,000 with the remaining $31,603.000 for all other aged (including railroad retirees).

The foregoing costs assume a skilled nursing home utilization by the OASDI aged of 0.60 days per year (at $12 per day, this produces an annual cost of $7.23 per person).

For the other aged, the utilization is assumed at 0.80 days or an annual cost of $9.60 per person.

It is to be noted that HEW has never published specific assumptions as to the basis for its determination of the costs of the skilled nursing home benefits.[19]

It should be noted, further, that HEW has reduced its estimated costs for hospitalization on the assumption that the availability of nursing home benefits will reduce such costs.[19] Such an assumption is questionable, particularly since there is no financial incentive for aged persons to leave the hospital until the maximum limit of 45, 90, or 180 days has been reached. Moreover, the nursing home benefit, under terms of the amendment, is available after only 1 day of hospital confinement. This very liberal qualifying requirement could easily result in increased use of the hospital in order to qualify for nursing home benefits.

Summary of costs for OASDI eligibles in 1966

	Cost per person per year in 1966 [1]
Inpatient hospital services	$148
Outpatient hospital services	4
Skilled nursing home care	7
Home health care	6
Total	165

[1] These costs have been rounded to the nearest dollar.

At a cost per person per year of $165 in 1966, and with 16 million OASDI eligibles,[20] the total cost of the amendment (excluding administrative expenses) for this portion of the aged will be $2,640 million in that year. With administrative expenses of 5 percent added,[21] the cost for OASDI eligibles in 1966 will total $2,772 million.

It should be noted that these estimates of cost are based upon an estimated eligible OASDI population under the social security law as now constituted and as proposed under H.R. 11865. Any further change in the law which added additional eligibles would increase these estimates.

ESTIMATE OF COST IN 1966 FOR AGED NON-OASDI ELIGIBLES (EXCLUDING RAILROAD RETIREES)

The following table indicates the development of hospitalization costs for the non-OASDI aged in 1966. The methodology and source material employed is similar to that for the OASDI aged.

[18] Based upon a review of the relative use of nursing facilities of the 2 populations as shown by the age curve of nursing use in the Connecticut 65 experience. By letter from the Aetna Life Insurance Co., May 1963.

[19] See footnote 7.

[20] From Division of the Actuary, HEW, by telephone, August 1964.

[21] Administrative expenses could easily reach 10 percent; see Faulkner, E. J., testimony before the House Ways and Means Committee, July 1959. For the current program, expenses of 5 percent have been assumed.

Age	Non-OASDI aged population (in millions)	Days per person per year	Hospital costs (in millions)
65 to 69	0.8	2.60	$93
70 to 74	.8	3.10	111
75 to 79	.6	3.90	105
80 and over	.8	6.00	215
Total	3.0	4.09	524

Average cost per person (excluding administrative expenses) $174.67.

Application of the deductible under the 90-day plan will reduce the average cost per person from $174.67 to about $160.[22] To this cost must be added about 5 percent for antiselection and the actuarial imbalance of the three options (see previous discussion for OASDI eligibles) making the cost per person $168.

A summary of the above costs, together with those for skilled nursing home care (developed earlier in this memorandum), and outpatient care and home health care, which should be the same as for OASDI eligibles follow:

Summary of costs per non-OASDI in 1966

	Cost per person per year in 1966 [1]
Inpatient hospital services	$168
Outpatient hospital services	4
Skilled nursing home care	10
Home health care	6
Total	188

[1] These costs have been rounded to the nearest dollar.

With 3 million non-OASDI aged (excluding railroad retirees) in 1966, the cost (including administrative expenses of 5 percent) will be $592 million.

Cost estimates for years subsequent to 1966 for OASDI eligibles

Many factors, both inherent in the provisions of the amendment and in the particular patterns and trends in medical care and medical economics, will produce substantially higher costs in future years for the benefits provided by these bills. The association, after a careful review of these factors, has prepared the following estimates of the probable costs of the amendment for years after 1966.

Inpatient hospital services

Authorities in the hospital field expect hospital costs per bed per day to increase faster than the general cost of living for some years to come.[23] Other experts in medical economics agree with these hospital authorities. Thus, Assistant Secretary of Health, Education, and Welfare Wilbur Cohen has predicted that hospital costs following the current trend would reach $70 per day by 1972.[24] Other analysis at HEW have projected a cost of $57 by 1970 as indicated in the attached appendix table III (taken from an HEW publication). In a paper presented at a recent meeting of the Casualty Actuarial Society, Murray Latimer calculated a probable hospital per diem cost of $54 by 1970.[25]

It is to be noted that, as these hospital per diem costs increase in future years, the percentage savings due to the $10 per day deductible will decrease.

With the foregoing in mind, a conservative estimate is that hospital costs will continue to rise at an annual rate of 5 percent through 1968, and by 4

[22] The deductible for this group would be worth about $15, inasmuch as the weighted frequency of hospital admissions is 0.196 rather than 0.180 as in the instance of the OASDI population.

[23] For example, see the following: (*a*) Russell A. Nelson, past president AHA, Annual Group Insurance Forum, HIAA, February 1961; (*b*) "Forces Affecting the Community's Hospital Bill," Ray E. Brown, Journal of the AHA, September–October 1958; (*c*) "The Nature of Hospital Costs," Ray E. Brown, Journal of the AHA, April 1956, and Ray E. Brown, Journal of the AHA, July 1, 1963. Also, "Trends in Hospital Costs in the Metropolitan New York Area: 1947–67," United Hospital Fund of New York, May 1963.

[24] Barron's, Oct. 29, 1962.

[25] "Costs of Hospital Benefits for Retired Employees," Murray Latimer, annual meeting of Casualty Actuarial Society, May 5, 1961.

percent for the succeeding 10 years to 1978, and 3 percent thereafter. Of these total yearly percentage increases, 3 percent per year is estimated to represent the increase in the general earnings level and 2 percent and 1 percent respectively, the excess of the increase in hospital costs over the increase in the general earnings level. After 1978, it is estimated hospital costs will have caught up with the general earnings level and any future increases will be at the same rate as for the earnings level.

These increases will produce the following hospital per diem costs subsequent to 1966:

	Actual dollars	*In terms of 1966 dollars* [1]
1967	$47	$46
1970	53	48
1975	65	50
1980	77	[2] 51

[1] Increase above yearly increase of 3 percent in general earnings level.
[2] For 1978 and later years.

It is to be noted that HEW has assumed; (1) that Congress will keep the system sound by increasing the wage base as earnings rise; and (2) that hospital costs, on the average, will increase no more rapidly than the general earnings level after 1971. By 1966, the increase in earnings level alone would require a taxable wage base of $5,900 to conform to those assumptions. Thus, with regard to the association's projection of per diem costs it is only the additional increase in hospital costs above that caused by increases in the general earnings level which will result in greater benefit expenditures under the program. The association does not agree with this assumption but has used it in this instance for comparative purposes only. It will be observed that the foregoing hospital per diem projections are below costs predicted by the HEW sources cited.

The following table provides a calculation of the hospitalization costs to be expected in 1990, under the 90-day plan with no deductible. It is to be noted that there has been no allowance made for increased frequency of hospital utilization even though this has been increasing at about 1½ percent per year.[26] The HEW's assumption with respect to ultimate utilization is 2.98 days or almost 20 percent lower than the 3.65 days shown below.

Age	Eligible aged OASDI population (in millions)	Days per person per year	Hospitalization costs (in millions) [1]
65 to 69	9.4	2.60	$1,246
70 to 74	7.5	3.10	1,186
75 to 79	5.6	3.90	1,114
80 and over	5.4	6.00	1,652
Total	27.9	3.65	5,198

[1] Based on a hospital per diem cost of $51 expressed in 1966 dollars.

NOTE.—Average cost per person per year $186.31.

With no deductible, the average cost per eligible aged OASDI beneficiary will be $186.31 under the 90-day plan in 1990. The effect of the deductible (worth $13.50 as previously indicated) will reduce this cost to $172.81. As previously indicated, the effect of the actuarial imbalance of the other two options will increase this cost by 2.4 percent so that the overall cost of hospitalization in 1990 will be about $177.

Outpatient hospital services and home health services

For purposes of this memorandum, it is assumed that the costs for these benefits will not increase in future years.

Skilled nursing home services

Cost estimates for the benefits of nursing home care in future years are subject to a wide degree of variation. This is acknowledged by HEW. In a publication of the Department,[27] in referring to its nursing home cost estimate, it

[26] HEW, "1962 Edition of Trends" (annual).
[27] See footnote 7.

states "* * * analysis can produce a wide spread in the cost estimates—both short range and long range."

The association has prepared two long-range cost estimates for the cost of nursing home care. The "low cost" estimate is based, primarily, on the first 15 months of experience under the Connecticut 65 plan. The "high cost" estimate is based on the estimated number of beds which might become available for skilled nursing care in the future as indicated by estimates of need made under the Hill-Burton State plans and actual beds currently used in the five States with the highest ratio of beds per thousand population. The actual cost estimate used represents an average between the two results.

Low-cost estimate for nursing home care in future years

As stated, the low-cost estimate is based upon experience under the Connecticut 65 plan.[28] The Connecticut 65 plan has a 90-day maximum for nursing home care. Experience under this plan was adjusted by a factor of 1.5 to produce utilization rates for a 180-day plan as in the amendment. With this adjustment the following utilization of nursing homes is obtained:

Age	*Days per person per year*
Under 75	0.49
75 to 84	2.46
85 and over	5.24

Based on the age distribution of the eligible aged OASDI population in 1990,[29] the average annual number of days of nursing home care to be expected is 1.47 per person. With 27.9 million eligible OASDI aged in 1990,[29] this equates to 41 million days of nursing home care.

Because of their interrelatedness, the per diem costs in nursing homes in future years should rise, annually, at the same rates predicted on preceding pages for hospital per diem costs (i.e., 50 percent per year through 1968 and 4 percent per year through 1978, and 3 percent thereafter in order to be consistent with the corresponding assumption for hospital benefits). On this basis, the nursing home per diem in 1990, expressed in 1966 dollars, will be about $14 ($13.79). With 41 million days of care to be expected, this would mean an expenditure of $574 million or about $21 per OASDI eligible.

High-cost estimate for nursing home costs in future years

The high-cost estimates will be dependent primarily upon the number of beds made available for skilled nursing use because it can reasonably be assumed that such beds will be utilized if they are made available. These estimates make no allowance for any savings which may occur under the corresponding program of benefits for inpatient hospital care. Estimates of need for long-term care beds have been made under the Hill-Burton State plans and these estimates are in the neighborhood of 50 beds per 1,000 aged persons.[30] An estimate of possible development of skilled nursing beds can also be developed by projecting the average ratio of skilled nursing home beds per 1,000 of aged population in the 5 States with the highest ratios to the total aged population. This projection also results in an estimate of probable future beds in the neighborhood of 50 per 1,000 aged persons. Using this estimate, the total number of beds needed and available in 1990 would be 1,525,000.

If the following assumptions are made, the average number of persons resident in such facilities on any day and eligible for benefits under the amendment would be 410,000.

Assumptions:

(*a*) On any day, 80 percent of the beds are occupied by aged persons and 20 percent by persons under 65.

(*b*) Nursing facilities have an 80-percent occupancy rate.

(*c*) Thirty percent of the residents on any given day are actually not receiving skilled nursing care but rather domiciliary care which is not provided for under the amendment.

(*d*) Sixty percent of the aged persons resident in such institutions and receiving skilled nursing care on any day have been confined for less than 180

[28] See footnote 17.
[29] See footnote 20.
[30] Hill-Burton State plan data, a national summary as of Jan. 1, 1962, PHS Publication No. 930–F–2, 1962, pp. 46 and 48.

days and have been transferred to the institution from a hospital as required by the amendment.

At an average per diem cost of $14 in 1990, the assumptions outlined above would produce a total annual cost of $2,095 million for all the aged and $1,913 million for the OASDI aged (about $69 per eligible OASDI aged in that year).

The average of the low ($21) and high ($69) cost assumptions for nursing home care costs, in 1990, is $45 per person per year.

Summary of costs for OASDI aged eligibles in 1990

	Cost per person per year [1]
Inpatient hospital services	$177
Outpatient hospital services	4
Skilled nursing home care	45
Home health care	6
Total	232

[1] Expressed in 1966 dollars.

With 27.9 million eligible aged OASDI beneficiaries, at a cost per person of $232, and with 5 percent added for administrative expenses, the total cost in 1990 will be $6,796 million.

COST ESTIMATES FOR YEARS SUBSEQUENT TO 1966 FOR NON-OASDI AGED (EXCLUDING RAILROAD RETIREES)

A calculation of the hospitalization costs for the non-OASDI aged in 1990, based on methodology previously described for a 90-day plan, is shown in the following table:

Age	Non-OASDI aged, 1990 (in millions)	Days per person per year	Hospitalization costs (in millions)
65 to 69	0.7	2.60	$93
70 to 74	.6	3.10	95
75 to 79	.5	3.90	99
80 and over	.8	6.00	245
Total	2.6	4.01	532

NOTE.—Average cost per person per year $204.62.

The calculation for the approximately 2½ million non-OASDI aged (excluding railroad retirees) in 1990, yields an average cost of $194 ($205 less $15 for the value of the deductible plus 2.4 percent for the value of the other 2 options).

Based on similar methodology for estimating costs in 1990 for the OASDI aged, the per person costs for nursing home are estimated at $54, at $4 for outpatient hospital services, and $6 for home health care. For all services provided by the amendment, in 1990, the cost per non-OASDI eligible aged person will be $258 plus 5 percent for administration expenses. For the 2.6 million such aged in that year, this will mean an expenditure, from general revenue, of about $677 million.

However, almost all of the non-OASDI aged in 1990 will not actually be eligible for benefits under the amendment as presently written. Therefore, probably less than $60 million will be required from general revenue under the amendment unless the law is changed.

LEVEL PREMIUM COSTS

The level premium cost as a percentage of taxable wages required to finance the amendment based on the per capita costs developed herein, has been determined using the intermediate estimate of persons aged 65 and over eligible under OASDI, a 1966 earning level, a 3½-percent interest rate, and a $5,400 taxable payroll, in a manner similar to the procedures used by the Social Security Administration in the development of their estimate of a level cost requirement of 0.85 percent. The level cost and the combined employee-employer tax on this basis is estimated to be 1.66 percent.

As noted in the foregoing sections of this memorandum, the above HEW methodology assumes that the Congress will keep the system sound by further increases in the taxable wage base and the $10 per day deductible if the general earnings level rises. This means that in 1966 a taxable wage base of about $5,900 would be required to be consistent with the assumptions underlying the HEW level cost estimate of 0.85 percent. In addition, the HEW assumption is that Congress will continue to increase the taxable wage base by the average increase in the earnings level. For purposes of the above estimate the association has assumed that the wage base will remain at $5,400 and the deductible at $10 per day through 1966 in accordance with the provisions of the amendment as stated.

An estimate has also been prepared on a basis which provides for further increases in the earnings level at a rate of 3 percent per year through 1980 with no further increase in the $5,400 maximum earnings base and the $10 per day deductible contained in the bill. Based on this assumption, the level cost, as a percentage of taxable payroll, is estimated to be 2.13 percent.

APPENDIX TABLE I

Comparison of various hospital utilization rates for ages 65 and over

[Number of hospital days per person per year]

Age	NYS Insurance Department studies [1]		1962 Saskatchewan report, no limit	1961 Manitoba report, no limit	1959 British Columbia report, no limit	HIAA composite rate for 90-day plan [2]
	1957 study, 120-day maximum	1960 study, mass enrollment 31-day maximum				
65 to 69	2.66	2.53	4.33	4.61	3.01	2.60
70 to 74	3.22	3.22	6.25	6.01	4.05	3.10
75 to 79	4.05	3.74	8.08	8.32	6.27	3.90
80 and over	6.27	4.30	12.97	13.59	8.83	6.00

[1] Most of this experience was on a nationwide basis.

[2] The weighted average for all ages over 65, based upon the OASDI eligible aged population in 1965-66, is 3.45. In comparison, HEW has estimated a rate of 2.68 for this early period, and 2.98 for its long-range cost estimates for hospitalization.

Appendix Table II

Discharged cases and patient days, 70 years of age and older

Number of days	Number of cases discharged	Patient cost under H.R. 4222 per stay	Total patient cost
Part A—Old-age pensioner:			
1	396	$20	$7,920
2	351	20	7,020
3	373	30	11,190
4	374	40	14,960
5	387	50	19,350
6	436	60	26,160
7	524	70	36,680
8	462	80	36,960
9	426	90	38,340
10	406	90	36,540
11 to 14	1,382	90	124,380
15 to 19	1,153	90	103,770
20 to 20	1,338	90	120,420
30 to 59	1,260	90	113,400
60 and over	530	90	47,700
Total	9,798	[1] 76	744,790
Part B—Self-supporting:			
1	864	20	17,280
2	830	20	16,600
3	785	30	23,550
4	812	40	32,480
5	832	50	41,600
6	794	60	47,640
7	883	70	61,810
8	901	80	72,080
9	784	90	70,560
10	779	90	70,110
11 to 14	2,629	90	236,610
15 to 19	2,123	90	191,070
20 to 29	2,469	90	222,210
30 to 59	2,377	90	213,930
60 and over	789	90	71,010
Total	18,651	[1] 74	1,388,540

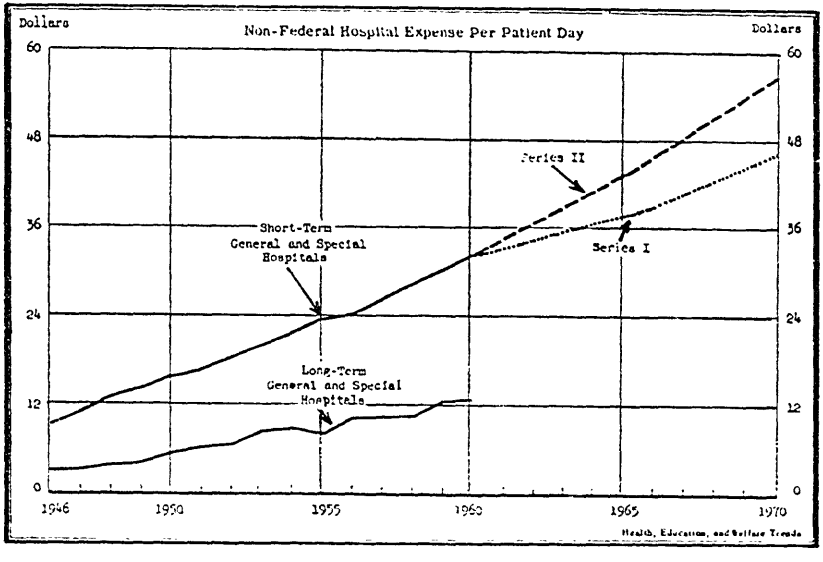
[1] Average.

Source: "Annual Statistics, 1960—Cases Discharged From British Columbia Hospitals," prepared by British Columbia Hospital Insurance Services.

APPENDIX TABLE III

Hospital expense per patient day

[Hospital expense per patient day in non-Federal short-term general and special hospitals increased from $9.39 in 1946 to $32.23 in 1960]



Hospital expense per patient day—Continued

Year [1]	Hospital expense per patient day (in dollars) [2]											
	Total expense						Payroll expense [3]					
	Total	Non-Federal				Federal [6]	Total	Non-Federal				Federal [6]
		General and special		Mental [5]	Tuberculosis			General and special		Mental [5]	Tuberculosis	
		Short term [4]	Long term					Short term [4]	Long term			
1946	5.21	9.39	2.97	1.39	4.57	6.14	2.93	4.98	1.64	0.80	2.38	4.06
1947	5.42	11.09	3.03	1.60	5.44	7.39	3.07	5.99	1.64	.84	2.82	5.23
1948	6.35	13.09	3.81	1.95	6.25	8.81	3.60	7.17	1.99	1.03	3.17	6.19
1949	7.70	14.33	4.07	2.84	6.68	13.30	4.53	7.96	2.35	1.53	3.70	9.53
1950	7.98	15.62	5.39	2.43	7.22	12.77	4.79	8.86	3.32	1.38	4.06	9.35
1951	8.26	16.77	6.30	2.46	7.37	11.91	5.01	9.65	3.89	1.43	4.25	8.68
1952	9.14	18.35	6.63	2.68	7.85	14.10	5.63	10.66	4.05	1.58	4.61	10.35
1953	9.73	19.95	8.26	2.83	8.54	13.93	6.10	11.86	5.28	1.74	5.11	10.44
1954	10.67	21.76	8.53	3.22	9.32	15.92	6.83	13.21	5.63	2.03	5.77	12.06
1955	11.24	23.12	8.06	3.73	10.13	14.60	7.20	14.26	5.36	2.17	6.48	11.63
1956	12.16	24.15	10.20	3.63	10.19	16.97	7.98	14.85	6.84	2.41	6.51	13.74
1957	13.48	26.02	10.33	3.91	11.16	17.68	8.76	15.74	6.79	2.66	7.14	14.27
1958	14.74	28.27	10.32	4.40	12.08	18.38	9.63	17.19	6.91	3.08	7.91	14.80
1959	15.65	30.19	12.50	4.71	12.80	19.62	10.37	18.76	8.39	3.26	8.54	15.98
1960	16.46	32.23	12.82	4.91	13.37	20.11	10.92	20.08	9.01	3.45	8.92	16.34
1961	18.46	34.98	14.49	5.53	14.72	23.34	12.25	21.54	10.12	4.00	9.88	19.15
1962	19.73	36.83	15.10	5.72	15.22	24.47	13.12	22.79	10.62	4.16	10.78	20.42
Series: [7]												
1965:												
I		38.57										
II		43.46										
1970:												
I		46.23										
II		56.73										

[1] Recent data are generally for hospital years ending Sept. 30. Hospitals in Alaska are included beginning with 1958 and those in Hawaii are included beginning with 1959.

[2] Data are based on a questionnaire completed by all listed hospitals, the number of which has increased from 6,199 to 7,000 since 1946, following the American Hospital Association's Uniform Chart of Accounts and Definitions for Hospitals (latest edition, 1959). Expense covers 12-month periods and includes payroll, noncapital or plant other than construction, equipment, cost of services, medicines, supplies, food, etc. An effort is being made to include depreciation (the gradual absorption over maximum useful life of the cost of contributions of buildings, fixed and major movable equipment).

[3] Based on full-time personnel plus full-time equivalents of part-time personnel calculated by total man-hours per workweek, residents, interns, and students are excluded from 1951 onward.

[4] "Short-term" hospitals are those in which the average length of stay is under 30 days.

[5] Includes short-term psychiatric hospitals.

[6] Expenses are estimated for 1957.

[7] Series I projection based on the time series trend line by least squares method, which takes into account effect of business and general economic growth cycles. $Y = 19.42 + 0.766X$ with origin at 1946. Series II projection based on the average annual increase of 8.79 percent for the period 1946–59.

Source: American Hospital Association, pt. II of the annual "Guide Issue" of the semimonthly hospitals.

Senator GORE. I am sorry, the Senate bells have just rung, which you heard, calling us to a vote.

I understand there will be another vote soon to follow. Therefore, I have no choice but to adjourn the committee.

I would like to ask you to comment, if you would, by an insertion in the record, on the disparity between your statements of the number of individuals under insurance company mass enrollment plans and the statements of the Senate Committee on Aging.

There is considerable variance there, and I would like to ask my staff member to submit two or three other questions to you and ask that you reply, if you would.

Mr. RIETZ. We have commented on that particular point in a footnote in our written statement.

We also have a letter that we have addressed, following the hearings to which you referred, to the Honorable Wilbur Mills, being sure that he understands what is involved, and I assure you that our estimate of numbers didn't include the 2 million.

This was merely to indicate how fast and how many people had enrolled, not how many were in force at any given point of time.

Senator GORE. Thank you for your appearance, and the committee will appreciate it if you will supply these additional answers.

(Senator Gore's questions and Mr. Reitz' replies appear in the following letter:)

HEALTH INSURANCE ASSOCIATION OF AMERICA,
Washington, D.C., August 13, 1964.

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

DEAR SENATOR BYRD: When my testimony before your committee on Thursday, August 13, was interrupted and terminated during its early stages due to the pressing business of the Senate, I was asked to answer three questions in writing from Senator Gore. These questions are based on the majority report of the Subcommittee on Health of the Elderly of the Senate Special Committee on Aging, July 1964.

The insurance business was shocked by the inflammatory, unwarranted, and unfounded statements contained in the subcommittee majority report. Many of my contemporaries have urged a strong response and have been anxious for an effective forum to refute and strenuously deny these unprovable and completely unjustifiable charges leveled at us and our business. Hence, I am glad to have this opportunity to present the facts for the record.

The questions and their answers follow:

"The report of the McNamara committee, signed by eight U.S. Senators, charged your organization with having 'distorted, manipulated, and concocted' figures 'to create an illusion of great strides by private health insurance in extending coverage to the aged.'

"Would you please give the committee your observations on this quote?" (McNamara report, p. 3, ff.)

Contrary to the record before the subcommittee the report is cast in a tenor intended to depreciate the progress made in extending health insurance to the elderly and, in both tone and language, questions the integrity of the private insurance business.

The institution of private health insurance has, during the past two decades, given every evidence of its awareness of the economic and social problems with which it is concerned. Today it is a primary basis upon which health care in our Nation is financed. It provides protection for over three-quarters of the Nation's population. It has continued to broaden the scope of its coverages and to experiment in such types of protection as those for nursing home care and dental care. It has made available coverages on both the group and individual policy basis which are continued into the years of retirement. As such, it has

gained wide public acceptance. One such development, unforeseen a relatively few years ago, has been a variety of coverages for persons already past age 65 and who were uninsured. That this effort on behalf of private insurers has been effective is evidenced by the fact that between 1952 and 1962 the number of persons age 65 and over with some form of health insurance protection trebled and the proportion of that population group with health insurance doubled. During the April 1964 hearings of the subcommittee, both Government and industry spokesmen testified in detail with respect to this progress. It is difficult to understand how the subcommittee majority report could totally omit any mention of this dramatic growth. One cannot escape the conclusion that the majority report, by presenting a grossly incomplete picture, purposely intends an unbalanced view which is tantamount to an attack on an economically necessary and highly respected institution.

Beyond this, however, we are disturbed by the use of language which accuses us of playing a "numbers game," of using "inflated coverage figures," of attempting "to create an illusion," of having "concocted" figures, and with an attempt to "substitute fancy for fact," and other such intemperate phases. This is obviously to lead the reader to erroneously conclude that we spend our time fabricating the truth. We protest the use of such language and question its place in a Senate committee report. It is not at all in keeping with the facts presented at the hearing.

The subcommittee has before it data, reports, letters, and exhibits (some, but not all, of which, are included in the appendix of the report), which show clearly that such accusations are without foundation in fact. While in some instances the subcommittee majority may have labored under some misunderstanding or misimpression, our representatives were always available to furnish any additional information needed. Furthermore, the public hearings held by the subcommittee presented full opportunity to clarify any such misunderstandings. Yet, the transcript of those hearings shows no evidence that a full attempt was made to clarify any doubts in the subcommittee's mind with respect to the subject matter at which these charges are directed. Since the data in question are gathered in accordance with accepted scientific methodology having to do with statistical collections, and are gathered in good faith with no other objective than to obtain the facts of a situation in a given period of time, it is difficult for us to conclude other than that the clear intent of the subcommittee majority was to criticize private health insurance regardless of the facts.

"Didn't you testify before the Ways and Means Committee that 'more than 2 million aged were covered under individual insurance company mass enrollment plans' when in fact less than 750,000 different older people are so insured?" (Source: McNamara report, pp. 7–8.)

We did not so testify. The foregoing quote is a distortion of a portion of the statement made by this association before the Ways and Means Committee on November 22, 1963. In that testimony we described the various approaches used by the insurance business to extend coverage to the aged. One such approach is individual company mass enrollment programs. For such programs we said: "Individual company mass enrollment programs, first introduced about 5 years ago and affording coverage irrespective of condition of health, which have already enrolled over 2 million senior citizens."

As is evident from the material shown on pages 110 through 123 of the Senate subcommittee report the questionnaire used by the association in obtaining the number of aged persons covered as of the end of 1962 did not attempt to determine a separate total, for mass enrollment alone, or for any of the principal methods used to extend coverage to the older population. Our intent was to determine the total number covered. The misunderstanding which resulted in the unwarranted challenge in the subcommittee report which completely misconstrued the impact and meaning of the numbers cited in the distorted quotation from our testimony may well be due to a lack of understanding of insurance terminology. In its use of the term "enrolled," this association was illustrating the potential inherent in mass enrollment programs, and referred to the number of persons that had been enrolled over a period of time; i.e., since the programs were "first introduced about 5 years ago."

The difference between the number of persons enrolled under the mass enrollment approach and the number covered at any given time will of course be significant in view of the high average age of this insured population with resultant substantial terminations due to mortality alone. In fact, the Senate subcommittee

report points out that one of the companies engaged in the mass enrollment program lost about 80,000 such policies during 1963.

You should clearly understand that the question is not only a distortion of what we have said but it is also totally irrelevant to the point about which it was first raised; namely, the extent to which the aged are covered under all types of health insurance. The 2 million figure, the number of enrollees to that date under mass enrollment programs, did not enter into the association's estimate that 10.3 million or 60 percent of the aged were covered under health insurance through all types of programs and approaches available to them at the end of 1962. A review of the material contained on pages 104 to 123 of the Senate subcommittee report makes this clear.

The release of the subcommittee report in July prompted us to write immediately to the chairman of the House Ways and Means Committee to be certain that he and his committee had no misunderstanding about the import of the 2 million enrollee figure. A footnote pertaining to this point is contained in our testimony of August 13, 1964, before your committee as footnote 11.

"1. You spend a great deal of time talking about the number of insurance policies held by the aged but say virtually nothing about the adequacy of those policies.

"2. Are you aware that, according to the McNamara report, only one in four of our older people hold adequate hospital insurance under the definition established by the American Hospital Association?" (McNamara report, p. 17, ff.)

It is not correct that my statement spent "a great deal of time talking about the number of insurance policies held by the aged." In an 18-page statement only two paragraphs (pp. 2 and 3) make such reference, and these paragraphs include reference to estimates other than our own. Furthermore, we do not talk about numbers of policies but rather numbers of persons insured.

It also is not correct that we have said "virtually nothing about the adequacy" of health insurance coverages. In my statement to the Senate Finance Committee, on pages 14 and 15, this subject is discussed and the nature of available health insurance coverages is mentioned. Because of the time limitation this discussion was necessarily brief. However, a more lengthy discussion and documentation of these areas was presented to the Subcommittee on Health of the Elderly of the Senate Special Committee on Aging by our association on April 28, 1964. (See pt. 2 of the proceedings of the hearings held by that subcommittee, pp. 92–94.)

From a review of the subcommittee hearings and report, I cannot conclude that in fact the American Hospital Association has undertaken to establish 75-percent coverage as a general test of adequacy of insurance. While I have not at this time, been privileged to see the document of the American Hospital Association from which this conclusion of a standard of adequacy is drawn by the majority of the subcommittee, the record would imply to me that the 75-percent figure was not established as a standard of adequacy to judge individual or family programs. Rather it appears probable that it was developed as one of a group of minimum requirements to be imposed on any Blue Cross-type organization seeking service contracts with hospitals and the endorsement of the American Hospital Association. Furthermore, it is quite apparent to me from my review of the record that the report in attributing support to 75 percent as a general test of adequacy to an insurance spokesman has drawn an erroneous conclusion from his testimony. The insurance representative's testimony from which this conclusion must have been drawn relates only to a description of the goals of coverage that were adopted for the New York 65 plan program—quite a different matter from defining or establishing a general standard which would be appropriate for all individuals.

Sincerely yours,

H. LEWIS RIETZ.

Senator GORE. The committee will adjourn until 10 a.m.

(By direction of the chairman, the following is made a part of the record:)

COUNCIL OF JEWISH FEDERATIONS & WELFARE FUNDS, INC.,
New York, N.Y., August 10, 1964.

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

DEAR SENATOR BYRD: I am writing to you in connection with the hearings which the Senate Finance Committee is holding in reference to the Social Security Act.

As you know, we are one of a group of voluntary agencies in the social welfare field for whom Mrs. Elizabeth Wickenden, technical consultant to the National Social Welfare Assembly, has presented testimony favoring the addition to H.R. 11865 of health benefits to the aged under social insurance. In addition, we would like to submit this individual statement expressing our point of view which is consistent with Mrs. Wickenden's testimony.

The position of our council has been expressed by our highest governing body, our general assembly, in resolutions adopted on November 18, 1962, and November 10, 1963. The latter urged the Congress to "enact medical care for the aged through the mechanism of the old-age and survivors insurance program while making adequate provision for those persons not so covered."

Our council is an association of 218 central Jewish community organizations responsible for financing and planning all types of health and welfare services. Our federations reflect the experience of 74 general and specialized hospitals; 76 homes for the aged; 81 family service agencies, a large part of whose caseload are the aged; and 44 vocational service and group counseling agencies, a number of which provide rehabilitation and retraining assistance to the aged, and other agencies in a comprehensive network of services to this part of our population.

Our conviction regarding the inadequacies of current provision for their health and hospital needs is based upon this very extensive experience throughout the country, and upon the special 4-year study on community health services for the aged and chronically ill which we recently completed. This experience has led us to conclude:

The requirements of the aged for health and hospital services continue to grow.

Private philanthropy cannot meet the deficits involved in providing services to patients unable to meet the full costs.

It has been demonstrated that the comprehensive health and welfare needs of the country require the pooling of funds from various sources: from individuals according to their capacity to pay, voluntary insurance, Blue Cross, governmental social insurance, public welfare assistance.

The social security system will provide medical benefits to spread the costs of premium payments over the earning years. It will do so most economically. It is the simplest to administer and can be most quickly effective. It respects the dignity of the individual and avoids a "means test" repugnant to American standards and principles.

The social security system would enable the aged to pay for their medical care, choose their own physicians, and safeguard a high quality of medical care. Such quality is indispensible to any program to be developed.

With such provision, voluntary philanthropy can continue to concentrate on the fields of social welfare not coming within the responsibility of government.

We therefore support enactment of legislation that would provide health benefits to the aged under the social security system.

Sincerely yours,

LOUIS STERN, *President.*

STATEMENT OF THE NATIONAL ASSOCIATION OF MANUFACTURERS ON AMENDMENTS TO PROVIDE HOSPITAL BENEFITS UNDER SOCIAL SECURITY (H.R. 11865), AUGUST 12, 1964

This marks the fourth occasion since 1958 on which the National Association of Manufacturers has registered its opposition, before a congressional committee, to the principle of social security-financed hospital benefits. The events which followed our first statement on the Forand bill, down to the most recent report of the board of trustees, have only intensified our skepticism. We believe now, as we did then, that once the principle of a national compulsory hospital care program has been established we shall witness an expansion that will alter beyond recognition both the practice of medicine and our self-supporting social security system.

We see a parallel in the evolution of disability benefits which at first was limited to a waiver of premiums for the permanently and totally disabled. Soon disabled people over 50 were drawing benefits on the theory that their misfortune was a form of forced retirement. Next it was claimed that age was irrelevant and benefits became payable regardless of age. Then benefits were extended to dependents of a disabled worker. Today, there is serious talk of a temporary disability benefit.

Have we any assurance that hospital care for the aged will not follow a similar pattern? What of those people retiring at age 62—can Congress afford to ignore them because of a 3-year age difference? And then there are the totally disabled, many of whom are already in hospitals, would they not be justified in demanding help to meet medical expenses? What of the medical needs of survivors—young children and mothers?

The basic issue here is much broader than the question of medical aid for the aged. It is simply a problem of dependency in all its aspects, with staggering cost implications if a social security solution is contemplated.

An analysis of the state of social security finances reveals a phenomenal growth in costs with the system straining to pay benefits already promised. The cost of OASI alone has quintupled in just 10 years with total disbursements of $14.5 billion in fiscal 1963; and the benefit rolls have been growing almost as fast with 17.2 million now drawing retirement and survivor checks. As a consequence, the system has failed to pay its way in 5 of the past 6 fiscal years. The OASI reserve has now dwindled to slightly more than 1 year's benefits.

These deficits have been incurred in a period of unmatched prosperity and in the face of predictions by the Board of Trustees that a surplus of funds would be generated. Whereas the Trustees in 1959 estimated an OASI fund of $50.3 billion by 1970, the report accompanying H.R. 11865 now puts the fund at $27.6 billion in 1970. This downward revision is no reflection on the ability of our social security actuaries. It simply demonstrates the futility of projecting costs in a program that permits the taxes required for added benefits to be spread into the future.

We believe there is some question as to the actuarial balance of the system, due not only to its political aspects but also the uncertainty of factors like employment, income, longevity and inflation. It would seem foolhardy under these circumstances to adopt a program of hospital benefits of unascertainable cost. We are aware of the administration's assurances before the Ways and Means Committee that the King-Anderson plan could be adequately financed by a 0.5-percent tax increase on a revised wage base of $5,200. But questioning revealed that the underlying assumption for this estimate—namely that wages and hospital costs will remain in the same future relationship as in the 1961 experience—is, in fact, contrary to past and present experience where wages are rising 3 percent per year and hospital costs 7 percent per year. If present experience prevails, and this is not beyond the reach of reason, it is estimated that a tax increase of 1 percent will be required instead of 0.5 percent of payroll.

The prospect of underfinanced hospital benefits is indeed alarming because it brings closer the possibility of Federal subsidies. How much more can be asked of the employer and employee with the maximum combined tax already scheduled for $144 by 1968, an increase of almost 400 percent since 1950? H.R. 11865 calls for a maximum employee tax of $259 by 1971—Is this not a sizable sum for a man earning $5,400 a year? In many cases the employee will be paying more in social security taxes than in income taxes. For example, a man earning $5,000 per year with a wife and three children—a typical situation—pays an income tax of approximately $185. Under present law his social security tax will exceed this amount ($198) by 1966. If this same man is earning $4,500 he will be paying a social security tax in 1965 almost double his present income tax ($84 versus $161).

The advent of general revenue support and the demise of the self-supporting principle will destroy the last stronghold of cost control and a way will be cleared for ultimate nationalization of all retirement security programs. This threat is implicit in the hospital care proposal.

And what of the alternative: Heavier tax levies on the employee? Today's new entrant and his employer are scheduled to pay $1.69 for every $1 he can expect to receive in benefits. The producer may not be receptive to paying hospital benefits for an estimated 17.5 million oldsters who will not have borne 1 cent of the added costs. The total value of the free gift has been put as high as $25 billion; young workers are already carrying a similar burden of some $300 billion attributable to past liberalizations. And bad as this burden is, will it not become doubly onerous as these young taxpayers begin to realize that many of the recipients are not in any sense needy? The inequity to the young is blithely ignored by those who are continually demanding a better deal for the aged many of whom are already drawing total benefits far in excess of their tax contributions.

Perhaps few young people today are aware of this situation since social security has been portrayed as a system where you "earn" or "pay for" your benefits. Sooner or later, however, the real nature of the bargain will begin to dawn. At that time Congres may become the target of irresistible pressures to either repudiate or subsidize the system.

Proponents of compulsory health care for the aged continue to base their arguments on widespread need and despite clear evidence that the facts have changed. Over the years, a remarkable pattern can be seen. In 1940, the era of the Wagner-Murray-Dingell bills, only about 10 percent of the total civilian population had some form of voluntary health insurance. But this figure had grown to 28 percent in 1945, to 38 in 1947, and today it is estimated that as of June 1, 1964, 78 percent of the population is covered by voluntary health insurance. The growth of coverage for people over 65 has also been spectacular; old people are joining voluntary coverage plans at a rate four times better than all age groups; the 60 percent now covered by private plans is an increase from 48 percent in 1959 and more than double the total a decade ago. Some experts predict that within 3 years 75 percent of our aged will be covered with a possible 90 percent coverage realized before the end of the decade. And, as coverage grows, so will benefits and services provided for the premium dollar.

In light of these facts one would assume that cries about "unfulfilled needs" would be diminishing whereas just the reverse is true.

In conclusion, we believe that any proposal to establish hospital or medical service benefits under social security strikes at the principle of paying only cash benefits related, in some measure, to the amount of contributions made by an employee and his employer. The concept of service benefits leads inevitably to flat-rate benefits and Government subsidies. Finally, it sacrifices the right of the beneficiary to spend his benefit check as he believes best.

STATEMENT OF T. DONALD PERKINS, SAN DIEGO, CALIF., IN BEHALF OF THE NATIONAL ASSOCIATION OF RETAIL DRUGGISTS

Mr. Chairman, and members of the Senate Finance Committee; my name is T. Donald Perkins and, for 40 years, I have practiced pharmacy in San Diego, Calif., where I own and operate a community drugstore.

I appear here as president of the National Association of Retail Druggists. The NARD, as you know, is a small business organization having a nationwide membership of more than 30,000 independent drugstore owners. The NARD speaks for its membership of family druggists on all legislative matters affecting their professional and competitive interests.

Accompanying me is Philip F. Jehle, Washington representative and associate general counsel of the NARD.

Mr. Chairman and gentlemen, I wish to state at the outset that the National Association of Retail Druggists shares with all responsible citizens the conviction that good health care should be readily available to all Americans regardless of age. The NARD further believes no American citizen, again without reference to age, should be deprived of adequate health care for financial reasons. But it must also be clearly stated that the NARD likewise believes that those financially able to provide for their own health care needs should do so irresponsible of age.

Financially secure persons should not be looking to Washington for material assistance they do not need. This policy, I am sure, is sound whether the aid being sought involves food, clothing, shelter, or health care. Our American tradition is to help those unable to help themselves—and only those. I might add that in the past only those unable to help themselves would either seek or accept aid from others, including the Federal Government.

In the light of these generally accepted economic and social principles, the NARD in convention assembled has formally examined and rejected, for many years in the past, legislative proposals of the nature and purpose of the Federal health care amendment, which Senator Abraham Ribicoff has offered in respect to H.R. 11865, the social security benefits bill now before this committee. For your consideration, I would like to offer in summary form, the main grounds for the NARD membership's opposition to the Ribicoff medicare amendment and its predecessor bills:

1. Medicare benefits would not be limited to those elderly persons in actual financial need. In fact, under the proposed legislation, almost all persons over 65, whether or not eligible for social security benefits, would be eligible for

Federal health care services. No consideration would have to be given as to whether an individual was in financial need of such assistance. Once a person living in the United States reached 65 years of age, he would become a medicare beneficiary, unless he were a retired Federal civilian employee having a separate Government health insurance program or a recently arrived alien. As a result, a rather considerable number of persons would have provided for them by the Federal Government services they could easily afford themselves.

What reasons can there be, morally, socially, or even politically, for making health care services available at no cost to almost all persons over 65, regardless of their income or personal resources? How can such a Federal medicare program be justified to the many medically needy persons under 65 ineligible for its generous benefits? Bear in mind that neither those over 65 nor the medically needy under 65 would have paid any social security taxes toward the medicare plan. That being the case, why should one group be granted Federal medicare and not the other? Surely, a 65-year-old millionaire executive has no greater claim to Federal Government aid than does the low-income 40-year-old with a sick wife and five children.

2. Medicare benefits would not be needed by a fairly large proportion of the 10.3 million aged persons—60 percent of those 65 or older—having adequate private health insurance plans. Such Federal aid would also be unnecessary in the case of the medically needy aged eligible for Kerr-Mills plan benefits, or for those eligible for the veterans' health care program, or for those covered by the plan for retired military personnel and their dependents.

3. The cost of the proposed medicare program, even in its present rudimentary form, would be simply staggering. Through the chairman of the House Ways and Means Committee, it has established that the initial costs of the medicare program would be about $2.5 billion annually, necessitating a social security tax hike of at least 1 percent on the first $5,200 of income rather than one-half of 1 percent claimed by the plan's proponents.

4. Financing of medicare benefits by means of social security taxes places a greater tax burden upon lower income workers than it does upon high income recipients. Percentagewise, the worker earning $5,200 would be paying a greater portion of his gross income than would a person earning in excess of that figure. Frankly, I feel that the burden of providing health care to the needy should be shared more equitably by the American people. The answer, of course, is to use general tax revenues and to limit such assistance to those financially unable to help themselves.

5. Benefits provided would not assure adequate health care for our aged citizens. As has been noted, neither physicans' services nor out of hospital prescription drugs are included in the plan. Thus, the plan is incomplete and would be of only limited value to the eligible elderly.

6. The plan would produce an administrative nightmare, with Federal officials first working out contracts with 6,000 hospitals, 25,000 nursing homes, 700 visiting nurse groups, and, later, should physicians' services and out-of-hospital drugs be included, with 208,000 doctors and 55,000 retail pharmacists.

The paperwork involved in processing claims for the 12 million beneficiaries of the plan staggers the imagination. An extremely large force of Government workers would undoubtedly be required to do the job.

Although opposed to the medicare plan of Mr. Ribicoff, the NARD does ask to be recorded again before this committee as offering its continuing support to the Kerr-Mills plan. That legislative program properly limits its benefits to those in actual financial need of such aid. Moreover, the plan authorizes a complete health care program for its beneficiaries. Through Kerr-Mills, Congress has reaffirmed its belief in the capacity of our traditional free enterprise system to meet the health needs of our senior citizens. In our view, Congress should be concentrating all of its efforts right now on making sure of the success of the Kerr-Mills health care plan.

I also wish to take this opportunity to state that independent retail pharmacists, like the Nation's physicians, would never deny essential services to the medically indigent. Personally, I have never refused to fill a prescription for a person unable to pay for it. The same, I am sure, can be said for retail druggists all over the country. Literally, millions of dollars of drugs are given to the medically needy every year by druggists like myself.

In passing, I should like to point out that the Kerr-Mills Act could be strengthened by an amendment expressly providing that plan beneficiaries are to be granted the same freedom of choice in making their prescription drug purchases as they will have in selecting a physician or hospital, for example. Even though

the "freedom of choice" principle is strongly evidenced in the legislative history of the act, its statement in specific statutory terms would once and for all preclude any possibility of administrative misunderstanding. Retail pharmacists believe that plan beneficiaries should have an absolute guarantee of the same freedom of choice that is enjoyed by citizens able to finance their own health care.

Thank you for this opportunity to present the views of the NARD on this proposed legislation. It has been a pleasure for me to appear before you, and I hope I have given you a better understanding of the reasons why the Nation's retail pharmacists must continue their vigorous opposition to the Ribicoff plan for medicare.

U.S. SENATE,
COMMITTEE ON LABOR AND PUBLIC WELFARE,
August 11, 1964.

Hon. HARRY F. BYRD,
Chairman, Committee on Finance,
U.S. Senate, Washington, D.C.

DEAR MR. CHAIRMAN: Please bring to the attention of the Committee on Finance the enclosed exchange of correspondence between this Senator and the White House on the subject of health care for aged citizens through amendments to H.R. 11865 (Social Security Amendments of 1964).

My position, as well as that represented to be the position of the President of the United States, is that the provisions of the King-Anderson bill are the preferred approaches to the formulation of a program of health care for senior citizens.

I call attention, however, to the assurances I have given in communicating with the President and his staff that I am prepared to support a compromise or substitute which would provide for an option allowing elderly social security annuitants to choose either an additional monthly cash benefit or a Government-paid hospital insurance policy.

It is my hope that the Committee on Finance will take affirmative action by accepting and reporting favorably an amendment to H.R. 11865 establishing a beginning elder citizens' health care program under the social security system.

Sincerely,

JENNINGS RANDOLPH.

U.S. SENATE,
Washington, D.C., August 5, 1964.

THE PRESIDENT,
The White House.

DEAR MR. PRESIDENT: The Social Security Amendments of 1964 (H.R. 11865, as passed by the House on July 29) commendably would provide 20 million social security beneficiaries with a 5 percent increase in monthly payments. I will support these provisions in the Senate if we cannot attain refinements of the program which I would consider to be improvements for our elderly citizens. I refer especially to the need for health care provisions for our senior citizens under the social security system.

There are no special problems in this legislation for West Virginia such as were involved in the Welfare Amendments Act of 1962 when a medicare amendment was offered in the Senate. At that time the vital programs of aid for dependent children of unemployed parents already had lapsed as of June 30, 1962, and thousands of West Virginians faced deprivation. Controversy over the medicare amendment created an inordinate time loss in the progress of the measure embracing the welfare amendments. Slowness in restoring the ADCU program was intolerable. Consequently, I voted to table the amendment which would have had the effect of further delaying restoration of the ADCU work relief and cash benefit provisions and thereby compound the deprivation of thousands of our people.

Now that the Social Security Amendments of 1964 have passed to the Senate from the House, I am ready to support a substitution which would provide (1) a flat basic increase in social security cash retirement benefits, and (2) a provision for an option allowing elderly beneficiaries to choose either an additional monthly cash benefit or a Government-paid hospital insurance policy.

In the House of Representatives in 1935, I voted for the original social security program. As in the past, I continue to believe it needs updating and expansion. H.R. 11865 is a means of accomplishing such a mission. But I

do not believe H.R. 11865 is enough. Hence, I refer also to S. 880, introduced by Senator Clinton Anderson, of New Mexico, and cosponsored by 36 Senators of whom I am one. It embraces a plan for health care of the aged which I believe can be appropriately modified and blended into H.R. 11865 by Senate action.

I feel that the Social Security Amendments Act of 1964 is a suitable and available measure to utilize as a base for making a beginning on a much needed plan of health care for elderly citizens to be financed by the social security trust fund which, in turn, would be augmented by adjustement in the rate of taxes dedicated to that fund. This differs from my position in 1962. As conditions developed in the late summer of that year, I could not agree then that the Welfare Amendments Act of 1962 was suitable legislation for this purpose, and for reasons which I explained earlier in this communication.

Mr. President, I urge active administration leadership in a movement for the inclusion of provisions for limited health care for aged retired persons in the Social Security Amendments of 1964. These provisions in the act are urgently needed. I reiterate that they will have my support and my vote, especially if the beneficiary has the option of selecting either increased cash benefits or hospital insurance paid from the social securirty trust fund.

Respectfully yours,

JENNINGS RANDOLPH.

THE WHITE HOUSE,
Washington, August 10, 1964.

Hon. JENNINGS RANDOLPH,
U.S. Senate, Washington, D.C.

DEAR SENATOR: I have been asked to acknowledge your letter of August 5 containing your views with respect to the desirability of enacting legislation which would institute a modified medical care program when H.R. 11865 reaches the Senate floor.

As you know, the Senate Finance Committee is now holding hearings on H.R. 11865. We are hopeful that something will come out of these hearings which will enable the Senate to take action. The President, of course continues to support the King-Anderson bill as the best approach to this problem.

With kind personal regards.

Sincerely,

LAWRENCE F. O'BRIEN,
Special Assistant to the President.

U.S. SENATE,
Washington, August 11, 1964.

Hon. LAWRENCE F. O'BRIEN,
Special Assistant to the President,
The White House.

DEAR LARRY: Thanks for the August 10, 1964, response to my letter of August 5 to the President on the subject of health care for aged citizens.

I share the hope expressed in your communication that something will come out of the current Senate Finance Committee hearings and deliberations on H.R. 11865 (the Social Security Amendments of 1964) which will enable the Senate to take action on a vitally needed program of health care for the elderly.

Your letter notes that "the President, of course, continues to support the King-Anderson bill as the best approach to this problem." I agree, and it is for this reason that I am a cosponsor of S. 880. Senator Gore, of Tennessee, has submitted amendment 1178 to H.R. 11865. It is a slightly modified version of S. 880. I hope the Committee on Finance will accept it as a committee amendment and report it favorably to the Senate.

But, as set forth in my August 5 letter to the President, I am ready to support a compromise or substitute proposal, such as one which would include a provision for an option allowing elderly social security annuitants to choose either an additional monthly cash benefit or a Government-paid hospital insurance policy.

If there is no committee amendment, I am prepared to support an amendment offered from the floor of the Senate if it provides health care for the aged citizens as a beginning social security system supplement to the Kerr-Mills program.

With best wishes.

Sincerely,

JENNINGS RANDOLPH.

STATEMENT OF SENATOR JENNINGS RANDOLPH

Mr. Chairman, I appreciate this opportunity to present these views on the desirability of amending H.R. 11865 to increase earnings limitations for recipients of old-age assistance and old-age insurance (OASDI) benefits. As chairman of the Subcommittee on Employment and Retirement Incomes of the Senate Special Committee on Aging, I have been keenly interested in measures to permit the senior citizens of our Nation to improve themselves economically by their own efforts and to be more independent and self-sufficient. It is with these objectives that I present suggestions for amending H.R. 11865.

In December 1963, our subcommittee began a series of three hearings on increasing employment opportunities for the elderly. Based on the information obtained at these hearings and other information reaching the subcommittee's attention, it issued a report to its parent group, the Special Committee on Aging. The committee on July 30, 1964, issued it as a report of the full committee, after minor changes.

I hereby urge that two of the recommendations on increasing employment opportunities for the elderly be implemented by adding appropriate amendments to H.R. 11865. The first of these recommendations reads as follows in the committee's report:

"Recommendation No. 3: The committee recommends that the present complex formula of permissive earnings for recipients of old-age assistance be eliminated in favor of a simple allowance of a certain amount per month of earnings by recipients without reduction of their grants."

The following comment was made in the report on this recommendation:

"Under section 157, Public Law 87-543, the Public Welfare Amendments of 1962, a State may disregard the first $10 of a recipient's earnings each month, and half of the next $40. Thus a recipient who earns $50 in 1 month, would suffer a reduction of $20 in his grant.

"This provision evolved from an amendment adopted on the Senate floor, which simply permitted earnings up to $50 without any reduction in grant. However, the compromise in conference substituted the provision now in effect.

"Testimony at the subcommittee's hearings revealed several shortcomings of this provision. It is complex and difficult to explain to recipients, who must understand it to take advantage of it. Perhaps for this reason, few recipients have availed themselves of this means of improving their economic position. It is difficult and expensive to administer.

"A provision simply permitting a certain amount of earnings without a grant reduction would be subject to none of these difficulties. It would be much more effective in encouraging recipients to improve themselves economically by their own efforts, and, hopefully, to regain their economic independence."

Both in subcommittee and in the full committee, the decision was made that no specific new earnings limitation should be recommended. My own preference is for a simple $50 limitation of the type adopted by the Senate in considering the Public Welfare Amendments of 1962, which was later compromised in conference.

Our subcommittee has been advised by the Bureau of Family Services of the Welfare Administration, Department of Health, Education, and Welfare, that only 22 of the 50 States have chosen to implement the present limited permissive-earnings provision; that the present annual Federal cost of the provision in these 22 States is approximately $8,500,000; and that they estimate that the additional annual Federal cost in these 22 States of a flat $50 limit would initially be $5,700,000 for these States and could eventually be $21 million for these same States. Thus, adding these increased costs to the $8,500,000 present cost of the permissive-earnings provision, the total cost of such provision if raised as we recommend would range between $14,200,000 and $29,500,000 per annum.

Since the other 28 States have not implemented even the present modest earnings limitation, it is believed that these States would be even less likely to implement a more liberal provision, and for all practical purposes these figures are a good rough estimate of the cost of the proposed simple $50 limit.

This would be a reasonable amount to pay for the benefits which could be expected to result. Among such benefits would be a higher standard of living for recipients of old-age assistance, an opportunity for them to escape from their loneliness, idleness, and isolation and to return to the "mainstream of life," encouragement and assistance for them to regain their economic independ-

ence and to leave the welfare rolls; and giving the public the benefit of their services.

The other recommendation in our report, which I am urging your committee to implement by means of an amendment to H.R. 11865 is that which, together with our comment, reads as follows:

Recommendation No. 4. The committee recommends that the amount of earnings which can be received by a recipient of old-age insurance benefits without loss of benefits be increased to a more realistic level, and that the present complex formula be eliminated.

Comment: Since the Social Security Amendments of 1961 (Public Law 87-64), the earnings limitations have been as follows:

Maximum annual earnings permitted without loss of benefits	$1,200
Range of annual earnings within which $1 of benefits is lost for each $2 earned	1,200-1,700
Amount of annual earnings above which $1 benefits is lost for each $1 earned	1,700

Under this recommendation, a recipient would be permitted to earn more than $100 per month ($1,200 per annum) without loss of benefits. Above the new limit, there would be a loss of $1 of benefits for each $1 earned. As compared with the present complex formula, this would have the advantage of simplicity.

Adopting this limitation increase would be a logical extension of the trend in recent years toward permitting old-age insurance recipients to be more self-sufficient. The earnings limitation was liberalized successively in 1950, 1952, 1954, 1958, 1960, and 1961.

A number of bills have been introduced in the Senate and House of Representatives to liberalize the earnings limitation.

Testimony was presented at the subcommittee's hearings in California in favor of liberalizing this earnings limitation.

Again, I emphasize the desirability of permitting this group to raise their standard of living through their own initiative and by means of their own efforts. There will be some cost in doing so, but the resulting benefits will be well worth the expenditures.

STATEMENT OF SENATOR FRANK E. MOSS

Mr. Chairman and distinguished members of the Committee on Finance, I am glad to have this opportunity to urge your favorable consideration of my bill, S. 466 (attached), to liberalize and simplify the social security retirement test.

The retirement test, which is also referred to as the earnings test, has been a part of the social security law in one form or another since 1935. I think it is fair to say that it has never been entirely satisfactory and has always been a point of controversy.

Several years ago the House Ways and Means Committee asked the Department of Health, Education, and Welfare to study the retirement test. In response to this request, the Department submitted a report to the Committee in 1960. In this report the Department made the following candid statement which reflects the inexorable conflict of desires inherent in the retirement test:

"The fact must be faced that the retirement test is the center of an insoluble dilemma. There is, on the one hand, the need to conserve the funds of the program by not paying benefits to people who have substantial work income, and on the other hand, the need to avoid interfering with incentives to work. Both of these objectives cannot be fully accomplished. The best that can be done is to accommodate the two, so that while the funds of the system are in a large part directed to the most socially useful purposes, at the same time interference with incentives to work is kept at a reasonably low level."

Mr. Chairman, it is my opinion that the present retirement test does not maintain a proper accommodation between the needs stated in the Department's report. I think that the present retirement test does interfere unreasonably both with the individual's inclination to work and his ability to find employment which will not result in financial disadvantage rather than advantage. Moreover, I think the vast majority of people affected by it—people in the early retirement years—share this opinion, and wish to have this impediment to useful part-time employment eliminated.

The retired worker looks upon the retirement test as an incomprehensible technicality that interferes with his desire to work and his efforts to be inde-

pendent and self-sufficient. Untold numbers on the social security roles are prevented from accepting part-time employment because of the retirement test. Many more are forced to work only intermittently or—worse still—to accept wages below what their skills would ordinarily command in order to retain their employment.

These unfortunate effects of the retirement test as it is now written have been made clear to us time and time again. I have had scores of letters from people in my State pointing out the inequities which the present retirement test has produced in their own situations.

Members of this committee will recall that during 1961 the Special Committee on Aging, of which I am a member, held hearings in 34 cities and towns throughout the country. In each of these hearings there were what we called townhall sessions in which senior citizens were invited to speak from the floor on any problem that was of concern to them. The problem most frequently mentioned related to the cost of health care. However, aside from that, one of the most frequently mentioned problems was some kind of inequity or frustration arising out of the social security retirement test. Bear in mind, Mr. Chairman, that these were not witnesses making prepared statements, but were ordinary citizens speaking extemporaneously in townhall fashion. The desire for useful employment and the desire to be self-sufficient were recurrent themes in these meetings in all parts of the country, and the barrier of the retirement test was one of the chief complaints in the minds of our older citizens.

Mr. Chairman, I serve as a member of the Subcommittee on Employment and Retirement Incomes of the Elderly of the Special Committee on Aging. That subcommittee, under the chairmanship of the distinguished Senator from West Virginia, Mr. Randolph, conducted hearings and supplementary studies earlier this year on ways to increase the opportunities available to our older citizens for part-time employment. One of the major conclusions of the subcommittee was that the retirement test should be both liberalized and simplified to enable older people to capitalize on the opportunities for part-time employment that exist or may be created. At the last meeting of the Special Committee on Aging this recommendation (No. 4) as well as several other recommendations of the subcommittee, were introduced and adopted as the recommendations of the full committee. Mr. Chairman, with your permission, I should like the record to show at this point the recommendation in the report of the Special Committee on Aging with respect to the retirement test, together with the pertinent discussion.

The bill which I have introduced, and which is now before you, would carry out this recommendation. It would bring about a more balanced accommodation between the conflicting considerations which call for a retirement test, and would meet the legitimate demands of our older people for a reasonable and understandable retirement test.

This bill would simply raise the basic exemption amount from $1,200 to $2,400 a year and provide for dollar-for-dollar reduction in benefits for earnings over $2,400. The basic exemption of $1,200 has remained unchanged since it was put into law in 1954. Living costs and wage rates have increased so much since that time that it is no longer a realistic base figure. I am convinced that this bill is needed to alleviate the discriminatory effect of the retirement test on those who are ready, willing, and able—and in many cases forced—to work.

I ask that the provisions of my bill, S. 466, be accepted as an amendment to H.R. 11865, the measure before the committee to amend the Social Security Act.

STATEMENT BY MRS. JUDY COLEMAN, OF THE AMERICAN ASSOCIATION OF MEDICAL ASSISTANTS, INC., RE H.R. 11865

Mr. Chairman and members of the committee, my name is Judy Coleman. I am a resident of Dallas, Tex., and I have the privilege of representing, as president, over 12,000 members of the American Association of Medical Assistants.

Members of our association are secretaries, receptionists, bookkeepers, nurses, and technicians in the employment of physicians in offices, clinics, hospitals, and nursing homes throughout our country.

We are in daily contact with millions of patients and feel that we have an unusual opportunity to evaluate the standards and facilities of health care in this Nation. Many of us are bookkeepers, and we discuss the financing of health and hospital care with patients daily. We know the costs, the ability of the patient to meet these costs and how the patient provides for himself by

prepayment voluntary health insurance and other personal means to meet the costs.

We are opposed to the financing of health or hospital care, optional or compulsory, through the social security system.

The majority of our members fall into the income bracket and age bracket who must pay this tax. The tax has increased in recent years and will continue to increase at a rapid rate should any such health care plan through the social security system be adopted.

We do not feel that such a health care plan is necessary or wanted by the average American. We see evidence daily that the American people have access to the best medical care in the world. We see patients daily who are adequately providing for their medical care through voluntary prepayment health care plans. We observe with regularity that our physician employers make it possible for every citizen to secure the medical care that he needs regardless of his economic status, his age, or any other circumstance.

We ask with great earnestness and with great respect for your sense of fairness that you stand with the American Association of Medical Assistants, Inc., in opposing any provision for financing of health or hospital care through the social security system.

Thank you for this opportunity to present our views.

STATEMENT OF CONGRESSMAN EUGENE KEOGH ON SECTION 9 OF H.R. 11865, SOCIAL SECURITY AMENDMENTS OF 1964

Mr. Chairman, I appreciate the opportunity to comment on section 9 of H.R. 11865, providing for covering as wages and therefore counting toward social security benefits, cash tips received by an employee in the course of his employment.

This proposal will provide better protection under the social security program for more than a million employees and their dependents. Since the cash wages of employees who customarily receive tips are relatively low, social security benefits based on their cash wages only are correspondingly low. The vast majority of these employees want social security protection based on their tip income. The inequity of forcing these employees to pay income taxes on tips while denying them the benefits of the social security program based on tip income is apparent.

Employer groups have complained to me that the proposal adopted by the House of Representatives will create serious bookkeeping problems for them. This is because the proposal would require the employee to report to his employer in writing the amount of tips received and the employer would report the employees tips along with the employees regular wages.

I do not believe anyone wants to create unnecessary or unjustified administrative problems for employers. In my opinion these problems can be virtually eliminated by the Senate Finance Committee by making a few changes in section 9 of H.R. 11865.

I would suggest, first, that employers be permitted to estimate tip income of employees for purposes of withholding employees contributions to the social security program. To prevent some employers who might fail to withhold any employee social security contribution, I would suggest that the employers would be required to estimate that wages including tips as defined under section 3121a be not less than $1 an hour.

Secondly, I would suggest that employees be permitted to report tip income to employers within 10 days after the close of each quarter. If employees fail to report within that time, the estimate of the employer will be presumed correct for employer and employee social security contributions.

These changes would eliminate, for all practical purposes, reporting by the employee of tip income to the employer. In some cases, of course, where employers significantly missed the mark employees would report but the employer could then adjust the estimate for future withholding of the social security contributions. With these changes penalties of employees for failure to report tip income to employers could be eliminated. With these changes every employee would be guaranteed social security protection on an income equivalent to at least $1 an hour. With these changes I would estimate that we would approach the maximum social security protection available on a practical basis for employees who customarily receive a substantial portion of their income in the form of tips.

I do not see how employers can, in justice, complain about this proposal if these changes are adopted. Tipped employees derive their tip income because of their employment. Because of the practice of tipping, employers pay these employees substantially lower wages than would ordinarily be required to obtain their services. Certainly, then, if coverage of tip income can be worked out on a practical basis employers have little grounds for complaint.

I take the liberty of suggesting that the foregoing might be accomplished by the following amendments to section 9 (see attached).

Thank you, Mr. Chairman.

PROPOSED AMENDMENT TO SECTION 9 OF H.R. 11865 RE COVERAGE OF TIPS UNDER SOCIAL SECURITY PROGRAM

1. Amend section 9(a)(2) by striking the word, "month" and inserting in lieu thereof the word, "quarter".

2. Amend section 9(b)(1) by striking the words, "are included in a written statement furnished to the employer" and inserting in lieu thereof the words, "as computed" and by striking the word, "month" and inserting in lieu thereof the word, "quarter".

3. Amend section 9(b)(3) by striking the word, "month" and inserting in lieu thereof the word, "quarter".

4. Amend section 9(c)(1) by striking the words, "are reported by the employee to the employer" and inserting in lieu thereof the words, "as computed".

5. Amend section 9(c)(2) by striking proposed new section 6053 of the code and inserting in lieu thereof the following new section: "Section 6053—Computing of Tips". Every employer of an employee who, in the course of his employment, receives tips which are wages as defined in section 3121a shall estimate not more than the reasonable tip income of said employee for purposes of withholding social security taxes under section 3102. Said estimate shall not be less than an amount necessary when added to other wages as defined by section 3121a to equal $1 per hour.

Every employee who, in the course of his employment by an employer, receives tips which are wages as defined in section 3121a may furnish to his employer within 10 days after the end of the calendar quarter in which the tips were received, a written statement of all such tips. Said statements shall be furnished under such regulations and in such form and manner as may be prescribed by the Secretary or his delegate and shall be used for purposes of section 3101, 3111, 6051a, and 6652c only to the extent that the tax imposed with respect to such tips by section 3101 can be collected by the employer under section 3102.

For purposes of section 3101, 3111, 6051a, and 6652c tips of an employee shall be considered equal to the amount estimated by his employer as provided above unless the employee reports tips to his employer within the period prescribed at the end of the calendar quarter as above provided.

6. Amend section 9(c)(2)B by striking the word, "Reporting" and inserting in lieu thereof the word, "Computing".

7. Amend section 9(c)(3) by striking it in its entirety.

8. Amend section 9(d) by striking the words, "reported by the employee to the tax payer" and inserting in lieu thereof the word, "computed".

9. Amend section 9(e) by striking the words, "who is furnished by an employee a written statement" and inserting in lieu thereof the words, "or an employee who receives" and by striking the words, "such statement is furnished the total amount of the tips so reported by the employee as received" and inserting in lieu thereof the words, "the tips received by the employee".

STATEMENT OF THE GOVERNMENT EMPLOYES' COUNCIL, AFL–CIO, ON H.R. 11865 (SOCIAL SECURITY AMENDMENTS—COVERAGE FOR FIREMEN)

Mr. Chairman and members of the committee, the Government Employes' Council, with 29 affiliated AFL–CIO unions representing classified, postal, and wage board employees in Federal agencies, desires to urge that the committee delete section 11 from the pending bill.

Amendment No. 1774, offered by Senator Abraham Ribicoff, will accomplish this purpose.

Existing law excludes social security coverage for service of firemen subject to a State or local staff retirement plan.

Section 11 establishes a uniform program for all firemen and policemen.

Pension programs for firemen were among the original staff retirement plans in this country. These systems have advanced over a long period of years with recognition of the special conditions firemen and their families encounter. There is little need to emphasize the unique physical dangers and health hazards to which these public employees are exposed daily. As an example, some States have approved legislation recognizing heart conditions of firefighters as prime facie evidence of duty-related injury. In other cases, firemen are permitted to retire between 50 and 55 years of age with a minimum number of years of service because of the constant exposure to injury and even death in carrying out their official duties. In this case OASDI retirement at age 65 or age 62 is not realistic for fire department employees since their work life is curtailed by the hazards of the job.

In 1950, social security was extended to public employees not subject to a State or local retirement plan. Firemen were excluded. And even with the 1954 amendments providing social security coverage under certain conditions for State and local workers having staff retirement benefits, the firefighters' exclusion was continued.

Excellent justification exists for these precedents. Social security is designed as an insurance program to guarantee older workers a minimum standard of living when they can no longer participate in a gainful occupation. Staff retirement programs are developed to meet the special needs of superannuated employees. Their coverage and benefits are based upon salary, length of service, age, and contributions. The worker with social security eligibility only is provided with a minimum subsistence monthly benefit. Individuals who desire a higher standard are expected to supplement this basic income with a staff plan or savings or other means.

Much of the apprehension of firefighters is based upon the threat of social security reducing the retirement special features now in effect in many communities for these public servants, and ultimately the annihilation of these staff plans in favor of the OASDI approach.

In localities where no programs for firemen exist, States and communities now possess the right to provide social security coverage to firefighter personnel.

While section 11 authorizes cities to undertake elections to determine the desire of firemen concerning coverage, this apparent advantage is offset by the peril to the existing staff systems.

It may be argued that acceptance of section 11 poses no immediate threat to an individual's equity in a local plan. Our concern is long range. Availability of OASDI coverage could very well lead in the years ahead to attempts by State and local officials to abandon the staff program because of cost.

One method of pursuing the authority in section 11 would be to maintain both the social security and staff retirement systems simultaneously as separate entities. It is known as supplementation. In that case, both the employee and the employer would contribute 3.8 percent of salary to OASDI. The worker and management would continue to maintain the staff plan and to finance it as before. An obvious advantage of this approach is the full benefits of both systems to be reaped by the employee when eligible for them.

However, in many cases, the total cost would be prohibitive to the workers and could very well be to the public department as the employer.

Another approach continues the same contributions by the employee for retirement purposes. This amount is divided into two parts—the money necessary to make the normal social security contribution, with the remainder being allocated to the staff plan. The employee is then permitted to retire at the normal age under the staff arrangement and to receive the original benefits provided by the staff system. However, upon reaching age 65 and receiving social security payments, the fire service's share is reduced by the amount of the social security benefits. This arrangement is titled "Integration."

A version of this plan involves the same procedure outlined under "Integration," but requires the employee to pay one-half the cost of social security and to receive in return one-half of OASDI benefits in addition to the normal pension. It would probably necessitate no greater investment by the employee.

But both of these methods could involve considerably greater expense for the community over a number of years. This, in turn, could encourage local government bodies to seek some other less costly way to finance the plan. An attractive alternative from their standpoint would be to gradually embrace social security as the sole means of retirement income.

A fourth plan "coordinates" the social security and staff systems. Entitlement to OASDI benefits is accompanied by a reduction in the annuity paid by the local retirement plan. In this case, however, the State or city makes advance adjustments in contributions and benefits during the employee's working life prior to his receipt of a retirement annuity and social security. The department computes the retirement benefits accruing to an individual employee at age 65 less the amount to be received through OASDI. It then revises the contributions and payments to account for this difference.

These are the methods available to achieve a closer relationship between two systems with completely different objectives. For the local firefighter retirement plan, they spell one result—absorption by the social security plan of the specialized annuity programs tailored to the specific needs of employees and public management.

Certainly there is a need to provide improved financial assurance to American workers when they complete their years of productive work. This principle applies to both private industry and public employees. But for those whose work for Government enterprise involves special consideration, we believe these improvements should occur within their own programs. Even if a longer span of time is needed to accomplish these changes because of the size of the plan and the funds available, it is essential that the independence of such systems be maintained. The desirable aspects of huge social programs should not be permitted to blind us to the necessity for continuing to protect the equities of small groups of citizens. We are convinced that in the case of firemen and their State and local retirement systems fairness dictates that they be preserved. This will enable the employees and local government bodies to continue the progress of their plans on the basis of the special needs of the workers and the ability of both the employer and the employee to finance desired improvements.

For these reasons, Mr. Chairman, we earnestly solicit the assistance of the committee in deleting section 11 from the bill now under consideration.

STATEMENT BY REPRESENTATIVE THOMAS P. GILL ON H.R. 11865

Mr. Chairman, I appreciate the chance to share a few thoughts with you on medical care for the aged. The House bill now before you was passed on a "closed rule," and it was impossible for us to add medical care to the improvements in social security benefits. However, it is the hope of many of us that you will do so in the Senate, and give us a chance to vote for this long overdue program.

Few contest the basic facts. After age 65, 9 out of 10 people are hospitalized at least once; 2 out of 3 more than once. People over 65 use three times as much hospital care as people under 65, and when they are in the hospital they stay twice as long. Hospital costs have gone up from about $9 a day in 1946 to around $36 today. Incomes of persons over 65 tend to be fixed and are often very low; half the couples over 65 have less than $2,800 a year between them, which is below the poverty level; half the single persons over 65 have far less—in the vicinity of $1,000 to $1,200 annually.

Only a few months ago the opponents of hospital insurance under social security used to say that the Kerr-Mills medical welfare program met the need. It has become abundantly clear that it does not and will not. Only about three-fifths of the States have implemented the Kerr-Mills law in any fashion and in most it is inadequately funded. In many States the beneficiaries under the Kerr-Mills law are largely old cases, formerly corried under old-age assistance.

My State of Hawaii is a case in point. We have been cited as one of the States with a better than average Kerr-Mills program, yet less than 2 percent of our people over 65 are receiving benefits. If you disregard the number of cases who were already getting benefits under old-age assistance the percentage will drop to about 1 percent or less. The figures supplied by the State of Hawaii Department of Social Services on June 19, 1964, are as follows: "The percentages of persons over 65 in Hawaii who have actually received and are receiving Kerr-Mills assistance since the law went into effect are shown below by years."

	1961-62	1962-63	1963-64
Estimated population 65 and over	30,000	30,000	32,000
Average monthly recipients (unduplicated)	367	530	[1] 600
Percent	1.2	1.8	[2] 1.9

[1] Estimated.
[2] Based on 30,000 persons over 65.

"The percentages will be less than 1 percent when item 2 in the succeeding paragraph is considered.

"For the period July 1, 1961, through December 1963, approximately 375 old-age assistance cases were transferred to Kerr-Mills (medical assistance to the aged)."

Based on an aged population of over 30,000 the normal incidence would mean several thousand hospitalizations in a given year. What of these people? Are they all covered by insurance? Do they all find it possible to meet their hospital bills? Figures are hard to come by but we have strong indications of need. Queens Hospital, in Honolulu, one of our largest, announced last year that it loses about $500,000 annually caring for indigents; and losses on persons ineligible for State assistance alone runs about $140,000 annually.

In my State I believe you will find that most persons competent in the social welfare field will agree that Kerr-Mills has not done the job. For example, Mrs. Ah Quon McElrath, a specialist in medical care and welfare for the IIGWU, was reported in June of this year as saying just that. According to Mrs. McElrath, under Hawaii's interpretation of the Kerr-Mills law, a person over 65 with $75 a month from social security and $75 additional from a pension plan would be denied Kerr-Mills coverage for even a modest $350 hospital bill. They would require him to live on $100 a month and pay for the hospital out of the other $50.

Such a situation is probably quite common, and is a modest problem compared with the overwhelming cost of a disastrous illness. Mrs. McElrath, and her union incidentally, agrees the only feasible solution is basic hospital insurance under the social security system.

Faced with the obvious inadequacies of Kerr-Mills, our opponents have now shifted ground. They now say the law is adequate but the States are at fault for not implementing it. This quick shuffle may be useful in debates but it doesn't solve the problem. The States are not going to implement Kerr-Mills in such fashion that they will meet the need. They don't have the money. Most States are already heavily burdened with demands for education, roads, and other facilities and services. If States were to raise taxes to meet the real costs of Kerr-Mills the people who shift the blame to them would be among the first to complain.

What about private insurance? Similarly, it is not doing the job. Only about 9 million, or half the people over 65, have any private insurance, and most of these are only half covered. The high and rising cost of private insurance in this field—running from around $100 to several hundred dollars annually—insures one thing: that only the aged with reasonable means will be even partially covered.

Private insurance is burdened by excessive overhead. In some group nonprofit plans 80 percent or more of the premiums are paid back in benefits; however, at least half of the commercial health insurance policies held by old people are not of this type. Many of these individual policies return less than half the premiums paid in benefits; the other half is overhead paid to the insurance company.

In light of this, it is little wonder that some of our friends in the insurance industry have suggested that the Federal Government subsidize insurance premiums.

For example, Senator Fong from my State, who opposes financing of medicare under social security, suggested in his separate views in the report of the Subcommittee on Health of the Elderly in July of this year that:

"* * * additional Federal legislation is needed to assist older persons to finance comprehensive health protection, with the Federal share paid out of general revenues of the Treasury."

I would suggest strongly that there is no need for the Federal Government to pay a 50-percent subsidy to private insurance companies. It would be far better to spend that money taking care of the old folks.

In summary, Kerr-Mills has not and cannot meet the need; private insurance cannot be expected to do so because it cannot spread the risk far enough to lower its premiums to workable levels.

The only solution that makes sense so far is to incorporate basic hospital insurance under the social security system in the manner suggested by the King-Anderson bill. This would give basic coverage to almost all over 65 as a matter of right, and without a "means" test. Then Kerr-Mills and private insurance could help fill the gaps. Kerr-Mills could cover those cases of complete medical disaster. Once basic hospitalization needs were covered the person over 65 could invest what little he had available in private insurance to cover other costs such as doctor's bills.

I certainly hope this committee will give us a chance to vote this issue up or down on the floor of both Houses.

STATEMENT BY ILLINOIS MANUFACTURERS' ASSOCIATION RE AMENDMENTS TO SOCIAL SECURITY ACT (H.R. 11865)

The Illinois Manufacturers' Association embraces in its membership of 5,000 industrial firms practically every representative manufacturing firm in Illinois—large, small, and medium sized—engaged in a wide variety of production.

We have carefully considered and are vitally concerned about the proposed amendments to the Social Security Act, as embodied in H.R. 11865. The IMA is concerned primarily with the serious implications of those changes relating to the substantial increase in benefit payments, the large increase in the OASDI tax rate on both employee and employer, the liberalization of the insured status requirements, and other proposals to liberalize the provisions of the act. We also are opposed to any attempt to amend H.R. 11865 to include any provision for medical or hospital care for aged persons.

The manufacturing firms in Illinois seriously question the need for or advisability of any major changes in the social security system at this time.

It is significant that in nearly every election year since 1950, social security benefits have been liberalized, while in nonelection years Congress has made no changes. The program is being treated as a political expedient a short time before the 1964 election, instead of being based upon the facts of the economic situation in the Nation. Frequent inflationary changes in the benefit structure and cost structure of the program should be avoided.

Increases in benefits are not justified

H.R. 11865 provides for a substantial increase in the monthly benefits for both present and future beneficiaries under the old-age, survivors, and disability insurance program.

It would give increased gratuitous benefits to presently retired beneficiaries, even though most of them have already received benefits which are far in excess of the taxes paid by them and their employers. The bill magnifies the existing inequities in the social security system. Benefit eligibility and the amount of benefits for present and future beneficiaries arbitrarily disregard the amount of taxes which have been paid.

Workers who have been in the program for a number of years would pay a higher tax on the $5,400 wage base but would not receive the benefit of higher benefit payments because they would never qualify with a $450 average monthly wage. On the other hand, individuals who would have only a few years of coverage could qualify for the maximum monthly benefit amounts. This is certainly unfair to those persons who have been paying social security taxes ever since the inception of the program in 1937. Credit should be given to the total amount of taxes which such persons have paid and to the number of years of coverage, in computing the benefit amounts.

Increase in widow's benefits

H.R. 11865 would liberalize widow's benefits. This proposal would create inequities in the benefits paid to widows as compared to the benefits to which retired workingwomen are entitled. Under the present provisions of the law, many women in the latter group did not earn sufficient wages to entitle them to benefits in an amount equal to those received by widows. The proposal under consideration would widen this inequity.

Change in the insured status requirements

The bill would liberalize the insured status requirements so that a retired person would qualify for benefits if he has as few as three quarters of coverage as contrasted with the present requirements of six quarters.

This generosity is unfair to those who have been paying social security taxes since the inception of the program in 1937. Benefits are now being paid to persons who paid a very small amount in taxes and this situation would be amplified.

Would increase taxes

Now let us consider the ever-increasing costs of the OASDI program. The Congress cannot grant these additional benefits to recipients without extracting the funds to pay for them from other citizens. Each move to make benefits bigger or easier to obtain brings the Congress face to face with the need to make the social security tax still higher.

Repeated increases and extensions in benefits could very well endanger the whole social security program by adding additional costs which might jeopardize the availability of benefits in future years for those who are really in need and who have been paying into the fund for many years. People are now wondering whether there will be any money left for them by the time they retire. The whole history of social security has been to make it more and more liberal and more expensive.

As the law now stands, the tax on both employee and employer is 3.625 percent, or a total of 7.25 percent. It goes up in 1966 to 8.25 percent and finally, in 1968 to 9.25 percent. H.R. 11865 would raise the tax 7.6 percent next year and finally to 9.6 percent in 1971.

This bill also proposes that the wage base upon which taxes are paid, be increased from $4,800 to $5,400 per year. IMA objects to such proposal. This would make an additional tax of $31.20 to be paid by every covered employee and $31.20 to be paid by his employer in 1965 on annual wages of $5,400.

The tax increase which is proposed in H.R. 11865 amounts to a 17-percent increase. The purported reason for a tax increase is to finance the increased benefits. However, benefits would be increased 5 percent. There is no justification for increasing the tax 17 percent.

The social security tax started out in 1937 at 1 percent, paid by the employer and the employee on wages of $3,000 per year, or $60 per year. Now it is proposed that the tax be 9.6 percent on wages of $5,400 by 1971, or a total of $513.40 per year. This represents an increase of 863 percent. This assumes that there will be no further increases in benefits by 1971, an unlikely assumption. The following figures show how social security taxes have gone up since 1949.

How social security taxes have grown

Period	Maximum earnings base	Combined employer and employee tax [1]	
		Tax rate (percent)	Amount per year
1937–49	$3,000	2	$60.00
1950	3,000	3	90.00
1951–53	3,600	3	108.00
1954	3,600	4	144.00
1955–56	4,200	4	168.00
1957–58	4,200	4.5	189.00
1959	4,800	5	240.00
1960–61	4,800	6	288.00
1962	4,800	6.25	300.00
1963–65	4,800	7.25	348.00
1966–67	4,800	8.25	396.00
1968 and after	4,800	9.25	444.00
INCREASES PROPOSED IN H.R. 11865			
1965	5,400	7.6	410.40
1966–67	5,400	8	432.00
1968–70	5,400	9	486.00
1971 and after	5,400	9.6	518.40

[1] ½ deducted from employees' pay checks and ½ paid by employers.

It is a strange paradox that so soon after Congress reduced income taxes, you are being asked to turn right around and increase the social security tax by more than $2½ billion per year. Your committee decided that income taxes should be reduced in order to increase purchasing power and to bolster the economy of the country. The social security tax which is deducted from employees' paychecks is, for a large number of people in the country, a much larger bite out of their paychecks than the income tax which they pay. These are the same people the tax reduction bill is intended to help. Their taxes would be increased substantially instead of reduced.

Medical care for the aged

An attempt is being made to amend H.R. 11865 to include medical and hospital care for the aged in the social security system. Medical and hospital care legislation has been proposed in various forms several times since 1935. The Senate Finance Committee and the House Ways and Means Committee have spent many hours in hearing witnesses and considering these proposals—hours which might have been spent on more needed legislation. In each instance, the committees have wisely rejected such proposals and the reasons for rejecting it now are stronger than they have been previously, but the proponents of such socialistic legislation never give up. The Illinois Manufacturers' Association urges you to again reject it.

Such legislation not needed

There has been no demonstrated proof of the need for health care legislation. This proposal is based upon the false assumption that most older persons are hardship cases and are unable to finance their health care costs or to secure voluntary health insurance. Some are needy. Most are not.

Statistics prove that a large majority of the aged persons are financing their own health care costs adequately through health insurance and that such coverage is increasing at a rapid rate. Voluntary health insurance is a sound and economic means for providing older persons with the medical care they need. It is available at reasonable premiums.

It is not fair or proper to impose a compulsory tax on all workers, including those who can least afford it, in order to set up a vast hospital care program for the elderly people whose illnesses are now being taken care of through other means.

Kerr-Mills program takes care of those who need help

In 1960 the Congress passed the Kerr-Mills bill and this program has been adopted by most of the States and it is operating satisfactorily. It provides for Federal financial participation with the States in furnishing medical and hospital services for needy individuals 65 years of age and over who need medical and hospital treatment. These are the people who the proponents of medical care under social security are supposedly concerned with.

The administration of this Federal grant-in-aid program for the needy and near needy was placed in the States, where it belongs. It is administered locally for the benefit of locally determined beneficiaries. No facts have been submitted to prove that older people have suffered because they have been unable to secure proper medical care.

Contrary to basic social security principles

The proposed hospital care program departs entirely from the basic principles underlying the present social security program. The social security program is a cash benefit program in which each person must contribute taxes based on his earnings for a minimum period of time before he is eligible for retirement, death, or permanent disability benefits. The amount of his benefits is based upon the wages he has earned in covered employment.

Proposals which have been made would pay hospital charges for beneficiaries even though they had never paid a penny in taxes to finance this program. There is no dollar limitation on the amount that would be paid. Everyone would receive the same payments regardless of past earnings.

Health care for the aged would provide an opening wedge for expanding the program and establishing a compulsory health care program for citizens of all ages. It would eventually lead to socialized medicine. The quality of medical and hospital care in the country would be weakened.

The cost of such a program would be stupendous and increasingly burdensome on both employers and employees. It would require a big increase in social security taxes—much larger than is now being proposed in H.R. 11865. This

would just be the beginning. If hospital care under social security finally gets upon the statute books, there will be constant pressures to expand it, with consequent increases in taxes on the employee and the employer to finance it.

Duplication of social security and workmen's compensation benefits

We urge you to adopt legislation to correct a situation whereby a disabled person is able to receive duplicate and overlapping payments under social security and under the workmen's compensation laws of the various States.

In a strange, almost unbelievable way, it has come about that there can be a reward for getting disabled on jobs. In some 40 different States a man or woman can do better financially with a disabling work-connected injury than can be earned at regular wages.

Such artifice is the byproduct of inroads that the Federal social security system is making into the Nation's 50-year-old workmen's compensation system which has been conceived and administered under the laws of the various States.

In 1956 the Federal Social Security Act was amended to provide for payment of disability benefits. Such disability benefits were reduced by the amount which a disabled person might receive under State workmen's compensation laws. However, in 1958 the provision for the deduction of workmen's compensation benefits was eliminated. The amount which such a person may receive frequently makes possible for more pay off the job than on the job. To illustrate: A disabled person with a wife and two children who earned $400 per month is entitled to receive $254 in social security disability benefits. If the disability was caused by an accident in which he was involved when he was at work, he could, in addition, receive benefits provided under the State workmen's compensation laws.

In Illinois such a person would receive $55 per week or $238.33 per month in workmen's compensation payments, which, when added to his social security benefits, would be a total of $492.33 per month. This would be tax free, as compared with his former gross earnings of $400 a month, which would be subject to income tax deductions of $34.10 and social security deductions of $14.50, or a net of $351.40, except that union dues, cost of transportation to work, lunches, work clothes, etc., would also reduce his spendable earnings. He would receive $351.40 for working and $492.33 for not working.

Obviously it is a travesty to have both a Federal and a State system to pyramid benefit payments for the same disability. Such duplication is a step toward destroying the workmen's compensation systems of the States. Among other detrimental effects, this would remove the incentive for employers to continue their effective safety work in reducing accidents to workers in their plants. Duplication of benefits encourages malingering, lessens the desire to return to work, and tempts many persons to live the life of ease.

In 1963 the Senate of the State of Illinois adopted a resolution memorializing Congress to amend the Social Security Act to restore the offset provision whereby benefits received under workmen's compensation laws would be deducted from social security benefits.

IMA prediction in 1935 was 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 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 ending June 30, 1963, the taxes collected under the retirement survivors and disability insurance program totaled $14,400 million. This was a substantial portion of total Federal taxes.

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.'"

Social security constantly liberalized

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 25 years group after group has been added to the eligibility rolls, benefit payments constantly raised, age limits lowered, eligibility broadened, and taxes increased.

The social security law has been liberalized in every election year since 1950. Now we are in another election year and you are being pressured by those who are unwilling to accept the fact that the needs of those 65 and over are adequately being taken care of.

We fear for the future

We believe that the situation is getting out of hand. We are alarmed when we envision the end product of these constant changes in the social security program. The insidious growth and extension by steps on many different fronts and further pyramiding of the costs must be stopped or it will pose a serious threat to both the Nation's economy and the morale of the people. The ultimate burden of OASDI costs might exceed the willingness of future generations of American people to support them.

The Illinois Manufacturers' Association believes that hospital care and the changes in the Social Security Act which are proposed in H.R. 11865 are unsound and undesirable. We respectfully submit that this measure should be rejected by this committee and by the Congress.

AMERICAN HOSPITAL ASSOCIATION,
Washington, D.C., August 12, 1964.

Hon. HARRY F. BYRD,
Chairman, Senate Finance Committee,
U.S. Senate, Washington, D.C.

DEAR SENATOR BYRD: We are pleased to send you the following statement setting forth the views of the American Hospital Association in respect to H.R. 11865 and the related bill, S. 880. We would appreciate your including the statement in the record of the hearings held before your committee on the subject of health care of aged persons.

The American Hospital Association is a voluntary, nonprofit membership organization including within its membership the great majority of all types of hospitals, among which are 90 percent of the Nation's general hospital beds. These hospitals in 1962 admitted more than 26.5 million patients. Our primary interest—and the reason for the organization of the association—is to promote the public welfare through the development of better hospital care for all the people.

For several years, representatives of the American Hospital Association have appeared before committees of the Congress to express its views with respect to the subject of providing for the hospital needs of aged persons. We have also discussed in detail the provisions of various bills through which the Federal Government would assist in providing for the financing of health services.

Although we have opposed certain proposals, we have in all cases made specific suggestions for changes and improvement because we believe it to be our responsibility to the Congress to do so.

A detailed review of the long history of thought and effort which this association has given to the subject would be repetitive of what we have in the past provided for the record and would not be of particular help to the Congress. The record shows clearly that hospitals and this association have not treated the problem of the health needs of the older members of our population casually. We have devoted substantial resources to both study and action.

Since 1954, the association has undertaken four thorough appraisals of the problem. These were discussed in detail in hearings before the House Ways and Means Committee. The last complete study undertaken jointly by our association and the Blue Cross Association in 1961 included an exhaustive study of the dimensions of the problem of financing the health care of the aged. The findings of the study underscored two basic conclusions reached in each of the previous studies: One, aged persons face a great and serious problem in providing for their health needs; and two, the financial participation of Government is needed for an adequate solution to the problem. This report was published and a copy was sent to each Member of the Congress in 1962.

The American Hospital Association called a special session of its house of delegates in January 1962, to review the position of the association on the health care of the aged in light of this study, and the following policy statement was officially voted by our house of delegates on January 4, 1962:

"1. We reaffirm the crucial need to continue vigorous efforts to foster realistic and equitable programs in every State for the adequate health protection of the indigent and medically indigent under a mechanism similar to the Kerr-Mills Act.

"2. We recommend the earliest possible implementation of a national Blue Cross program for a voluntary, nonprofit plan available to all persons aged 65 and over.

"3. We recognize that Government assistance is necessary to effectively implement this national Blue Cross proposal in order to enable many retired aged persons to purchase this health protection through the voluntary prepayment system. Conditional upon the administration of this proposed plan by the voluntary nonprofit prepayment system, the tax source of the funds is of secondary importance to us.

"4. The individual aged person should receive governmental financial assistance on a decreasing scale related to income, the low-income person to receive major, or even total assistance, and the higher income person to receive less. The determination for Government assistance should be made in accordance with current income reported for Federal income tax purposes or, if this is not possible, some legally acceptable declaration of income. The determination should not be made in accordance with the usual means test determination made under public welfare programs.

"5. We emphasize the urgency and important of planning for the provision of adequate facilities and personnel in order that skills and services may be available to render high quality care to the aged.

"6. It is the sense of this meeting of the house of delegates of the American Hospital Association that the best interest of the retired aged will not be served by passage of the King-Anderson bill. Our opposition to this bill is based upon careful study of the needs of the retired aged and the overall economic effect of such a program. We believe that the retired aged will be better served by a program such as has been proposed by Blue Cross plans."

With respect to the first point in the policy statement I have just cited, the association has carried out a vigorous program directed toward the full development of the Kerr-Mills Act within the States. When the act first became effective, we called a special conference with representatives of each of the State hospital associations and representatives of the Department of Health, Education, and Welfare. The program and its implications were explored at length. Following this, a list of guiding principles was developed by the association and sent to all the States to assist them in their development of the Kerr-Mills program.

The association staff traveled extensively and worked with many States on their problems. Further, an advisory committee of experienced and informed persons was formed by the association to work with the Federal Administrator of the Kerr-Mills program. This group has had a number of meetings with the staff of the Department of Health, Education, and Welfare to discuss problems and explore particular situations. The association also has surveyed all the States to determine the major factors limiting the growth of the program. Nine chief factors were found. Solutions to these seemed to lie primarily at the State level and not the Federal level.

To assist the States, a program of regional conferences, to be sponsored by this association and the Department of Health, Education, and Welfare, was proposed by the association. Three such conferences have been held. The first regional conference, covering six States, was held in Denver, Colo.; the second conference held in Atlanta, Ga., covered six States in that region; and the third held in Boston, included the six New England States. A fourth conference planned to be held in Oklahoma City was postponed. Representatives of the State governments responsible for administration of the Kerr-Mills program and representatives of hospitals, Blue Cross plans, the American Hospital Association, and the Federal Government participated. The purpose of these conferences was to discuss specific problems and to determine what could be done to expand and improve the program. From the reports of those attending the meetings, they were felt to have been thoroughly constructive and beneficial. We hope that additional conferences to cover all sections of the country can be held.

We do not propose to attempt any detailed analysis of the Kerr-Mills program for the indigent and medically indigent aged here. Kerr-Mills has stimulated

considerable improvement and extension of State programs for the indigent aged under the old-age assistance part of the program. We have stressed our belief that this should be the first goal of the States and that before the States undertake to develop programs for the medically indigent, they should first make sure that they are doing an adequate job for the indigent aged.

With respect to the medically indigent aged, progress is much more difficult to evaluate. State legislative bodies have been understandably cautious in advancing this side of the program. There is great uncertainty as to the number of potentially eligible aged and the costs of services. The services offered and the criteria for eligibility vary greatly among States. Apparently, too, some States have used the Kerr-Mills program as a means of obtaining substantial additional Federal financing without a commensurate increase in the number of aged who are being given care. Any complete evaluation of the Kerr-Mills program would require facts and figures that are not presently available from either the Federal Government or the States.

An overall review of the Kerr-Mills program was presented to our house of delegates last August. A copy of this review is attached hereto.

We are very pleased that some States now have programs publicizing the purposes of the Kerr-Mills program and making known its benefits. Communications between the welfare agencies and hospitals are excellent in many States and inadequate in some others. The problems of determination of eligibility, limited scope of benefits, methods and amounts of payment for care, and the inadequacies of financing provided by the States, together with the involvement of the recipients' relatives in determination of financial responsibility seem to be the most difficult.

It is realized that many State governments are under great financial pressure. However, proposals for the care of indigent and medically indigent aged that do not adequately reimburse hospitals simply raise the price of care to the rest of the community and do not solve the problem.

As stated earlier, we strongly support Kerr-Mills and urge its strengthening. We believe the program would be improved if it were treated as a health program, which it really is, rather than a welfare program. We believe its administration at the State level, should be located in the agency concerned with health matters.

Eligibility for Kerr-Mills benefits could be predetermined on a graduated income basis and not, as is generally the case at present, by a means test at the time the service is needed.

The second, third, fourth, and fifth points of the policy statement adopted by our association, which have been listed, relate to the implemenation of a national Blue Cross program, utilization of a Blue Cross program with Government assistance, a program of graduated benefits, and the need for adequate facilities and personnel. Since these matters are related, they will be discussed together.

The second point of our 1962 policy statement said:

"We recommend the earliest possible implementation of a national Blue Cross program for a voluntary, nonprofit plan available to all persons aged 65 and over."

The Blue Cross plans were providing benefits to 5.3 million persons 65 years of age and over at the end of 1962. The number of such persons enrolled in Blue Cross continues to grow. Lacking governmental assistance of a kind acceptable to our membership, and because there was no assurance that such assistance was likely in the future, the individual Blue Cross plans proceeded with a wholly voluntary program.

It continues to be our hope that one nationwide Blue Cross program will be possible. Meanwhile, we support the development of strong statewide Blue Cross programs. The efforts of the Blue Cross plans in the development of these programs can best be described by them. Our house of delegates in its establishment of policy, in addition to expressing its concern that governmental financing should be adequate, stipulated two conditions as essential to a program of governmental financing.

Our house of delegates acknowledged in 1962, as it had many years earlier, that governmental assistance is necessary in order to provide adequate health care to many of the aged. The house established the two firm stipulations on any program of governmental financing for the health care of the aged.

The following is a restatement of points three and four of the policy statement adopted in January 1962:

"We recognize that Government assistance is necessary to effectively implement this national Blue Cross proposal in order to enable many retired aged

persons to purchase this health protection through the voluntary prepayment system. Conditional upon the administration of this proposed plan by the voluntary, nonprofit, prepayment system, the tax source of the funds is of secondary importance to us.

"The individual aged person should receive governmental financial assistance on a decreasing scale related to income, the low-income person to receive major, or even total assistance, and the higher income person to receive less. The determination for Government assistance should be made in accordance with current income reported for Federal income tax purposes or, if this is not possible, some legally acceptable declaration of income. The determination should not be made in accordance with the usual means test determinations made under public welfare programs."

The first stipulation made by our house was that administration, and in our view this means underwriting, be by the voluntary, nonprofit, prepayment system. We are opposed to the overall direct administration by the Federal Government of a program to provide for the hospital needs of retired aged persons. We believe that the desirable manner in which to plan for Government financing is through the voluntary, nonprofit, prepayment system. We have stressed our opposition to administration by the Social Security Administration because that agency is the one designated in the legislation under discussion here. However, we would be equally opposed to direct administration by any other Federal agency.

The second stipulation was that any governmental financing should be provided for the individual in relationship to the income of that retired aged person. Our house said: "The individual aged person should receive governmental financial assistance on a decreasing scale related to income, the low-income person to receive major, or even total assistance, and the higher income person to receive less." We know that many aged persons need total assistance in the financing of their health needs. We know that there are some who need no assistance. We believe, therefore, Government financing should be scaled in a realistic ratio to the income of the retired person. We believe the determination of need should be based solely on the current income reported by the individual for Federal income tax purposes or some other equally acceptable method. We oppose the use of the public welfare means tests as the basis for determination of need for governmental assistance.

Recognizing that whatever expertness we had was in the field of health services, our house of delegates said that so long as these stipulations as to administration and scaled assistance were met, the source of the tax funds was of secondary concern to us.

The administration of the program could be handled by underwriting through the voluntary nonprofit plans. This would use the already existing mechanisms of the nonprofit plans which have contractual arrangements with the providers of services. This would avoid any vast duplication of skilled and experienced personnel; it would permit statewide and local administration; and the individual recipient would in every way appear as an independent, voluntary subscriber and not as a ward of the Government. Underwriting would give the Congress assurance as to the costs of the program each year.

The value of this approach has been amply demonstrated in the Federal employees program. The Government would benefit by possible savings resulting from the addition of this group to an already existing and very much larger group of participants. Procedures for utilization, control and transfer of patients very likely would be much more effective if carried out through existing voluntary means. The Government would be providing support of voluntary health insurance and protecting the continuity of coverage of the worker until his retirement.

We believe that the tax funds, from whatever source, should be spent to assist the individual to purchase a program of health-care benefits which have been negotiated for by the Government, from voluntary health organizations.

On July 9, 1962, the association stated its opposition to the amended version of the King-Anderson bill as it had been presented to the Senate. We stated that the proposal did not meet the conditions deemed essential by our house of delegates. We also reiterated our concern about whether the proposed financing was adequate. We still believe that the best interests of the retired aged will not be served by the passage of S. 880.

We wish also to emphasize two other aspects of providing for the health needs of aged persons. These are the provision of adequate facilities and of adequate numbers of well-trained personnel. It is realized that these matters may not come within the purview of this committee, but unless the Federal

Government makes a much greater effort to provide adequate facilities and personnel, it is unlikely that the health needs of the American population, including the aged members of that population, can be met. No program of governmental financing voted by the Congress can buy services that are not available and cannot be provided. We are pleased that the Congress has approved a program to provide greater numbers of physicians, dentists, and other health-care personnel. We believe the program of Federal assistance to provide greater numbers of well-trained professional nurses that has been passed by the House of Representatives and is to be before the Senate very shortly is urgently needed. The association is deeply concerned with these aspects of personnel and facility needs. We recognize the special problems in long-term care and have created a council to study this specific area.

The Congress has done a good deal during past years to help meet the Nation's needs for various health facilities; but, however, we still have a very long way to go. We believe the continuing deterioration and inadequacy of much of our existing hospital plant is one of the most serious problems facing the country. The legislation just passed by the Congress should provide valuable assistance toward getting at this problem. We have a pressing need for long-term care facilities, which is a matter of particular concern to aged persons. The Congress is providing assistance through a variety of programs, but shortages of adequate facilities in which high-quality care can be given persist.

We are deeply sensitive to the concern of the committee and its earnest endeavor to both appraise the problem and find solutions. We sincerely hope that this statement will be of assistance.

Sincerely,

KENNETH WILLIAMSON, *Associate Director.*

REPORT ON KERR-MILLS PROGRAM

Presented by Thomas Hale, M.D., chairman of advisory committee to Social Security Administration on health care of indigent and medically indigent aged, house of delegates, American Hospital Association, August 28, 1963

I have divided this report into two parts: first, a review of the development of the program within the States with certain supporting figures; and second, a review of the steps taken to assist with the development of the program throughout the country.

1. Program to date.

It is now 3 years since Congress passed the law setting up the Kerr-Mills program to help provide health care for the aging. Its major purpose, of course, was to aid those aged who—as determined by each State—could be classified as medically indigent, as distinct from the elderly on welfare. Officially known as medical assistance for the aged—or, more commonly, MAA—the program authorizes Federal Government grants-in-aid to States adopting medically indigent plans which receive approval from the Welfare Administration of the Department of Health, Education, and Welfare. Kerr-Mills, in addition, provided for some expansion of health care services for the aged receiving benefits under the old-age assistance program—public assistance (OAA), that is—set up in the mid-1930's with the passage of the Social Security Act.

A progress report on Kerr-Mills was made to the house of delegates last year. There has, of course, since been expansion of the MAA program. Additional States are now taking part and the monthly caseload has increased in a number of States which were earlier participants.

Department of Health, Education, and Welfare (HEW) records are tallied for 54 jurisdictions—50 States and the District of Columbia, Guam, Puerto Rico, and the Virgin Islands. A year ago HEW officially listed 27 jurisdictions with MAA programs in effect. As of early this month, the number had increased to 32 with 8 more States needing but one or two final steps to get the HEW formal classification of "programs in effect."

These are the 32 jurisdictions with that formal classification: Alabama, Arkansas, California, Connecticut, District of Columbia, Florida, Guam, Hawaii, Idaho, Illinois, Kentucky, Louisiana, Maine, Maryland, Massachusetts, Michigan, New Hampshire, New Jersey, New York, North Dakota, Oklahoma, Oregon, Pennsylvania, Puerto Rico, South Carolina, Tennessee, Utah, Vermont, Virgin Islands, Washington, West Virginia, and Wyoming.

The status of the additional eight close to participation early this month was: South Dakota had submitted its MAA plan to HEW and intended to begin the program as soon as HEW approval was received. Iowa was drafting a plan. Five States had enacted the necessary legislation to take part in MAA but had not yet submitted plans to HEW. Nebraska is one. North Carolina is another, with July 1, 1963, having been set as the starting date. The other three are Kansas, with a scheduled starting date of January 1, 1964; Minnesota, planning to make the program effective July 1, 1964; and Virginia, with an effective date of January 1, 1964. One more State, Missouri, had approval from its legislature and was awaiting its Governor's action.

Monthly figures are complied on the program. The latest available are for May 1963, which we can compare with similar tallies for May 1962—the latter being the figures reported to the house of delegates last year.

For May 1963, per the HEW figures, the national total of MAA recipients was 129,468 in 29 jurisdictions. A year earlier, the MAA recipients for the month totaled 102,378 in 26 jurisdictions. In other words, the May 1963 caseload was 27,000 higher than 1 year earlier with 3 jurisdictions added. But only a very minor share of the increase came from the three additional jurisdictions. They are the District of Columbia, Guam, and Vermont; and, for the 3 of them, HEW tallies show a total of 187 recipients in May 1963.

Payments for May 1963 under MAA are given as $28,370,612 which was an increase of more than $5½ million above the May 1962 total of $23,220,666. For May 1963 the average payment per recipient was $222.99, as compared to $226.81, 1 year earlier. It is interesting to note here that while both the total monthly payment and the caseload increased in the year between May 1962 and May 1963, the average national monthly payment decreased by nearly $4 per individual.

At the present time, we cannot make any significant comparisons of health care benefits to the aged under OAA with those under MAA. Current OAA statistics are for all benefits to the aged under public assistance—that is, food, shelter, and other aid as well as medical care, with no breakdown as to the number of individuals receiving only medical care. However, on a dollar basis as computed for the calendar year 1962, approximately 20 percent of total OAA payments was for vendor payments for medical care.

This percentage can be applied to May 1963 total OAA payments to give an estimate of how much OAA money is going into medical care. The total OAA payments in May 1963 were $171,551,811. It can therefore be estimated that about $34.3 million of this total was for medical care for OAA recipients last May. This figure compares with the nearly $29 million reported for the same month for MAA recipients.

HEW has now started collecting data from the States to give specific details on recipients and type of medical care under OAA as well as MAA. The initial figures will cover fiscal year 1962. Meanwhile, we should consider a frequently asked question on MAA's effectiveness. It is whether accomplishments attributed to MAA are primarily due to transfers of former OAA beneficiaries into the newer program for the medically indigent aged.

HEW's latest statistics on transfers into MAA from other public assistance programs for the aged—including, for example, aid to the blind and permanently disabled, but primarily from OAA—are through September 1962. They tally total shifts from the start of MAA in October 1960. The transfers are recorded at 81,423. For the same 2-year period, MAA recipients other than transfers are totaled at 265,424. Percentagewise, therefore, the transfers were about 23 percent of MAA recipients through September 1962.

The bulk of transfers were in MAA programs in three States. They were: Massachusetts, which initiated MAA in October 1960, 22,553; New York, which started MAA in April 1961, 28,677; and California, an MAA participant as of December 1961, 17,972. Connecticut, about which there was considerable discussion in this House last year, had 4,346 transfers.

There is also a point as to whether the transfers into MAA on a national basis have continued in proportion to the 81,423 recorded as of last fall. HEW reports in the negative. The number of transfers since last fall have been nowhere near the earlier rate, according to HEW estimates. The explanation is that the transfers primarily take place at the time the MAA program is started and the majority of the large population States were already MAA participants by last fall.

MAA benefits vary, of course, in each State. This is reflected in the HEW statistics on monthly payments and caseloads. In May 1963, for example, there

was this range among the 50 States: New York had the highest total payments, $11,492,721 and the largest number of recipients, 33,491. Its average payment per recipient for the month was $343.16. On the other hand, Illinois had the highest average payment in May 1963, $445.44, but its MAA recipients for the month totaled only 904 and payments added to $402,682.

At the other end of the scale, the State with the least number of recipients in May 1963 was Vermont with 74. Payments for the month totaled $28,685 making an average per individual of $387.64. The lowest average per recipient in May 1963 was Kentucky's $26.33. However, its caseload for the month was 6,471 with payments amounting to $170,388.

These statistical variations make it clear that the Kerr-Mills program cannot be judged intelligently on a national basis. The MAA operations, particularly, must be studied on a State-to-State basis. There are each State's eligibility requirements to be considered as well as the benefits provided. Also, several States have themselves made revisions in their MAA plans subsequent to adopting the program.

Of all the Kerr-Mills programs in effect this summer, HEW classified only four as having a comprehensive plan: Hawaii, Massachusetts, New York, and North Dakota. A comprehensive plan is one defined as offering five kinds of major services with no significant limitations on conditions. The five major services are hospital care, nursing home care, practitioner's services, dental care, and drugs. Even within the comprehensive plan category, time and payment limits on care and services may vary in different States. What are described as "significant limitations on conditions" cover such requirements as the one existing in a number of noncomprehensive plan States that the illness be classified as life endangering.

On a national basis, the single largest sum for health care services under MAA has been paid for inpatient hospital care. The latest full-year figures supplied by HEW cover the calendar year which ended December 31, 1962. Total vendor payments for MAA for that year were $250,862,000. Of this sum, $121,057,000, 48.3 percent, was for inpatient hospital care. Nursing home care was next, $117,343,000 or 46.8 percent.

An interesting comparison can be made with vendor payments under OAA during calendar year 1962. The total was $383,146,000 of which 35.3 percent ($135,373,000) was for inpatient hospital care (compared to 48.3 percent MAA). OAA nursing home care payments accounted for 33 percent ($126,398,000) in contrast to 46.8 percent MAA.

Other items tallied for 1962 included physicians' services and prescribed drugs. Under OAA they were $47,301,000 and $47,021,000, respectively—each of which was 12.3 percent of the year's total vendor medical care payments for public assistance to the aged. Under MAA, the payments for physicians' services amounted to $5,452,000 and for prescribed drugs, $5,122,000—which were 2.2 percent and 2 percent respectively of the total 1962 MAA vendor payments.

What percentage of the Nation's aged is receiving MAA benefits is another question frequently asked to evaluate the program's effectiveness. The latest figures on this from HEW are for the month of December 1962. They show that at that time there were benefits under MAA for 10.7 per thousand people 65 and over in the 28 jurisdictions then covered by the program. This was about 1 percent of the aged in those areas.

A significant factor in increasing caseloads is the relaxing of eligibility requirements, which, of course, is primarily a matter for the individual States. HEW tallies for the first 2 years of the program show that roughly 20 percent of those who applied in their States as medically indigent were turned down as not meeting eligibility specifications. There were about 81,500 such refusals as of September 1962 at which time MAA had a 2-year cumulative recipients total of about 347,000 including the 81,423 transfers from other public assistance programs which I mentioned earlier in this report.

It is expected that the number of State MAA plans will increase. Wisconsin early this month had legislation pending to authorize adoption of an MAA plan there. The Georgia Legislature approved the needed legislation in 1961 but no funds are available. New Mexico has legal authority to take part in the program but a 1963 appropriation request was denied. Nevada enacted the necessary legislation this year but did not vote tax funds to put MAA into operation.

Ten States need enabling legislation. One is Indiana, where the Governor vetoed a bill passed by the legislature. Texas needs a favorable popular vote on a resolution for a constitutional amendment passed by its legislature, which would have to be followed by enabling legislation. The other eight States requiring

legislative authority are: Alaska, Arizona, Colorado, Delaware, Mississippi, Montana, Ohio, and Rhode Island.

Last year question was raised in the discussions before this House as to the adequacy of the facts and figures which were made available. Serious question was raised as to the overall picture which was being presented on the basis of the available figures. Our committee discussed this matter at length with the representatives of the Federal Government and expressed a strong hope that additional and more specific figures might be obtained. Although the Department of Health, Education, and Welfare agreed to check the matter carefully, the information given to you here is as complete as it is possible for us to obtain. Looking forward to future reports to this House of the Kerr-Mills program, we know that HEW is making progress in collecting data from the States, with the initial statistics for fiscal year 1962 to be the basis for continuing similar reports. Consequently, we hope to give you more complete Kerr-Mills data next year.

2. Further program development

The American Hospital Association has, as you know, made every effort to assist in the full development of the Kerr-Mills program. The progress that has been made has been reported to the house of delegates at its meetings in the past. At its special meeting in January 1962 the house of delegates reaffirmed "the crucial need to continue vigorous efforts to foster realistic and equitable programs in every State for the adequate health protection of the indigent and medically indigent."

The committee, of which I am at present chairman, was established in order to enable the association to work closely with the Department of Health, Education, and Welfare. There has continued to be a fine interchange of information and discussion of problems between the individuals responsible for administering the Kerr-Mills program within the Federal Government and the representatives of the association. Last year, it was reported to you that a series of regional meetings were planned so that representatives of hospitals and the State agencies operating the programs might be brought together under the auspices of the American Hospital Association and the Department of Health, Education, and Welfare for a thorough discussion of problems which might exist and for an exchange of information to lead toward the strengthening of State programs.

Due to a number of factors, this effort was delayed. However, the first regional conference was held in Denver, Colo., on March 21, 1963, and six States participated. Representatives of the American Hospital Association and the Department of Health, Education, and Welfare, reprsentatives of hospitals within the States, representatives of Blue Cross plans, and representatives of the State agencies administering the programs within the States participated. It was felt to have been highly beneficial for the groups to exchange information as they did. We hope it will lead toward improved programing within the States.

Certainly, there was evidence of the value of opening up new corridors for discussion between the various groups involved at the State level.

The following major points were elucidated in this conference:

1. How can the caseload in a state be estimated?
2. How can the benefit structure be determined?
3. How and by whom should programs be administerd—the Blues, other?
4. How should rates of payment for hopsital care be determined?
5. Methods of publicity and communications.
6. Control of utilization.
7. Control of quality of hospital care.
8. The problem of rising cost of hospital care.

An attempt was made to proceed with conferences in two other sections of the country. Unfortunately this was not successful. On June 5, 1963, the committee reviewed the program with the Department of Health, Education, and Welfare in Washington; and it was jointly agreed that the initial conference was of value, and that we should proceed with additional regional meetings. It was further agreed that the details for conferences which should cover the entire country would be worked out by the staffs of the association and HEW in the fall of this year so that the meetings could be held in the latter part of this year or as early as possible next year.

It has been abundantly clear in all of our discussions that adequacy of reimbursement to hospitals for services rendered was a most critical aspect of the program. For government agencies and others to herald the development of Kerr-Mills program to meet the needs of aged persons if it means increasing

the load of patients hospitalized and the financial burden upon hospitals because of inadequate payment is rather a mockery. Our committee was pleased indeed, to find the representatives of the Federal agency entirely responsive and understanding of the absolute need for the hospitals to be adequately reimbursed. It is important that we keep in mind, therefore, that inadequate reimbursement of hospitals is not a result of any intention or requirement on the part of the Federal Government but is totally a result of State government action.

We have been particularly hopeful that the State programs might be administered by the Blue Cross plans, and we are pleased indeed to see the progress being made in this direction. It was because of this particular interest that Blue Cross representatives were invited to participate in the Colorado conference. It is especially noteworthy, I think, that the State of New Jersey has embarked on a program of underwriting of aged beneficiaries of the Kerr-Mills program in the local Blue Cross plan. Although administration of the program by Blue Cross is a fact in several States and being considered in others, the development in New Jersey which makes the participants regular members of the Blue Cross plan is especially noteworthy.

In the overall, progress is being made in the development of the Kerr-Mills program even though the benefits are somewhat limited and eligibility requirements restrictive in some States. There is a need to continue to follow the progress carefully and to move toward continued improvement. The basic impetus, of course, for significant expansion and betterment of the Kerr-Mills program must come from the State level.

U.S. SENATE,
Washington, D.C. August 13, 1964.

HON. HARRY FLOOD BYRD,
U.S. Senate, Washington, D.C.

DEAR SENATOR BYRD: This letter is to urge the Finance Committee to consider S. 225, which I introduced last year as an amendment to H.R. 11865, when the committee prepares its version of the amendments to the Social Security Act for 1964.

This bill would lower from 72 to 68 the age at which old-age and survivors insurance benefits are payable regardless of earnings and would increase from $1,200 to $2,400 the exempt amount of earnings that a beneficiary may earn in a year and still get all of his social security benefits. It would also raise from $100 to $200 the monthly measure of retirement—the amount that a beneficiary not engaged in self-employment can earn for a given month without losing benefits for the month regardless of the amount of his annual earnings. One dollar in benefits would be withheld for each $1 of earnings above $2,400.

The retirement test provisions operate to discourage our older citizens working as much as they can and would like to and, therefore, keeps them from making a contribution to production and to the national economy and from bettering their own situations. I submit that this very modest increase in the outside earning limitation is necessary to compensate for the reduced purchasing power suffered by our elder citizens through the devaluation of the American dollar which has occurred since the adoption of the Social Security Act in 1935. Many of our elder citizens now receiving benefits under the social security program began contributing to this retirement plan when the American dollar had a valuation of 100 cents. That valuation has now diminished to approximately 47 cents, and it seems to me that good faith obligates Congress to increase the outside earning limitation to a level which will realistically compensate our elder citizens for the shrinking value of the dollar.

I sincerely hope that the Senate Finance Committee will give this matter their serious attention in considering amendments to H.R. 11865 and amendments to the Social Security Act.

With best wishes, I am
Cordially yours,

KARL E. MUNDT, *U.S. Senator.*

STATEMENT OF SENATOR WINSTON L. PROUTY, REPUBLICAN, OF VERMONT, BEFORE THE SENATE FINANCE COMMITTEE, AUGUST 14, 1964

Mr. Chairman, the number of older Americans in our land is on the rise. In the early years of the 20th century, older America represented only 3 million people, or 4 percent of our population. It grew to 12.3 million, or 8 percent of

our people within the first half of this century; it is projected by the Social Security Administration that the advances in science and technology will further extend the average lifespan so that by the year 2000 nearly one-third of our entire population will be age 65 or over.

These men and women, who gave so much of their lives to making America a better place to live, are not mere statistics. No numbers can tell their story; no computers share their sorrows. They are our parents, brothers, sisters, and friends. When we look to their needs let us keep the people in mind—not merely their mathematical representation.

My mail reflects a constant, gnawing problem. Our older people are asked to exist on woefully inadequate incomes.

Let us take a look at how deceptively statistics treat their problem. In 1950 there were 12.3 million Americans age 65 and over with a total income of about $15 billion; in 1961 there were 17 million older citizens with a total income of $35 billion. In other words, while the population of older America had increased by 40 percent, its cumulative income had jumped by more than 130 percent.

But over the same period our dollar had diminished in purchasing power by 20 percent, and many of our older citizens moved to urban areas where the cost of living is higher, but where needed medical facilities are located. Then, too, a substantial part of the increased income went to a relatively small group of well-to-do people. Over 200,000 older American, 1 out of 85, had incomes of $20,000 or more, and over 50,000 had incomes of $50,000 or more in 1961.

Looking more closely at this apparently beneficial rise in the income of older people we see that in 1950 about half of all incomes of older people was from earnings. In 1961 less than one-third of the total came from earnings. While income shot from $15 to $35 billion, earnings had increased from only $7.5 to $10 billion.

Of the $17.5 billion increase in incomes other than earnings, almost one-third came from private pensions, life insurance, income from savings and investments and other private sources. More than two-thirds came from Government programs. Of that $12 billion nearly $9 billion came from social security.

Yet, above the cloud of these statistics, the picture is still not very bright. The average older couple has an income of only $2,530 per year, or half that of an average young couple. And even they are better off than single older citizens. The average older person living alone has an income of only $1,055.

Put this income next to what it takes to live modestly and comfortably. The Bureau of Labor Statistics notes that in an average city an average couple needs a minimum of $3,010 a year for a modest but adequate existence. Such a $500 gap between income and needs looms very large indeed.

What is our goal—what are our objectives? We cannot ignore these crying needs.

Are we to stand idly by and chide our elderly for not putting more aside while they were young? You cannot put aside what you have never had or what you have lost to illness or despair.

Are we to create a national dole with fixed income for all Americans regardless of their contributions to society and the future? That is not our way of doing business.

Or are we to provide a dignified level of existence for all our older people through a partnership of sharing? We can and we must make that effort.

The social security system is the foundation of such a partnership. Based on the theory that workers and employers can, through a program of contributions, create a public "retirement and disability fund," the system attempts to provide income continuation during a participant's lean years. But it is not a complete and useful partnership when it declines participation to those in great need.

As of the beginning of 1964, 82 percent of our men and women aged 65 or over were receiving benefits or would have been able to draw them if they or their spouses had not been working. Of the people turning 65 this year, 91 percent are eligible for benefits under the program.

But there still remain a number of our senior citizens for whom no hope of relief avails. There are those who commenced contributions to the program but who for any number of reasons could not obtain the necessary quarters of coverage. Perhaps they were disabled prior to becoming "insured"; perhaps their occupation was not covered until it was too late for them to get coverage; perhaps through some malfunction of the system they were never entered on the rolls.

I cannot predict the scope of errors and omissions under this law. I do, however, know that there are a number of older people without social security benefits or any private assistance who are in dire need of help.

If we are to have a true social insurance system, then we cannot permit large numbers of our old people to suffer the consequences of legislative and administrative omissions. Therefore, Mr. Chairman, I shall introduce an amendment to H.R. 11865 which would "blanket in" coverage for all those 70 years of age and over who do not presently receive social security.

Within Vermont alone there are 2,500 people 70 years of age or over who are on public assistance but who are not eligible to receive social security retirement pensions. Their plight is serious. They receive not so much as $1 of the $9.3 billion distributed nationally under the social security old-age provisions in 1963. They received not $1 of the $23 million distributed under the old-age provisions in Vermont in 1963. Why? Maybe they made some contributions to the system, but not enough to acquire coverage; perhaps they worked in a field not covered by the program. Perhaps they retired before eligibility. But, whatever the cause, the facts are cold and hard—they are now too old to work, contribute to the system, and receive its benefits. They live from day to day without the benefit of our farthest reaching national program to aid people in their situation.

Mr. Chairman, I have great difficulty trying to tell these people America has not forgotten them. I have great difficulty trying to explain why the law does not provide for them. I have even greater difficulty understanding this patent omission myself.

My amendment would recognize, plainly and simply, that America owes these people something better than poverty and despair. It owes them its thanks and its gratitude for being a part of one of our most creative generations. It owes them its recognition of their lost loved ones and friends in the two World Wars spanning their life. And, it owes them a promise of hope in their twilight years—the promise that they will live free from want, the beneficiaries of a new national awareness.

I do not propose that the present system bear the entire burden of costs. While the contributors to the various trust funds would no doubt be willing to absorb all necessary additional expenses, I propose to remove that weighty choice; I offer instead a plan to finance this expanded coverage out of general revenues. In that way, all of us could join in this tribute to older America.

But, even if this amendment is adopted, we have not met our obligations head-to-head. Assuming all those age 70 and above who are not now eligible for social security were "blanketed-in" for coverage at the minimum benefit level could we honestly say that they were removed from the threat of poverty?

At the present time the minimum benefit level is $40 per month. It doesn't represent much purchasing power in terms of current prices. The average monthly benefit under the old-age provisions of social security is close to $75, but benefit recipients in the lower benefit categories will take little comfort from that fact.

Our whole lower bracket benefit scale is out of tune with reality. Indeed, all benefit levels fail to reflect the elevation of the cost of living over the period since the last adjustment in benefits, but the disparity is most noticeable in the lower brackets where poverty has the greatest inroads.

To partially remedy this unfortunate situation, and to give meaning to my previous amendment, I offer for your consideration a proposal to revise all benefit levels upward. My plan would mean a 10-percent benefit rise for the lowest benefit level with roughly a 5.5-percent rise at the highest levels. The intermediate levels would be proportionately scaled.

In almost every instant this proposal results in a benefit rise in excess of that provided for by the bill which passed the House of Representatives, both in the individual benefits and the maximum family amounts. However, since the greatest increases are at the lower dollar amounts, the additions to the cost of the program are minimized, while more meaningful benefits levels are provided.

I am sorry that the social security system is not in a better financial condition—able to absorb a full transition to a meaningful standard of benefits. But, within the actuarial confines, I feel that my proposal offers a significant addition to meeting the overall objectives of this long-range, far-reaching social insurance program.

Without these amendments, the social security system will never meet its fundamental aim of providing a basic floor against want. But, even if these amendments carry, there are further inequalities to abolish.

For example, as is true in so many of our laws, we take away with one hand what we have just given with the other.

Take the case of one of my constituents. At age 85 he is still running his farm, although he is not in good health. His net farm earnings are quite small. He receives social security payments of $52.20 per month, while his wife receives $18 per month. Last year they paid social security contributions of over $60 based on their farm income. The effect of this transaction was really to require them to pay back most of one month's social security benefits.

Now their farm income was on the order of $1,800. Their total social security receipts were $842.40. They paid no income tax because of their deductions and exemptions. Their total income then was $2,642.40, or some $400 below what some have concluded to be the minimum level of income for an elderly couple as protection against contingent needs. And from that submarginal amount the Federal Government takes a social security contribution of some $60 from an 85-year-old man and his 70-year-old wife to finance his or her retirement, disability or death.

Clearly, here is a point when the philosophy of compulsory social security crashes against the rocks of reason. When the program was initiated, contribution was made mandatory so that those imprudent enough to elect not to be covered while young would not be unfinanced wards of the state while old. But this reason surely will not justify or support the taking of needed living expenses from people in their situation of life. There is a point when this paltry $60 per year represents a form of self-insurance against immediate want.

Mr. Chairman, I shall therefore introduce an amendment which permits a fully insured person, age 65 or over, to choose whether or not his subsequent earnings should be taxed for social security purposes and taken into consideration for recomputations of benefits. Surely, it makes little sense to ask these people to "put something away for a rainy day."

At a time when we are concerned, not only with providing a floor against want for our older citizens, but also attempting to preserve their dignity, it seems incredulous to me that our program penalizes those who desire to work in their later years. Now, of course, to be consonant with its role as a floor of protection, the social security program must not finance the whims and caprices of the elderly of means. But, at the same time, it seems to make little sense to tell an employed person over 65 that he must limit his earnings to $1,200 per year if he hopes to receive the full benefits to which he is otherwise entitled.

Take the situation of a person receiving the minimum monthly benefit of $40 under existing law. Suppose his yearly income from earnings is $1,200; his total income is $1,680 ($40 times 12 plus $1,200). Now, under present law he is told that if he earns over $1,200 per year his benefits will be reduced. What we are saying then, to this man, is that the Congress deems $1,680 per year to be a livable income, any excess above which must come at the expense of his right to collect full social security benefits. Mr. Chairman, the cost of living has increased some 121 percent since benefits first became payable in 1940. The average weekly earnings of production workers in manufacturing has increased 32 percent since the $1,200 earning limitation was imposed in 1954. Over the same period the cost of living index has risen some 14 percent. The time has come to take another look at this problem.

I have long supported proposals raising the earnings limitations. As long as our senior citizens are restricted to $1,200 per year outside earnings, I think we are defeating our purpose. We do not permit them to have a meaningful standard of living with or without social security. They are damned if they work full time and damned if they don't. Yet, over the years these people have made their contributions into the social security system. Look at their situation.

John D. X retires from his executive position at age 65 because of company retirement rules. He was granted stock options while employed which he timely executed. He has an income of $5,000 per month from dividends, with a maximum social security benefit of $114 per month under existing law. His social security benefit will buy one weekend's gas for his yacht.

John D. Y has worked all his life as a printer. At age 65 he elects semi-retirement and commences receiving his social security benefits. However, he continues working 20 hours a week rather than sit home clipping coupons. If his earnings exceed $1,700 per year he will lose all his social security benefits. But his counterpart, John D. X has $5,114 income per month and suffers no

diminution in his social security. It is only when John D. Y reaches age 72 that he can earn in excess of $1,700 without losing his social security. In the meantime, however, John D. X has amassed 60 months of income at a monthly rate three times that of John D. Y's annual income without losing a single penny of social security.

Mr. Chairman, clearly something is amiss. First of all, the annual earnings limitation should be liberalized; secondly, the age after which earnings may be unlimited without an effect on social security payments should be reduced; finally, some review should be made of the role played by passive income in the overall income limitations. I cannot think that the framers of the original Social Security Act meant for social security to be paid to those who have large dividend or interest incomes and not to those who choose to or have to keep working for a living.

Finally, Mr. Chairman, something in the House debate on this measure disturbed me. As the bill now stands, veterans receiving benefits under certain veterans' pensions stand a chance of losing that pension if the additional benefits provided for by this bill put them over a certain income limit.

This provision is equally as senseless as the provision which requires a loss of social security benefits for certain earnings in excess of $1,200 per year. For a $1 increase in social security a veteran could theoretically lose all of a much valued veteran's pension.

Therefore, I shall introduce an amendment to the House bill which would prohibit the inclusion of the increases in benefits provided by the bill from being taken into consideration in the computation of income limitations for veterans' pensions. The amendment further recognizes that this is a stopgap effort and directs the Administrator of Veterans' Affairs to study this problem and make recommendations for permanent legislation to the Congress no later than June 30, 1965.

Mr. Chairman, I realize the pressure of adjournment are great. But, measures of this importance cannot easily be put aside. I hope that you will find time before the close of this session to have the Committee on Finance give careful consideration to these proposals.

STATEMENT OF THE AMERICAN COLLEGE OF RADIOLOGY RE AMENDMENTS 1163 AND 1178 TO H.R. 11865

The members of the American College of Radiology appreciate the opportunity to submit this statement in regard to amendments 1163 and 1178 to H.R. 11865. Members of the American College of Radiology are 6,000 doctors of medicine in the United States who specialize in the use of X-rays and radioactive substance in the diagnosis and treatment of disease and injury.

We are opposed to enactment of either of these amendments, or any other legislation that defines the medical specialty of radiology as a part of services properly rendered by or through hospitals. We are further opposed to legislation that establishes sickness benefits as a part of the social security system to be financed by social security taxation.

We specifically oppose these amendments because:

(1) Enactment of either will adversely affect the care physicians are able to render all patients now, and will gradually destroy the medical specialty of radiology.

(2) Enactment is not necessary and is for many reasons positively undesirable.

If we believed that adoption of either of these amendments would improve medical care, we would support one, or both.

THE PRACTICE OF RADIOLOGY

We have stated that enactment of this proposed legislation will gradually destroy radiology. We will review what radiology is and why we believe as we do.

Training

After completing a 4-year course in medical school and 1 year of internship, a physician is eligible to undertake from 3 to 4 years of additional, concentrated training in a teaching institution in the use of X-rays and radioactive substances in medical diagnosis and treatment. After such training he is eligible to be

examined by the American Board of Radiology, a group of selected, senior specialists in radiology. Approximately three out of four candidates are successful the first time they are examined. Those who do pass are then recognized as radiologists.

But this is only a beginning. To retain abilities, to keep abreast of new developments and to continue to perform radiologic services at a high level of competence, requires two things. First, and foremost, it requires full time application of skills and knowledge to the practice of radiology. Second, it requires a lifetime of continuous study.

From 85 to 90 percent of radiological practice involves making diagnoses based upon radiological examination of patients; from 10 to 15 percent involves treating patients with diseases—principally cancer.

Radiation therapy

Radiation is probably the most used modality in cancer therapy. Approximately 70 percent of all patients with cancer are treated by radiologists. There are other diseases and conditions in which radiation is the treatment of choice. In treating with radiation, adequate equipment is desirable and necessary, but the apparatus is far less important than the competence of the physician using it. The radiologist must decide whether, how and when to treat each individual patient who is referred. The patient's age, sex, physical condition, psychologic state, family situation and the like all have a bearing on the medical decisions that must be made. This is the so-called art of medicine and it has tremendous bearing on whether and how a patient reacts to treatment.

Diagnostic radiology

There is no system of the body that radiologists are not now examining with X-rays and radioisotopes. Diagnostic radiology is the single most important adjunct in the development of modern medical diagnosis. It cuts across all fields of medicine. Radiologists consult with all other physicians.

With refinements of the familiar chest X-ray, we can now identify and differentiate chest conditions: cancer, pneumonia, emphysema, etc., with greater accuracy than in the past. With variations in the common gastrointestinal examination, we now recognize new indications of disease, anomaly and injury. With neurologic and vascular studies, we are now able to predict strokes and recommend prophylactic surgery. Our examinations of the kidney and other organs now allow patients to avoid exploratory surgery that was at one time routine. With cardiovascular studies we can now anticipate heart failure and recommend how to avoid it. With techniques combining fluoroscopy, television, and motion pictures, we can now study and restudy complex problems.

It is to be emphasized that this composite of improvements in old and familiar examinations, plus new knowledge, belongs to men—not machines. An estimated $650 million is invested in equipment in radiologic installations used by radiologists in medical practice. This investment is all but valueless without radiologists who can medically interpret the data these installations will allow trained people to produce.

Radiation protection

Finally, in the essential field of radiation safety and protection, involving as it does the present and future interests of all living matter, radiologists occupy a vital position. Better and safer use of ionizing radiation in agricultural, astrophysical, biological, commercial, and military fields requires medical radiological guidance. Radiologists are the group of physicians whose training and experience enable them to provide such guidance. It is a fact that radiologists have supplied leadership in radiation protection in the United States for over 40 years (via the National Committee on Radiation Protection and Measurements) and have staffed the International Commission on Units and Protection since the 1920's.

EFFECTS OF ENACTMENT ON RADIOLOGY

This has been of necessity an immodest presentation of what is involved in the practice of radiology insofar as patients and the public are concerned. We have had to make such a statement because both amendments under consideration purport to provide social security beneficiaries with hospital benefits, but in so doing include the medical specialty of radiology. The services of other physicians are specifically excluded from these amendments. Under these proposals only a hospital can be designated as a "provider of services" and yet both proposals cover the services we provide patients in the practice of medicine.

The present

The proposed legislation would, we believe, swamp many hospitals with neglected and mildly infirm people over 65; the seriously ill of any age would often find it difficult to obtain a bed. It is reported that in Great Britain and New Zealand, patients who are entitled to beds often wait 6 months to obtain such.

As an example, in Saskatchewan, approximately 95 percent of the population is covered by a compulsory tax-supported Government plan. In Indiana a large proportion of the population is covered by voluntary hospitalization insurance. For those 65 and over, the Saskatchewan hospital admission rate per thousand is reported as 173 percent of the Indiana rate.

Our colleagues in Canada tell us that nonemergency outpatients have had to be refused radiologic examination in Canadian hospitals in order that adequate examination be available to inpatients.

The quality of medical services included in the proposed amendments will unavoidably drop. Departments of radiology in hospitals will be crowded with senior citizens requesting examinations. It is a fact of radiologic practice that demand for X-rays almost always exceeds need. If these radiologic examinations are "free" (as in VA hospitals), the utilization greatly exceeds the actual need.

There are approximately 6,500 radiologists in active practice in the United States today. This is approximately 1 radiologist for each 30,000 patients. These men are all busy—many of them overly busy. As the complexity of examinations has increased, so has the need for a greater number of radiologists to take care of the same volume of practice. Our considerable current efforts in regard to recruitment of physicians into radiological practice are discussed later, but we here assure you that any substantial increase in the volume of radiologic examinations requested will unquestionably and immediately result in a loss of quality of service. It is axiomatic in the practice of medicine that volume is the enemy of quality.

The future

Under the discriminatory provisions of the proposed amendments, radiology, as a medical specialty, will not be able to recruit young physicians. Domination of radiologists by hospitals is inherent in these measures. Under these amendments hospitals would provide our services to patients under contract with the Federal Government. If we become captives of such a scheme, we will not be able to compete for bright young men.

If we cannot attract young physicians into the specialty of radiology, there will be a gradual attrition in numbers—and in quality too—which would seem to assure the demise of this medical specialty. This will adversely affect the services that all physicians are able to render patients.

We already encounter recruitment difficulties which we believe are based upon:

(1) The attack on the professional independence of radiologists by the organized hospital world; and

(2) The threat to radiology posed by the amendments under consideration and similar legislation that has been proposed annually for many years.

In 1962, among 24 specialties listed as offering residency training programs by the American Medical Association, radiology ranked 16th in percentage of residencies filled. In 1963, a year later, among 23 specialties so listed, radiology ranked 17th. Of those ranking below radiology in both years, three—pathology, physical medicine and anesthesiology—are also included as a part of hospitalization in the proposed amendments.

We are trying to eliminate the recruitment difficulty in several ways. We believe that we are gradually escaping from hospital domination of the practice of radiology. In this connection, the trend in radiologist-hospital practice arrangements has been away from salaried employment. In 1939, 37 percent of radiologists practicing in hospitals were on a salary; by 1947 the percentage had dropped to 32 percent; and in 1960 and 1961, the percentage had dropped to 11 percent. In addition, twice as many radiologists now present bills to patients for their services than was true 6 years ago.

We are currently working on a series of films with which to teach medical students, radiologic technologists, and others anatomy and physiology. The principal purpose of these films is to make a positive contribution to medical education, but we hope that they will also tend to excite the interest of medical students in our specialty and that some of these men will then enter radiological training.

From 50 to 60 percent of radiologists are associated with full- or part-time office practice outside the hospital. Some 25 to 35 percent of patients referred to private office radiologists are 65 years of age or older. Many of these offices will close if these patients can obtain "free" radiological service in a hospital. Lacking the possibility of office practice, decreasing numbers of physicians will enter radiology.

The basic problem is that most physicians desire to be free, not employees of hospitals or of the Federal Government. This being true, any medical specialty that is singled out as radiology is in this proposed legislation is disadvantaged insofar as the broad spectrum of medical practice is concerned. That specialty cannot compete for physicians and that specialty will ultimately wither.

GENERAL CONSIDERATIONS

Members of the American College of Radiology would oppose enactment of the proposed amendments even if they were not subjected to special discrimination in the terms of the amendments.

We believe that a definite minority of people over 65 need to have the Federal Government provide hospitalization and medical care benefits to them. It is certain that though there is a substantially larger aged population today than there was in 1952, currently a much larger proportion of the elderly have protection against health care costs under private health insurance or through one of several current Government programs. There were an estimated 8.5 million persons over 65 without such protection in 1952 and this had been reduced to 1.4 million in 1962.

A study by the Health Insurance Institute indicates that, "four out of every five employees * * * have the right to retain their health insurance protection upon retirement, either by conversion to an individual policy or by continuation under a group policy."

All studies indicate that the incomes of aged families have been rising substantially because people now becoming 65 have worked regularly at rising wage levels during the years preceding retirement.

We believe that it would be unwise to seek to solve a declining problem by adoption of a program that would go on in perpetuity.

As we understand it, social security was inaugurated to replace income the individuals no longer earned because of disability or retirement from the work force. The programs proposed under these amendments are not replacement of income, or even cash, but provision of medical and hospital benefits. Unlike other social security benefits, there is no "work test" under which benefits are withheld until the individual retires from the work force. Further, the proposed program deviates from the concept that benefits should be wage related so as to mesh the social security system with the American free enterprise concept. In 1958 the AFL–CIO testifying before the House of Representatives Committee on Ways and Means stated: "We think that it is highly important that this wage-related approach be maintained in our whole social security system." We agree.

In the past the AFL–CIO opposed elimination of the requirement that income be lost before social security benefits be awarded because such elimination would "go counter to the basic purpose of the system which is to replace a part of earned income lost on retirement." We agree.

It is implicit in the philosophy of these amendments that the authors believe that persons upon attaining the age of 65 are no longer capable to manage their own affairs. What is proposed is not provision of additional income to be used as an individual may choose, but rather the provision of benefits that implicitly the individual is not wise enough to obtain for himself. In testimony before the House of Representatives Committee on Ways and Means one of the principal administration proponents of this sort of legislation admitted not trusting the aged to make intelligent decisions on their own behalf.

We are not experts in Federal finance, but we believe that the cost of providing this system has been underestimated and we are aware that social security taxes are scheduled to go up 1 percent in 1966 and another 1 percent in 1968. Further, the wage base is being raised in the principal bill. We are mindful of the needs of the elderly, but we believe that consideration should also be given to the remainder of the population who are raising families and to whom social security taxes are already a significant item in the budget. It seems very strange to us to decrease personal income taxes as has been recently done only to take away any benefits bestowed by such tax cut by raising social security taxes.

Finally, we believe that a positive program to provide medical care and hospitalization to persons over 65 who need help is in being and is capable of providing the benefits needed. We support this program which consists of—

(1) Medical care and hospitalization for all Americans under voluntary insurance, or prepayment programs.

(2) Improvement in local and State programs for the medically indigent, aided when necessary with Federal support via legislation such as the Kerr-Mills bill.

(3) Analysis of operation of voluntary insurance, or prepayment programs, so as to make such more efficient and more useful. (To this end, the college financed a study of hospital and health insurance operations in Maryland.)

(4) Availability of good radiology as a part of insured medical care: (The college has prepared and made available to insurors, labor, and management, a model clause for the provision of insured radiological benefits, and has likewise widely distributed a relative value scale for radiological benefits.)

The plea of the American College of Radiology is that the Congress of the United States not legislatively destroy our medical specialty through enactment of these amendments. We believe that we are currently serving our patients and the public well. We see a bright and exciting future potential for even greater service. We think that patient care and public health will suffer if specialized radiology is erased.

AMERICAN PODIATRY ASSOCIATION,
Washington, D.C., August 12, 1964.

HON. HARRY F. BYRD,
Committee on Finance,
U.S. Senate, Washington, D.C.

DEAR SENATOR BYRD: On behalf of the American Podiatry Association, I respectfully request that this statement concerning the amendments to H.R. 11865 relating to medical care for the aged be considered by your committee and included in the printed record.

The American Podiatry Association is a voluntary nonprofit organization of 52 component societies: 1 in each State, the District of Columbia, Puerto Rico. Podiatrists are licensed to treat our people by medical and surgical means and our colleges are accredited nonprofit institutions which provide a 4-year curriculum following 2 years of prepodiatry college training.

Previous statements presented to the Congress by the American Podiatry Association have emphasized the importance of keeping older people ambulatory. Public health reports stress the need for including the services of podiatrists in medical care for the aged programs. The amendments currently being considered will not insure that these podiatric services will be available to older people. It is therefore urgently recommended that the term "podiatrist" be included in the language of the legislation describing the providers of services.

The other item of deep concern to us is the definition of "inpatient hospital services" in the proposed amendments. The Council on Education of the American Podiatry Association has been approved by the Office of Education as the accrediting body for podiatry colleges and hospitals. The facilities of podiatric hospitals can contribute to this program and should be included along with other approved hospitals.

I urge that careful consideration be given to these recommendations which will provide an essential service in the health care of older people.

Respectfully yours,

SEWARD P. NYMAN, D.S.C.,
Executive Director.

STATEMENT IN SUPPORT OF MEDICARE BY HON. JOHN D. DINGELL, DEMOCRAT, OF MICHIGAN

Mr. Chairman and members of the committee, I am John D. Dingell, the Representative from the 15th Congressional District of Michigan. Thank you for this opportunity to urge you to add the medicare hospital insurance proposal to the pending social security bill. I support the King-Anderson plan. I know it will make a basic change in the social security system, although no more basic than adding disability insurance or death benefits.

All of you know the problem. The Senate Committee on Aging reports that three-fourths of the senior citizens of this Nation do not now have adequate health insurance protection, and that the number of people over 65 who are protected by private insurance may even be declining. Surveys of the Department of Health, Education, and Welfare indicate that private insurance pays less than 15 percent of all health care bills of older people.

This is not too surprising, when you think about it. Perhaps many of the people over the age of 70 in this country did not expect, during their working years, to live as long as they have. Certainly most of them did not expect to be ill as often as they are, or to encounter such expensive medical bills.

I doubt that anyone dreamed 20 or 30 years ago that sickness costs would rise to $40 and $50 a day. Or that hospital visits of older persons would average nearly $800.

It is really no wonder that most older persons are not now well protected against the cost of falling sick. This is the one most unpredictable expense of old age. And, in a real sense, most senior citizens have no way now to protect themselves against major hospital bills.

I consider the Kerr-Mills program inadequate because it is a welfare program, and this to me is not solely a welfare problem. As given effect by the different States, the Kerr-Mills program does not treat all Americans alike. State tax revenues do not provide enough money. Even my own prospering State of Michigan simply could not afford to develop a good Kerr-Mills program.

For 8 years now we have struggled to find answers which would be acceptable to everyone. There have been conferences and parleys and hearings. I think the time has come now for decisions.

I hope you will vote for the senior citizens and for those of us who hope to become senior citizens someday. And if your decision is to compromise now and to start on a small scale, I hope you will reach a meaningful compromise and propose a meaningful start. Thank you.

AMERICAN MEDICAL ASSOCIATION,
Chicago, Ill., August 14, 1964.

Hon. HARRY F. BYRD,
Chairman, Committee on Finance,
U.S. Senate, Washington, D.C.

DEAR SENATOR BYRD: It has been brought to the attention of this association that on August 11, representatives of the American Optometric Association recommended for your committee's consideration the addition of an amendment to H.R. 11865 (the Social Security Amendments of 1964), which is presently pending before your committee. In essence, this amendment would provide that any individual entitled to benefits under title I, IV, V, XIV, or XVI of the Social Security Act would be eligible to have payment made in his behalf for services provided by an optometrist. These services would be paid for at the same rate as would similar services rendered by "any other duly licensed practitioner." In other words, the services of an optometrist would be equated with those of a medical doctor who has undertaken postgraduate training in the care of diseases of and injuries to the eye.

The American Medical Association does not believe that this proposal is in the public interest.

In addition to urging the rejection of the proposed amendment, the American Medical Association recommends that title X, section 1002(a)(10), and title XVI, section 1602(a)(12) of the social security law be amended by deleting from those subsections the words "or by an optometrist, whichever". These subsections authorize the determination of blindness by an optometrist.

The determination of blindness is a diagnostic procedure. Diagnosis, as much as medical therapy, requires medical training. Such training is not necessary to qualify one to perform refractive tests, nor is it always necessary to qualify one to prescribe satisfactory glasses. However, complete medical training is required to qualify one to determine the need for medical treatment, to diagnose, and to assume the responsibility for detecting or determining the presence or absence of diseases.

The granting to optometrists of the right to make examinations to determine blindness may result in a failure to ascertain the cause of blindness and thus prevent the administration of necessary medical rehabilitative care. Unfor-

tunately, in too many cases proper treatment has been delayed or possible rehabilitation or cure denied because of diagnoses rendered by others not qualified as medical practitioners. On the other hand, the medical skills possessed by physicians have resulted in the detection and successful treatment of the organic and systemic causes of blindness.

During the debate in the House of Representatives on H.R. 10606, 87th Congress, which provided for amendments to the public assistance provisions of the social security law, it was brought out that the Department of Health, Education, and Welfare has since 1950 been in accord with the position of the American Medical Association that only medical doctors are qualified to determine whether an individual is blind.

In view of the above medical facts and the departmental support, it is this association's sincere hope that your committee will give favorable consideration to our proposed amendments.

I will appreciate your making this letter part of the record of your hearing.

Sincerely yours,

F. J. L. BLASINGAME, M.D.

(Whereupon, at 3:20 p.m., the committee recessed, to reconvene at 10 a.m., Friday, August 14, 1964.)

SOCIAL SECURITY; MEDICAL CARE FOR THE AGED AMENDMENTS

FRIDAY, AUGUST 14, 1964

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

The committee met, pursuant to recess, at 10:10 a.m., in room 2221, New Senate Office Building, Senator Herman E. Talmadge presiding.

Present: Senators Byrd (chairman), Long, Smathers, Talmadge, McCarthy, Ribicoff, Williams, Bennett, and Curtis.

Also present: Elizabeth B. Springer, chief clerk; and Fred Arner and Helen Livingston, of the Education and Public Welfare Division, Legislative Reference Service, Library of Congress.

The CHAIRMAN. The committee will come to order.

In the questioning of administration witnesses as the beginning of these hearings, a question was asked as to what would be the maximum tax on the self-employed farmer in 1971 under the Gore amendment 1178. The spokesman's answer was that the total under the Gore amendment would be $421.20 as contrasted to $388.80 under existing law. However, an integral part of the Gore amendment is the assumption that if earning levels rise, as they undoubtedly will, the social security wage base ($4,800 today) will have to be increased after 1965 above the $5,400 wage base provided in the Gore amendment. Thus, as shown by the correspondence from the Chief actuary of the Social Security Administration, Robert J. Myers, which I place in the record, the tax on a self-employed farmer, keeping the Gore amendment actuarially sound under its own assumptions, would have to be as follows:

Year	Tax	Maximum taxable earnings base
1971	$503.10	$6,450
1975	566.30	7,260
1980	656.00	8,410

Let me state again the amount of tax which the self-employed farmer pays under existing law for 1964 is $388 on a maximum taxable wage base of $4,800. This assumes no change in the social security tax rates.

(The letter from Mr. Myers follows:)

DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE,
SOCIAL SECURITY ADMINISTRATION,
Washington, D.C., August 13, 1964.

Hon. HARRY F. BYRD,
U.S. Senate,
Washington, D.C.

DEAR SENATOR BYRD: Secretary Celebrezze has asked me to reply to your letter of August 10, requesting information about the social security taxes that a self-employed farmer would pay in certain future years under H.R. 11865, as passed by the House of Representatives, and under the Gore amendment (Amendment No. 1178), since your questions are of a technical and actuarial nature.

As you indicate in your letter, the figures that we gave at the hearings on August 7 as to what a self-employed farmer would be paying in social security taxes in 1971 under the House bill and under the Gore amendment were calculated upon the earnings base of $5,400—as contained in both the bill and the amendment.

Let me first discuss the situation under H.R. 11865 (that is without any hospitalization or related benefits). The financial provisions of H.R. 11865 are based on actuarial estimates using the level wage assumptions that have been customary in estimates for this program. The $388.80 figure which we gave at the hearings as the amount payable at the maximum by the self-employed person is what is necessary under the policy of charging the self-employed 1½ times the employee rate if wages remain level and no changes are made in the program. If, on the other hand, it is assumed that earnings levels rise on the average at the rate of 3 percent per year from 1965 to 1971, which seems a reasonable rising-earnings assumption, the benefit provisions of the House bill could be financed with a lower contribution rate than is provided in the bill for 1971 and thereafter. In fact, under these assumptions a rate in 1971 and thereafter of 4.6 percent on the employer and a like amount on the employee, with the self-employed paying 6.9 percent, would be sufficient—instead of the provisions of the House bill, which set the rates in 1971 and thereafter at 4.8 percent and 7.2 percent, respectively. Thus, under this assumption, a contribution by a self-employed person with the maximum taxable earnings ($5,400) in 1971 of $372.60 would be sufficient, rather than the $388.80 which results under the House bill and which we referred to in our testimony on August 7.

I would like to point out, however, that although projecting an increase in earnings at 3 percent per year has the result indicated above if no changes are made in the benefit provisions of the law, it seems to me undesirable to base the financing of the program on the assumption that earnings rise, but the law is not changed to reflect these changes in earnings levels. It seems to me more reasonable to assume that, if earnings increase at an average rate of 3 percent per year from 1965 to 1971, then both the earnings base and the benefits of the program will be more or less kept up to date with the rise in the earnings level. If this is done, assuming a continuation of the 3 percent average annual increase in earnings levels after 1971 also, the earnings base would be $6,450 in 1971, $7,260 in 1975, and $8,410 in 1980.

Under these circumstances, it would be possible to provide for across-the-board increases in the cash benefits as a result of the saving to the system (from the higher earnings level and from the higher earnings base) without any increase in the contribution rates provided in the House bill. Under the assumptions given, the general benefit increase that could be provided in 1971 would be 8 percent, while in 1975 it would be 12 percent (as contrasted with the 1965 benefit level), and in 1980 it would be 20 percent. The higher benefits for workers who earn more than the $5,400 base in H.R. 11865 which arise from crediting additional earnings for benefit purposes would also be fully financed under these assumptions.

If the earnings base and the cash benefits are kept up to date in the future as described above, then the dollar amounts of the contributions of self-employed persons would, of course, be higher than would result under the present House bill under a continuation of the policy that sets their contribution rate at approximately 1½ times the employee rate. Under these circumstances, the 7.2 percent self-employed contribution rate in the House bill when applied to the higher earnings bases would result, at the maximum, in the following contributions for self-employed persons: $464.40 on the $6,450 base; $522.70 on the $7,260 base; and $605.50 on the $8,410 base, as compared with $388.80 on a $5,400 base.

I will now proceed to discuss the situation under the Gore amendment. If under conditions of an average increase in earnings of 3 percent per year, the earnings base is kept up to date as indicated above, and if the self-employed contribution rate remains at the 7.8 percent provided in the Gore amendment, then the maximum amounts payable by the self-employed would become $503.10 on the $6,450 base, $566.30 on the $7,260 base, and $656 on the $8,410 base—or annual increases for the maximum earnings category as a result of the addition of hospital insurance of $38.70, $43.60, and $50.50, respectively. It is significant to note, however, that these higher payments would not be any more of a burden when measured as a percentage of earnings than those provided by the Gore amendment, since the changes in the earnings base keep constant the proportion of total earnings taxed for social security purposes.

The changes described above would keep the hospital and related benefits financed on an actuarially sound basis and would, as indicated, allow for substantial increases in the cash benefits. For example, the maximum primary benefit that would be payable under these circumstances to the person paying regularly at these maximum tax rates would be $175.10 per month on the basis of the earnings base established in 1971, $197.80 on the 1975 base, and $236.30 on the 1980 base—as compared with $143.40 under H.R. 11865.

It follows from this discussion of possible increases in the cash benefits that, desirable as it might be, it would not be necessary to raise the earnings base to the levels indicated solely for the purpose of financing, on a sound actuarial basis, the combined benefit provisions of H.R. 11865 and the Gore amendment. I estimate that, if no changes are made in the law after the adoption of the Gore amendment, and if earnings rise on the average at the rate of 3 percent per year, the overall contribution rates would be sufficient to maintain both parts of the system on an actuarially sound basis for many years without any increase in the earnings base. Although employers, employees, and the self-employed would not have to pay higher contribution rates under these assumptions, it would be necessary to allocate a larger portion of the income of the program to the hospital insurance trust fund (that is, larger than the allocation of 0.80 percent of taxable wages in the Gore amendment), with a consequent reduction in the amount of benefit increases that could be provided in the cash-benefits portion of the program.

Alternatively, the earnings base might be increased somewhat, but not sufficiently to keep the program fully up to date. Under these circumstances, the hospital insurance program could be maintained on an actuarially sound basis by increasing its allocation (from part of the gains to the cash-benefits portion of the program), and the benefit increases could be made somewhat larger than if the earnings base were not increased—but not as large, of course, as indicated in the previous discussion of H.R. 11865 without hospital insurance.

It should be noted that the entire foregoing discussion is based on the premise that the actuarial experience for all other cost factors than the earnings level will follow the assumptions made. Of course, actual experience with respect thereto could be more favorable or less favorable than the assumptions.

In summary, the answer to your question in relation to the Gore amendment as to the "* * * maximum amount of tax a self-employed farmer would have to pay in 1971, 1975, and 1980, based upon (your) most realistic estimate as to what the earnings level will be at those times and, correspondingly, what wage base would be required for actuarial soundness" is that for many years the amount could be the same as provided by the Gore amendment—that is, $421.20—if the savings to the system that arises from the increased earnings level are entirely allocated to the hospital insurance program, rather than to increases in cash benefits.

It seems to me, however, that although increases in the earnings base are not needed under these circumstances solely in order to maintain the hospital insurance program on an actuarially sound basis, such increases in the earnings base under conditions of rising earnings are necessary to maintain the cash benefits in a reasonable relationship to the earnings of persons covered by the program. I believe, therefore, that under the assumption of an increase in the average level of earnings of 3 percent per year, it is reasonable to assume that there will be increases in the earnings base and in benefit levels which will be approximately sufficient to keep the cash benefits program up to date. Under these circumstances, the hospital insurance program would be maintained automatically on an actuarially sound basis without using for it any of the net advantage which arises to the cash-benefits portion of the system from increased earn-

ings and, therefore, without changing the allocation to the hospital insurance trust fund of 0.80 percent of taxable wages provided in the Gore amendment.

Sincerely yours,

ROBERT J. MYERS, *Chief Actuary.*

Senator TALMADGE (presiding). I am sorry we don't have more members of the committee present but we are trying to complete the Senate's business next week and virtually every committee is meeting at the present time, and the Senate is in session also.

The first witness is Mr. Roy D. Simon, National Association of Life Underwriters.

STATEMENT OF ROY D. SIMON, CHAIRMAN, COMMITTEE ON SOCIAL SECURITY OF THE NATIONAL ASSOCIATION OF LIFE UNDERWRITERS

Mr. SIMON. I am Roy D. Simon of Chicago, Ill., and I am the chairman of the Committee on Social Security of the National Association of Life Underwriters, and also a member of the association's board of trustees.

I have with me this morning Mr. Dave Pattirson, counsel, and Mr. Robert Turner, director of health insurance activities.

My organization is a trade association composed of 50 State and 845 local life underwriter associations with an aggregate membership of 85,000 individuals, principally life insurance agents, general agents, and managers. Most of these individual members sell health insurance as well as life insurance.

My purpose in appearing before your committee today is to acquaint you with my association's views with respect to both the issue of social security-financed health care for the aged and H.R. 11865, which was recently passed by the House of Representatives.

H. Lewis Rietz, the witness for the American Life Convention, the Health Insurance Association of America, the Life Insurance Association of America, and the Life Insurers Conference, has outlined for your committee yesterday the tremendous progress that has already been made in providing health care for the aged, both by the private insurers, in the case of those individuals who are able to buy their own health insurance, and by existing Government plans, in the case of those individuals who lack the resources to meet the cost of their health care needs.

We will not burden the record of these hearings with repetitious testimony on these points, but we would like the record to show that we associate ourselves with and support Mr. Rietz' statements regarding them.

I also want to make it abundantly clear that my association is, of course, in favor of Government-financed health care for those aged individuals who, for one reason or another, are unable to meet the costs of their own health care needs.

We have, for example, long supported the Kerr-Mills program and will, through our affiliated State and local associations, continue to work for its implementation and improvement at the State level. It is our belief that tax funds can be most equitably and effectively used in a program of this type, which is directed at helping only those aged who are truly in need.

By the same token, we are opposed to any measure, such as the King-Anderson bill (S. 880, H.R. 3920), that would exact additional taxes from the younger, working population—many of whom are often more financially hard-pressed than many individuals over 65—to provide health care benefits to all aged individuals irrespective of their ability to finance their health care costs.

In this connection, we call to the attention of your committee that the Department of Health, Education, and Welfare estimates that, as of January 1, 1965, when the King-Anderson program would become effective, there will be 15¾ million people aged 65 and over who will be receiving or eligible to receive cash social security or railroad retirement benefits and who would therefore also be eligible for the King-Anderson health care benefits.

The Department of HEW further estimates that among these 15¾ million people will be between 1½ and 2 million who, because of their own or their spouses' continued employment and earnings, will not be entitled to receive cash benefits but who would nevertheless be entitled to receive the benefits of the King-Anderson program.

In addition, there will be included among the 15¾ million potential King-Anderson beneficiaries just referred to an undetermined number who will be receiving both full cash social security or railroad retirement benefits and income from other sources such as pension plans, insurance, savings, investments, and the like.

In short, the King-Anderson bill would increase the already substantial social security taxes paid by the younger workers and their employers to provide for an extremely large group of aged individuals health care benefits for which such individuals are completely capable of paying on their own.

I would now like to comment briefly upon the costs of the King-Anderson program, as estimated by the Department of HEW, without expressing any opinions as to the validity of these cost estimates.

Over the years, HEW's estimates have proved to be very mercurial, to say the least.

For example, when the King-Anderson bill was first introduced in the 87th Congress, HEW estimated that it could be financed by increasing the combined employer-employee social security tax rates by one-half of 1 percent, and by raising the taxable earnings base from $4,800 to $5,000.

Later, HEW revised its estimates to show that while the proposed tax rate increase of one-half of 1 percent would still be adequate, it would be necessary to raise the earnings base to $5,200, as is provided in the present version of the King-Anderson bill.

During the current hearings, however, your committee has been told by the HEW representatives that sound financing of the King-Anderson program, if added to H.R. 11865, would require either that the employer-employee tax rate be increased by eight-tenths of 1 percent and the earnings base to $5,400 or that the tax rate be increased by four-tenths of 1 percent and the earnings base to $6,600.

Now, it has already been brought out at these hearings that even under H.R. 11865, as passed by the House of Representatives, the social security taxes paid by many gainfully employed people would, in a very short time, be greater than their Federal income taxes.

Obviously, therefore, the number of people in this category would be enormously increased if H.R. 11865 were amended to include the provisions of the King-Anderson bill.

For example, if such a combined bill were enacted and provided for an earnings base of $5,400, the ultimate maximum social security tax rate paid by a self-employed person would be 7.8 percent. Thus, such an individual with earnings of $5,400 per year would pay a social security tax of $421.

On the other hand, assuming that he had a wife and two children, filed a joint return, and took the optional standard deduction, his Federal income tax would be only $354.

Moreover, it is of the utmost importance that your committee clearly recognize that HEW's above assumptions with respect to the increases in tax rates and the earnings base necessary to finance the King-Anderson program—even if accurate for the time being—would not be fixed for all time.

Rather, the HEW admittedly bases its estimates on the further assumption that the tax rates or the earnings base, or both, would be adjusted upward from time to time in the future as the cost of health care increased.

In addition, the HEW's present cost estimates do not and, of course, cannot take into account the still further increased costs that would result from the virtually inevitable expansion and liberalization of the King-Anderson program that would follow its initial enactment.

In summary, we oppose enactment of the King-Anderson bill or similar legislation either as an addition to or a substitute for H.R. 11865 for the reasons that the proposed health care program (1) is unnecessary and would deter and even tend to destroy the remarkable progress made thus far by private insurers and existing public programs in meeting the health care needs of the aged; (2) would superimpose upon the already heavy cost of the existing social security program an additional substantial and, indeed, unpredictably high financial burden; and (3) by materially increasing the social security taxes paid by the gainfully employed, impair both the incentive and the financial ability of such individuals to provide for their own economic security through private programs.

In conclusion, while I have thus far directed all of my remarks to legislation of the King-Anderson type, I want to make it clear beyond peradventure that my association is equally opposed to any form of Government program—not matter how watered down it might initially be—that would provide health care benefits to aged individuals irrespective of their ability to finance their own health care needs.

The past history of the existing social security cash benefits system furnishes the clearest possible evidence that once established, even in the most diluted form, the principle of social security-financed health care for the aged would inexorably and inevitably be expanded into a full-blown and comprehensive program.

In regard to H.R. 11865, although the social security program is intended to provide covered workers and their families with only a basic floor of economic protection to be supplemented by private thrift, millions of the citizens of this country have come to look upon the program as at least a principal source of economic security.

Thus, we feel that the primary obligation of Congress toward these present and future social security beneficiaries must be to take all

steps necessary to assure that the financial condition of the program is completely sound at all times. Therefore, we are disappointed that H.R. 11865 gives only token recognition to strengthening the financial condition of the overall program and provides that the lion's share of the increased social security taxes to be raised by the bill will be used to finance increases in benefits for existing as well as future beneficiaries.

As a result, the bill would reduce the actuarial imbalance of the overall program from the presently estimated 0.24 percent of covered payroll to only 0.20 percent.

Of course, we realize that an actuarial imbalance of this magnitude has long been viewed by Congress as acceptable. Be that as it may, however, we do feel constrained to call to your committee's attention that the projecting of the long-range actuarial balance of the program is not the most exact science in the world and that estimates thereof have, in the past, occasionally varied substantially even within very short periods of time and in the absence of any changes in the Social Security Act itself.

For example, according to the report of the House Ways and Means Committee (p. 20), which accompanied H.R. 11865, it was estimated that the program was out of balance by only 0.10 percent of covered payroll immediately following enactment of the Social Security Amendments of 1952.

In 1954, however—just 2 years later—revised estimates indicated that the lack of balance under the 1952 act had grown to 0.57 percent of payroll. In enacting the 1954 act, Congress has to increase taxes sufficiently to bring about a substantial reduction in this imbalance.

Again, immediately following passage of the 1956 act, the actuarial imbalance was estimated at 0.13 percent, whereas in 1958 it was discovered that the imbalance had increased to 0.42 percent. In enacting the 1958 act, Congress felt obliged once more to take corrective action.

In the circumstances, we recommend that your committee and Congress take action this year to amend H.R. 11865 to the end that the increased taxes to be generated by the bill will be applied to eliminate completely at least the presently estimated actuarial imbalance of the program rather than to increase benefits, as the bill now provides.

We understand from HEW that the tax rate increases now provided in H.R. 11865 would be sufficient for this purpose without any change in the present $4,800 earnings base. And we would therefore further recommend that the $4,800 base be left alone. We make this recommendation for two reasons.

First of all, since the program benefits all covered social security taxpayers, the burden of keeping the program sound should be shared equally by all of these taxpayers and not simply by those who earn in excess of $4,800 per year.

Second, if the wage base is increased to $5,400, this will necessarily result in increased future benefits to the better-paid workers (and their families)—and only to them—even though these individuals are in much less need of Government benefits and are much better able to provide for their own economic security than their lower paid fellow men.

In closing, I want to express to you my deep appreciation for having been permitted to appear before your committee to express the

views of my association on these important issues. If we can be of further service to you, we hope that you will feel free to call upon us.

Senator LONG (presiding). I have made the statement on occasion that it seemed to me that the cheapest insurance anyone can have is self-insurance, with regard to risks that the person can afford to take.

For example, very few people try to insure themselves against the danger of a common cold or some minor illness because it is cheaper just to pay their medical expenses when they incur it.

I take it that from your statement you feel that there would be a lot of things that the Government would not have insurance to apply to where the person is well able to look after himself.

Mr. SIMON. I believe that is correct, sir.

Senator LONG. You are talking about the cost of this. When I computed the costs, I believe the estimates showed that for everybody's health care, it is going to cost about 4 percent of payroll and I have never been able to look upon the King-Anderson proposition as anything but putting the foot in the door.

I want to ask you if you share my view that once this thing starts, sooner or later we will be insuring everybody's health and taking payroll taxes to pay for it.

Mr. SIMON. This has been the indication based on the past history of social legislation of this type.

Senator LONG. It is hard for me to see how we would be justified in taking care of one man's medical expenses if he is in the hospital for 2 weeks although he is well able to pay for it himself, and decline to look after some younger person who might be laid up for a year and who might really need assistance.

Once you start it seems to me as though you are going to have to extend it to a great number of other people. I don't see how you are going to stop that.

Mr. SIMON. I believe I share your fears.

Senator LONG. Senator Smathers?

Senator SMATHERS. Mr. Simon, you mentioned the fact that the insurance industry is doing a great deal toward making it possible for people to insure themselves. What specifically has the insurance industry done in the last 2 years to make it possible for people to insure themselves?

Has it cost—has the cost of insurance gone down and the coverage been extended?

Mr. SIMON. As to whether the cost has changed, Senator, I don't feel competent to answer that because there are many variables involved and I doubt very much that costs are going to go down in the face of increasing costs of the services for which people are being insured.

Senator SMATHERS. How do you say then that it is possible, more easily for people, for elderly people, to get insurance if the cost of it is not going down?

Mr. SIMON. The availability of it is substantially increased. If we go back just a very short time, you would find that many people 65 and over who wanted to get any sort of hospitalization or health insprance would find that there was nothing available.

In the last few years there have been——

Senator SMATHERS. By that you mean not available at any price?

Mr. SIMON. At any price.

There was no coverage being written for this risk.

Senator SMATHERS. Right.

Mr. SIMON. Today there have been, as you will find outlined much better in Mr. Rietz' testimony yesterday, and the reason that we did not elaborate on it.

For instance, there is open enrollment periods by several companies, no medical questions asked. There are certain times when they will come out and say anyone 65 and over may have this coverage simply by signing his name and paying the current premiums.

Senator SMATHERS. Let me say this, I am for the insurance industry, I want to see them stay alive but what I am interested in frankly and briefly is whether or not it is a fact in this field of health coverage they have made it possible for elderly people with very modest means to buy an insurance policy which will cover them in their illnesses after they reach age 65 or look after them in a nursing home, and so forth. Is there such a policy available?

Mr. SIMON. There are such policies available, Senator.

Senator LONG. What is the cost of such a policy?

Mr. SIMON. I would be glad to supply this information for you, I do not have it.

Senator LONG. It is not a fact that the cost is very high? Is it not a fact that it runs in the neighborhood of some roughly $1,200 to $1,500 a year, something like that?

Mr. SIMON. Oh, no, sir.

Senator LONG. What does it cost?

Mr. SIMON. I would make a guess that such a contract would be available, and this is a guess, please, I do not have rate figures with me, but I believe a good coverage would be available for something in the neighborhood of $20 or $25 a month.

Senator LONG. $20 or $25 a month?

Mr. SIMON. About $250 to $300 a year.

Senator LONG. All right.

Mr. SIMON. This is without regard to evidence of whether the person is or is not a good risk.

Senator LONG. All right.

Well, secondly, do you recognize that there are some people in the elderly aged group who really don't have $300 extra a year, too, which they can put into this insurance policy?

You recognize there are a number of people like that?

Mr. SIMON. Yes, sir.

Senator LONG. What do we do with those people?

Mr. SIMON. As we have indicated we are very much in favor of the Government giving assistance to the people who are not able to meet their own health needs from a financial standpoint.

Senator LONG. In other words, what you are saying is that you do favor the Kerr-Mills bill?

Mr. SIMON. Yes, sir, we have specifically mentioned this. Our association, our State associations are active with the State legislatures in the implementation of the Kerr-Mills program.

Senator LONG. Do you have any idea how much the Kerr-Mills bill is going to finally cost?

Mr. SIMON. No, sir.

Senator LONG. Do you think that it is a sounder fiscal program to have the Government reach into the Treasury and take money out of it and pay all of certain people's medical and health bills or do you think it is a sounder program to have them save along the way during their working years to provide for their own health care when they get to be 65?

Mr. SIMON. I think we have two separate points involved here. We have the problem of the some 18 million people who in 1965 will be over 65 years of age, who have not had any particular method for doing this other than in those rare instances and I say rare because percentagewise I believe it is quite small, that they have a continuing hospitalization program from either a group employment contract or from something which they purchased a few years ago, which is still in effect, so that this is one phase of the problem, what do we do with the people who are already there who can't provide.

The other is the people who are now under 65, who are now the employed group, and the number of people who are covered today on some form of health insurance, the percentage of them, is quite high.

I don't happen to have the exact figure with me but I think you are familiar with the fact that the difference between this today and 20 years ago is fantastic.

Senator LONG. Can you get us those figures?

Mr. SIMON. Yes, sir.

Senator LONG. Mr. Chairman, I ask that they be made a part of the record because there is a lot of conflict as to the testimony, within the testimony, as to how many people in fact are covered.

Let me ask you just to get on with this and I won't delay you much longer.

(Mr. Simon subsequently advised as follows: "The figure with which I am familiar is that 60 percent of persons over age 65 have some form of health insurance. This is about 10½ million aged persons. I believe you will find the components of this figure in Mr. Reitz' statement before the committee on Thursday, August 13th.")

Senator LONG. You recognize that under Kerr-Mills which I have supported and in the absence of anything new I expect to continue supporting, that there is no limit with respect to how much the Kerr-Mills bill can provide as to medical care, doctor's bills, nursing bills, drug bills, everything else?

Mr. SIMON. The Federal law is completely——

Senator LONG. Wide open.

Mr. SIMON. Completely unrestricted.

Senator LONG. It is left to the States to set the standards. You have been around long enough to know what that often results in. When each State legislator begins to run for the State legislature he is going to say to the old people, "As far as I am concerned, I am going to run on a platform that in this State we are going to provide that every person who has an income of less than $5,000 a year, is entitled to free medical care under the Kerr-Mills bill."

His opponents will come along and say, "Well, I am going to outdo him. I am going to recommend that anybody who has got an income of $6,000 or less will get free medical care and attention."

And the first thing you know it is going to increase, do you not fear, to $8,000 or $10,000. How much do you think that will cost the

Federal Government, money taken right out of the Treasury? What do you think that will amount to?

Do you favor that type of program?

Mr. SIMON. This could happen, Senator, except that there is a practical checkrein on this in a number of cases in that the States must provide their share of any such Pandora's box.

Senator LONG. Is it not true that in some States they will only provide 20 percent?

Mr. SIMON. This I understand is the case. Those are the States where it may be more difficult for them to provide the 20 percent than for some of the other States to provide 50.

Senator LONG. Looking at it just as a fiscal matter rather than as a social matter, what do you feel is the most conservative approach to it fiscally? Might it involve the requirement that every employee begin to put aside certain money when he is 25 years old, 26 years old, and his employer put aside as he goes on up so that when that day comes when he is 65 there is some money to take care of his health needs? Is that in your judgment sounder fiscally or is it the other approach which is sounder, where they make no provision for themselves during their working and productive years but the U.S. Treasury and other people reach into their pockets and say, "Here, we take care of you for everything you want after you get to be 65"?

Fiscally speaking, not socially, which approach do you think is the sounder?

Mr. SIMON. Before giving you the specific on that, I would like to call to your attention the fact as I have mentioned that a very substantial percentage of the working population today have some sort of health insurance protection for hospitalization, in many cases for income, through commercial sources.

Senator LONG. You favor their saving when they are working and young in order to provide for themselves when they are older. That is what you are saying.

Mr. SIMON. Yes, sir.

Senator LONG. By private insurance?

But you don't go so far as to say that everybody should be, in effect, required to save.

Mr. SIMON. I would much prefer the present route, because I think that it would work out——

Senator LONG. Being the spokesman for the underwriters you should, but I just wondered as a fiscal matter which way you thought.

Remember I am still on the Kerr-Mills side, but as a matter of just fiscal soundness——

Mr. SIMON. If this auction, as you describe it, of the benefits, were to take place, and become widespread, then either Federal law would have to be amended to observe prudent checks on this needs clause in the law or the States would have to come up with a tremendous amount of money to meet their promises, and what we really see as a possibility——

Senator LONG. I want to ask you one other question and let you go.

In your experience around here in Washington have you ever seem a time when the Federal Government has tightened down on a program of this matter?

Mr. SIMON. I think I mentioned earlier that the history of social legislature never rolls backwards.

Senator LONG. That is all. I just wanted to give him time to express a few views.

Senator BENNETT. Mr. Chairman, I should like to offer for the record a statement dated August 3 from the Blue Cross of northeastern Ohio showing a case of an 81-year-old woman where $26,110.31 was paid for over 2 years' hospitalization.

Under the King-Anderson proposal, she would have received $3,130 and her family would have had to dig up the remaining $23,000.

I would like to offer the complete statement for the record.

Senator LONG. Do you want it printed in the record?

Senator BENNETT. Yes.

(The information referred to follows:)

[From Public Relations Department, Blue Cross of Northeast Ohio, Cleveland, Ohio, Aug. 3, 1964]

Payment of a subscriber's hospital bill for services worth more than $26,000 was reported today by Blue Cross of Northeast Ohio.

The payment is the largest ever in the 30-year history of BCNO and is believed to be one of the largest ever paid nationally for any one person's hospital care.

John R. Mannix, executive vice president of BCNO, estimated that at current rates, the $26,110.31 payment is equal to subscription fees for more than 99 years for the service held by the subscriber.

The huge payment covered hospital services received during a 2-year stay by an 81-year-old woman patient who was suffering from heart and kidney ailments and cancer. She was protected under a group Blue Cross 730-day extended benefit contract. The patient who was treated at a northeast Ohio hospital not in Cleveland has since died.

Although her 730 days of coverage had been used up during her stay, full benefits would have been restored if the woman had remained out of the hospital for 180 days.

Mr. Mannix pointed out that if the woman had been covered under the broadest provisions contemplated in the King-Anderson bill she would have paid a $90 deductible amount followed by a Government payment of $3,130. The remaining expense of nearly $23,000 would have fallen entirely on the patient and her family.

The payment was one of two unusual bills which have been processed recently at Blue Cross. In another case at the other end of the age spectrum payment of nearly $10,000 was made for the care of an infant who was hospitalized for the first 323 days of his life.

"Most people are aware that older persons use much more hospital care than the average, but it is often overlooked that infants receive considerable care." Mannix said.

"While the care received in this instance was considerably above the average for newborns, the large payment illustrates the importance of a community program which provides coverage for young and old alike regardless of age.

"It is not uncommon," Mannix said, "for insurance programs to begin for infants only after the 15th or 30th day of life; such a procedure in this case, with a hospital bill of $9,836.74, would have meant financial ruin for the baby's parents."

Doctor's charges of $600 for inhospital medical services were paid in full by Medical Mutual of Cleveland, Inc., the Blue Shield plan in northeast Ohio. Blue Shield also paid $120 for delivery and anesthesia charges.

The baby's father employed by one of the automakers holds a contract which provides 365 days of hospital service. The benefits of this contract renew in full after 90 days.

Senator SMATHERS. Does it show how much she paid for that particular policy?

Senator BENNETT. It does indirectly by saying the payment she received was the equivalent of 99 years of premiums.

Senator SMATHERS. You are a great mathematician. What does that figure out to?

Senator BENNETT. $26,000, if you will let me call it a hundred years, then $26,000 represented about $260 a year for which she paid, I don't know how long she paid it, and then the statement says that after 180 days under her contract she could have gone back for 730 days more.

Senator LONG. They had better be careful how many risks they take like that or they will go broke.

Senator BENNETT. So there is the Government.

Senator CURTIS. Mr. Chairman, I will be very brief.

Following the questioning of the distinguished Senator from Florida, he didn't suggest it, but the thought came to me that individuals reading the record might think of a compulsory Government plan where individuals in early and middle life would be taxed for hospital-medical benefits.

Based upon the experience in social security you wouldn't have a case of an individual putting in his own money and having it build up for old age, would you?

Mr. SIMON. No, sir. The whole concept is a tax.

Senator CURTIS. Yes.

One of the most difficult problems in social security has come about by the misuse of words.

It is not insurance, it is a tax taxing the producers now to pay benefits to people who already are old. The individuals who are drawing benefits have paid just a tiny token part of what they draw out, and it is not a self-prepaid system at all so far as the present benefits are concerned, isn't that true?

Mr. SIMON. It surely is not.

Senator CURTIS. It is a tax, people would be in trouble if they did not pay it. If the employer does not pay it, they will sell out his business. It is not earmarked but it is used currently to pay the benefits of the present beneficiaries, isn't that right?

Mr. SIMON. Correct; it is a payroll tax.

Senator CURTIS. And if there is a well-to-do person over 65 receiving social security benefits he is receiving it because all the people, including those who are of modest means and they are buying homes and raising youngsters, are paying a tax to send him his Government check, isn't that right?

Mr. SIMON. Yes, sir.

Senator CURTIS. And some of this misunderstanding has been accidental, some of it has been deliberate on the part of Government socialistic planners, they have fooled the people and they have called social security an insurance and it isn't at all.

I would like to say while I have some insurance agents before me that I think a problem that ought to have attention of the underwriters of the country, it has to do with people who carry a hospital insurance policy that was written 10, 15, or 20 or more years ago.

The individual may feel they have protection; the cost of hospitalization has gone up so much that when they have to turn to that policy, they are going to find it doesn't meet their needs.

They are going to be, some of them, agitating a Government plan that might be unsound, and they may turn against the voluntary private system, and I think the insurance agents have a responsibility there to call on these present policyholders and if they have a policy that they took years ago that would pay them $5 a day for hospitaliza-

tion, explain to them that it wouldn't amount to anything, isn't that right?

Mr. SIMON. You are so correct, Senator, and this is something that we believe our 85,000 member agents are giving attention to.

Senator CURTIS. But I run into, right along, individuals who say, "I have a hospital insurance policy. Would you please read it?"

I read it and it isn't worth very much at all.

Mr. SIMON. Of course, unfortunately——

Senator CURTIS. Because the costs have gone up.

Now, it is true some may have moved away from where they bought the policy.

This is a responsibility that the companies and the agents together must face or they are going to have a more difficult problem on their hands so far as having satisfactory relations with their policyholders.

Do you have any idea what it costs for a hospital bed in your area?

Mr. SIMON. In the Chicago area, I believe the cost of a hospital bed, the cost of a semiprivate room average in the area, is around $24 a day. This is the bill, what the bill average price is.

Senator CURTIS. Yes.

Now, these costs are there for labor and maintenance and all the things it takes, whether the Government pays it or whether it is paid from private sources.

Do you know whether or not this is true, that in most places due usually to local law, the hospitals have to take the indigent and welfare patients that are paid for by the city or the county at a very low fixed rate?

Are you familiar with that?

Mr. SIMON. I was not familiar with this.

Senator CURTIS. Here is one of the reasons why people are having to pay tremendously for hospitals. There are a lot of other things and some of the hospitals, I don't think, have had some of the best management working for them. But if it costs, say, $15 or $18 for a bed in a hospital, and right here in the District of Columbia, indigent patients go to that hospital and the amount that the Welfare Department pays is much less than that, I don't know, I think it is $6 or $7, either the hospital goes broke or the difference has to be charged to other patients, isn't that right, when that situation exists?

Mr. SIMON. That is correct, other patients or charity.

Senator CURTIS. Yes.

I think that in the insurance field, and in the hospital management field, and in the field of local government where they are sending indigent patients to the hospital, they have got to update their process.

Mr. SIMON. They have inadequate hospital rates for these indigent people.

Senator CURTIS. Yes, and other people have to pay for it. There is so much confusion about this hospitalization. It is not uncommon for a Senator to get a letter from some fine old lady and she says that she and her husband are past 65, their income is very modest, she has to go to the doctor a couple of times a week, that her prescriptions cost so much, that she needs glasses, that her husband is such and such an age, he has to see his doctor every 10 days, and the prescriptions are so much, and that he needs surgery, and then ends up and says, "Please vote for President Johnson's medicare plan,"

if it were enacted it wouldn't pay them a nickel, not 5 cents, and I think it is time for the people promoting these various plans to tell the truth.

I think there are some plain facts and some work to be done before anything that this committee or the Congress generally do that would be just and fair to everybody.

I didn't mean to take so much time but I thank you.

Mr. SIMON. Thank you.

Senator LONG. Thank you very much, sir.

If there are no further questions we will call the next witness.

Mr. Mahlon Z. Eubank, Commerce & Industry Association of New York.

STATEMENT OF MAHLON Z. EUBANK, DIRECTOR OF THE SOCIAL INSURANCE DEPARTMENT, COMMERCE & INDUSTRY ASSOCIATION OF NEW YORK, INC.

Mr. EUBANK. Mr. Chairman and members of the committee, my name is Mahlon Z. Eubank. I am director of the Social Insurance Department of the Commerce & Industry Association of New York.

Commerce & Industry Association of New York, Inc., the largest service chamber of commerce in the East, represents approximately 3,500 employers, large and small, in all branches of industrial and commercial activity, including many corporations headquartered in New York but engaged in multistate operations.

Through its committees on health insurance and on social security, comprised of executives specializing in these fields from leading national business organizations, and its social insurance department, the association studies and actively presents management thinking on the Federal social security program and significant medical issues at both the National and State levels.

The Commerce & Industry Association appreciates this opportunity to testify before your committee concerning the Mills bill (H.R. 11865) and proposals to provide medical care for the aged under the social security system and to present effective alternative proposals.

The association recognizes that many expenses are reduced for individuals 65 and over, such as taxes, transportation, and the heavy costs of raising and educating a family. The requirements of health care, however, are apt to increase. Most elderly individuals can make this transition with the aid of savings, insurance, pensions, and employer-subsidized health and welfare plans.

A minority, however, encounter medical problems beyond their financial capabilities. Feeling strongly that senior citizens should have all necessary medical care available to them through a combination of individual responsibility and, where the need exists, governmental assistance on a local basis, the association favored the passage of the Kerr-Mills Act and actively supported its implementation in New York State.

Commerce & Industry Association believes that any governmental program (local, county, State, or Federal) providing medical care to the aged should—

(*a*) limit assistance to those who really need it;

(*b*) provide comprehensive medical care to those in need;

(*c*) maintain the present high quality of medical care;
(*d*) not undermine self-reliance and individual responsibility;
(*e*) place the responsibility for governmental assistance on the local community, the State and Federal Goverments, in that order; and
(*f*) be financed from general revenues.

While we believe it is meritorious for this committee to focus attention on providing medical care for the aged, we are convinced solution of the problem does not lie in providing this coverage under the social security system. The Kerr-Mills Act, properly implemented and amended, would do the job.

The association opposes any bill providing medical care of the aged under the social security system. We oppose such legislation because:

The financial and actuarial soundness of the social security fund may not be maintained if medicare is added to the social security system.

Commerce and Industry Association has been concerned with the financially stability of the present social security system because the combined assets (OASI and disability benefit insurance) decreased from $23 billion at the end of 1957 to $20.7 billion at the end of 1963.[1]

It appears from the House Ways and Means Committee majority report (accompanying H.R. 11865—H. Rept. 1548, pp. 20, 26, and 27) that the fund will be strengthened because the latest cost estimates under the 1961 act indicate that there is an actuarial deficit of 0.24 percent of taxable payroll for the combined system and this would be reduced to 0.20 percent if H.R. 11865 is enacted.

The report (p. 30) further indicates that there again will be a deficit of $383 million ($18,301 million minus $17,918 million) in 1965 but thereafter income will exceed outgo.

High income assumptions, intended to represent close to full employment, were used in determining future income and outgo. Apparently, unanticipated factors were not considered, such as the possibility of recession periods in the future when the outgo will be much greater than income and the predictability of increasing longevity.

Adding a medicare trust fund to the present social security system undoubtedly would create further actuarial deficits of the social security trust fund.

Presently the actuarial deficit of the OASI portion is 0.10 percent of taxable payrolls and for disability benefits, 0.14 percent.

According to the report (p. 27) the OASI actuarial deficit will be increased to 0.19 percent and the disability portion decreased to 0.01 percent.

If medicare is added to the social security system, a separate account in the trust fund with allocation of tax money would be maintained for it and it undoubtedly would have have an actuarial deficit the same as that now present for the OASO and disability insurance portions in the trust fund.

It will be difficult for Congress to know what taxes would be required to keep the portion in the trust fund for medicare financially and actuarially sound. Outgo for the system now is based on cash

[1] Attached to this statement is a table showing the assets of both OASI and disability insurance trust funds. The figures shown above are the combined assets of each in 1957 and 1963.

benefits set out in the statute, and predictions of the future cost can be made for new legislation by proper allocation of proposed cash benefits to future beneficiaries.

Assumptions, of course, would have to be made for future beneficiaries, but in making the prediction a specific figure for cash benefits would be used. This would not hold true in making predictions of future cost if medicare is added. Medicare payments to vendors not only vary among different localities and within localities but also have been increasing unevenly year by year.

This can be illustrated by how hospital daily service charges, the major cost item if medical care is provided under the social security system, have increased in the past, as shown by percentage in the following table; I have listed a table from 1940 down to the first quarter of 1964. I want to call your attention in the fourth quarter of 1963 to the first quarter of 1964 there has been an increase of 5.2 percent, and from 1963 the average of 138 to the first quarter there has been an increase of 8.1 percent. It looks like we are on another upgrade in hospital costs.

(The table referred to follows:)

[1957-59=100 percent]

Year	Hospital daily service charge	Percentage of increase	Year	Hospital daily service charge	Percentage of increase
	Percent			*Percent*	
1940	25.4		1958	99.9	5.4
1950	57.8	32.4	1959	105.5	5.6
1951	64.1	6.3	1960	112.7	7.2
1952	70.4	6.3	1961	121.3	8.6
1953	74.8	4.4	1962	129.8	8.5
1954	79.2	4.4	1963	138.0	8.2
1955	83.0	3.8	(4th quarter 1963)	(140.9)	
1956	87.5	4.5	1964 (1st quarter)	146.1	
1957	94.5	7.0			

Mr. EUBANK. These things indicate, this chart indicates not only uneven yearly increase in daily hospital service charges but also that past experience in cost cannot be used as a basis to calculate future cost. The pattern of the percentage of increases is upward and to calculate such cost for medicare assumptions would have to be made on what will happen in the future.

It would be difficult indeed to make proper assumptions of future pay rates of hospital employees (now usually low), expenditures for material and equipment when inflationary trends are considered, additions of expensive hospital equipment such as the "artificial kidney" and that used in open-heart surgery, utilization of hospital beds, and so forth.

The actuarial status of that portion of the fund to be used for medicare cannot be reliably forecast. Cost would increase to 10 percent or more each year within a decade if the present upward trend continues. Cost estimates are unpredictable and could be easily underestimated,[1] resulting in large actuarial deficits. When this occurs, there must be

[1] The difficulty of making estimates based on the assumption that the benefit rate and tax formula remain unchanged but that wages would rise is shown in a paper (p. 3, appendix) entitled "The OASDI Trust Funds and the Pragmatic Political Process" by R. M. Peterson, vice president and associate actuary of the Equitable Life Assurance Society.

a higher allocation of tax income to that portion of the trust fund for medicare. (H.R. 11865 makes a higher allocation of tax income for that portion of the trust fund for disability insurance to insure its soundness.[2])

This would result in an increase in the actuarial deficit of that portion of the trust fund allocated to OASI and disability benefits unless there were constant increases in the tax schedule and earning base and I also want to call your attention and I have attached to my statement a paper by Ray Peterson which shows what happens to estimations when Congress amends the law.

The inclusion of medicare for the aged in the social security system could cause an abnormal increase in social security taxes.

Since 1950 there has been a rising cost in providing old-age and survivor and disability benefits under our social security system.

This is shown in the attached table, appendix page 1, which presents the income and outgo of the fund from 1937 through 1963. Better to understand this table, the tax rate, earnings base, maximum tax withheld for each the employer and the employee, and the maximum primary benefit are tabulated in appendix page 2.

Today, a worker earning $5,400 a year pays $174 a year in social security taxes, with his employer paying an equal amount, and a self-employed person $259.20.

This ultimately would increase to $259.20 each for the employer and employee and to $388.80 for the self-employed if H.R. 11865 is enacted into law. That would result in a tax boost of a little over 50 percent, without tax payments for medicare, in the space of 6 years provided, of course, that Congress does not follow past practices and increase the tax rate and/or earning base every 3 or 4 years.

A higher percentage would result if medicare is added to the social security system.

It is logical to assume that Congress intends in the future to increase social security cash benefits further than provided in H.R. 11865, to keep pace with price levels or make further liberalizations in this program. If a bill providing medical care is enacted, there will follow insistent demands to provide medical coverage for beneficiaries 62 through 64, widows with young children, disabled beneficiaries, or to provide a wider range of medical services for which older people may feel they have far more need than for those proposed.

If such liberalization in the social security program were to come into being, it would be necessary, of course, to increase substantially the payroll taxes on both the employer and the employee. Social security taxes then would be almost as burdensome for many individuals as the income tax and, in some cases, more so.

Evidence of the size of the possible future tax burden may be found in the Congressional Record of April 6, 1961 (pp. 5166 to 5169) where Senator Carl T. Curtis, of Nebraska, introduced into the record the testimony of Wilbur J. Cohen before this committee when his appointment as Assistant Secretary of the Department of Health, Education, and Welfare was up for confirmation.

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[2] Estimates made under the 1961 act for cost of disability benefits was significantly higher than estimated (because benefits are not being terminated by death or recovery as rapidly as had been originally assumed). Accordingly, the actuarial balance for this program was found in an unsatisfactory position (p. 22, report of the Committee on Ways and Means on H.R. 11865, H. Rept. 1548).

In his testimony the now Assistant Secretary admitted he favored increasing the tax base in steps up to $9,000 in this decade and Senator Curtis brought out that the liberalization proposed would result in a tax of 14 or 15 percent (7 or 7½ percent on both the employer and employee) on that tax base.

Incomes of those 65 and over are improving.

The median money income of our 65 and over population has increased. This income for married couples was $3,204 and for single individuals $1,248 in 1962, compared with $1,956 (married couples) and $635 (single individuals) in 1951. The percentage increase during this period was 63.8 percent for married couples and 96.5 percent for single individuals.[1]

A breakdown applying only to OASDI beneficiaries is shown in the 1963 survey of the aged made by the Department of Health, Education, and Welfare; as reported on page 22 of the Social Security Bulletin (March 1964), in 1962 married couples had a median money income of $2,875, nonmarried men $1,365, and nonmarried women $1,015.

From 1951 to 1959, according to the survey, the median money incomes, even in constant 1959 dollars, increased two-thirds for couples, more than doubled for nonmarried women, and advanced more than 50 percent for nonmarried men.

Since 1959 there has been further improvement, as shown below:

Aged unit	Median income	
	1962	1959
Married couples	$2,875	$2,600
Nonmarried men	1,365	1,160
Nonmarried women	1,015	670

The median money income of those 65 and over, according to the survey (p. 7 of the bulletin), does not reflect the contributions of relatives with whom many make their homes. A precise money value cannot be placed on the amounts such individuals receive. More than one-fourth of the couples and more than two-fifths of the nonmarried aged were members of a household with their children or other relatives.

It is also interesting to note that at the end of 1962 three-quarters of all couples with man or wife 65 or over and two-fifths of the nonmarried aged owned their own homes. All this certainly indicates that it is neither appropriate nor realistic to judge the economic well-being of the aged solely in terms of current money income or based on their median income.

The primary reason for the increasing income among beneficiaries 65 and over, indicated by the marked rise in median income, is that those under age 73 are better off by way of income than those over that age. This trend in upward increase will continue in the future because:

1. Many now in their seventies and eighties suffered from the effects of the depression years in their working life and had little opportunity to share in the economic growth of the country which followed the end

[1] See table 8, p. 2, No. 12, U.S. Bureau of the Census, Current Population Reports, "Consumer Income," series 60; and table 3, p. 26 of No. 41.

of World War II. The newcomers to the ranks of the retired, however, spent their peak earning years during a period of prosperity and were in a much better position to accumulate savings.

Furthermore, the rapid spread of pension plans during and after the war, means that increasing numbers are receiving, and will receive, substantial monthly pension payments.

2. Benefits would be higher based upon higher average earnings.

3. The 87th Congress enacted H.R. 10, a measure which enabled self-employed individuals to establish pension plans for themselves. In order to enjoy these benefits, however, they must also provide for their own employees. The stimulus thus given to retirement programs for the self-employed and their employees should accelerate further the expansion of private pensions.

(See the November 16, 1963, issue of Business Week, p. 167, which indicates a new interest in providing pension programs under this act.)

4. At the end of 1960 about 600,000 individuals 65 and over received income from annuities purchased individually or elected a settlement under life insurance policies. The number of persons receiving support under veterans' compensation and pension programs is growing rapidly due to the aging of World War I veterans. At the end of 1960, it was estimated, persons participating in these programs, including aged wives of veterans, numbered nearly 1.7 million.

There is every reason to believe that the improvement in the financial picture of those retiring will continue in the future. More and more individuals will receive additional income from annuities or from interest, rent, or dividends as a result of their savings.

An increased number each year will be covered not only by pension plans but also by group insurance policies or by union contracts which provide continuance of health insurance or health benefit plans after retirement.

Voluntary insurance is increasing.

In 1952, only 3 million persons age 65 and over—or 26 percent of all such persons—had some form of health insurance coverage. Between 9 and 10 million persons age 65 and over were covered in 1962, with the proportion covered being either 52, 54, or 60 percent, depending upon which survey is used.[1]

The gap will be further narrowed by:

(1) The extension of the "65 plans." Several insurance companies have pioneered in mass enrollment plans of their own, offering coverage without the usual evidence of good health, and in California (western "65"), Connecticut, Massachusetts, New York, North Carolina-Virginia, and Texas special legislation has permitted insurance companies to operate such programs jointly, and they are now in full operation.

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[1] Fifty-two percent—1963 Survey of the Aged, p. 16, Social Security Bulletin, July 1964, published by the Social Security Administration of the U.S. Department of Health, Education, and Welfare; 54 percent—National Center for Health Statistics (Division of the Department of Health, Education, and Welfare), p. 6, Medical Care, Health Status, and Family Income, May 1964, published by same Division and Department (percentages according to income bracket are also shown); 60 percent—Health Insurance Association of America.

Variation between 52 and 54 percent primarily due to the assumption in 1963 Survey of the Aged that institutional population was uninsured and the inclusion of this number in the base; variation between 54 and 60 percent figures due to different methods of methodology, both subject to technical variations and technical errors, according to the Director of the National Center for Health Statistics. He also said the amount of coverage is somewhere between 54 and 60 percent—see p. 38 of the July report of the Senate Subcommittee on Health of the Elderly.

Many thousands of over-age citizens in those States have elected voluntarily to purchase such coverage—or their children have bought it for them.

Enabling legislation also has been enacted for similar joint operation in Michigan, Maine, Mississippi, Nevada, New Hampshire, New Mexico, Ohio, and Oregon and programs in these States should be in operation shortly.

Coverage will increase materially when plans in all 15 States mentioned, and in others where legislation is pending, are in full operation. It is interesting to note that in less than 2 years' operation, the "New York 65" plan has enrolled approximately 130,000 individuals.

(2) Coverage of more and more individuals by group policies which provide for continuance of health insurance after retirement or give the employee the right to convert without evidence of health status.

For example, within the last year, the companies in the Bell System (American Telephone & Telegraph and its subsidiaries) have adopted contributory health insurance plans which are available to their retired employees with the same benefits and at the same premium rates as apply to employees now working.

(3) Prefunding of health insurance. The 87th Congress enacted legislation (Public Law 87–863) making it clear that sums set aside currently for prefunding the cost of health insurance during retirement are deducted currently during working years for Federal income tax purposes.

Present and future generations will have to subsidize medical care for the aged under the social security system.

Medical care for the aged under the social security system would have to be subsidized by present and future workers and their employers. This burden would be added to that of the existing program under which they are required to subsidize payments for old-age and survivors' benefits.

For example, the primary monthly benefit amount for an individual who entered OASI in 1937 at age 38 and who retired on January 1, 1964 (with maximum creditable earnings throughout his working years) is now $123, and it is $184.50 if he has a wife who is also 65.

Under H.R. 11865, the monthly benefit would be increased to $129.20 for the individual and to $193.80 for husband and wife.

If H.R. 11865 is enacted, in about 43⅓ months, if single, he will acquire through his monthly benefit ($123 for 9 months and $129.50 for around 34⅓ months) the total value of the OASDI taxes with interest ($5,533 [1]) paid on his earnings by his employer and himself.

A married man receiving $184.50 for 9 months and $193.80 for 20 months will recover the same amount in a little over 29 months. Any payments beyond the periods cited are subsidized.

Robert J. Myers, Chief Actuary of the Social Security Administration, gives a rough estimate of what the subsidy would be in his

[1] Actual taxes paid by both employer and employee from 1937 through 1963 total $3,516; with intrest added at 3½ percent the total comes to $5,533.

article "The Actuarial Financing Basis of the OASDI System," in which he states:

> The benefits that a new entrant gets are not equal in value, over the long run, to the contributions that he and his employer pay. Present older employees and people now on the beneficiary rolls have paid far less in contributions—even including employer contributions paid on their behalf—than the value of the benefits that they will get. For those now on the rolls, it is likely that they would have paid, at most, for about 10 percent of the benefits actually payable to them.[2]

A more exact estimate can be made, however, on the basis of testimony given by Mr. Myers before the House Ways and Means Committee on November 18, 1963.

The preliminary tables for 1961, he said, list life expectancy for a man at age 65 at 13.1 years and at 16 years for his wife at the same age.[3]

During those periods the benefit expectancy of a couple retiring January 1, 1964, and both at age 65, would be $34,091,[4] if Congress does not increase the benefit amount set out in H.R. 11865 (benefits have been increased four times in the last 13 years.)

Even with no increase in benefits the subsidy would be $28,558 ($34,091−$5,533 total OASDI taxes with interest). A much higher subsidy would result for those who become entitled to benefits for shorter periods of coverage. The subsidiary, however, would be about one-third lower for single individuals.

The disparities in benefit amounts compared with tax contributions can only mean that present and future workers will have to subsidize OASDI benefits. Why, in addition, must the burden of paying for this generation's medical care be loaded on today's workers and employers and on their children and grandchildren and their employers?

KERR-MILLS ACT

Criticism of the Kerr-Mills Act at this time is unjustified.

State legislatures as well as Congress are inclined to be conservative when new social legislation is enacted. In adequacies can be corrected by amendment when there are sufficient guideposts to determine costs and the type of additional services to be added. Such maturing of a program takes time.

For example, the original Social Security Act was enacted by Congress in 1935. Extensive and significant changes have been made since that date by amendments to the original act.

Some laws amending an original act have made rather extensive changes to correct inequities. Among these laws are the Social Security Act Amendments of 1939 (53 Stat. 1360), the Social Security

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[2] This excerpt appears on p. 57 of the report of the Committee on Ways and Means on H.R. 11865—H. Rept. 1548.

[3] See hearings before Committee on Ways and Means on H.R. 3920, House of Representatives, 88th Cong., pt. I, p. 57.

[4] This figure would be around $32,000 if present benefit rates are used.

Act Amendments of 1946 (60 Stat. 978), the Social Security Act Amendments of 1950 (64 Stat. 477), the Social Security Amendments of 1954 (68 Stat. 1052), the Social Security Amendments of 1956 (70 Stat. 807), the Social Security Amendments of 1958 (72 Stat. 1013), the Social Security Amendments of 1960 (74 Stat. 924) and the Social Security Amendments of 1961 (Public Law 87-64).

H.R. 11865, the proposed Social Security Amendments for 1964, carries out this pattern and again makes extensive and significant changes in the social security program.

A review of the legislative history of the Social Security Act shows that the first amendment was made in 1939, 4 years after the original act was enacted. The Federal Kerr-Mills Act took effect on October 1, 1960, about 4 years ago, and State acts implementing it followed at later dates.

We feel there is ample justification for giving the Federal-State Kerr-Mills program of medical assistance for the aged an even longer period of trial before subjecting it to destructive criticism, illustrations of which were documented by Senator Karl E. Mundt, Republican, of South Dakota, and presented to the House Ways and Means Committee at its hearings on November 17, 1963.

(Statement reproduced in the Congressional Record of the same date, pp. 7155-7157—Extension of remarks of Hon. Steven B. Derounian.)

If Senator Mundt does not appear before this committee, each member may wish to read his statement in order to know of the barriers and obstacles placed in the path of implementing the Kerr-Mills program.

Certain constructive criticisms, however, have been made and it is regrettable that the inequities they indicated are not corrected in H.R. 11865.

Commerce & Industry Association has studied those inequities and its views on how they should be corrected follow.

Possible amendments to Kerr-Mills Act and to the tax law: Even with limited experience with the Kerr-Mills medical assistance program, we believe that the act can be made more effective by amend ments. These are our suggestions for amendment of the Kerr-Mills Act:

(1) Provide for a single matching formula for medical care for individuals 65 and over, regardless of whether or not the individual is eligible under the Old-Age Assistance (OAA) or Kerr-Mills Act (MAA). The present matching formula for public assistance would still be applicable to pay medical expense for individuals under 65 and to pay day-to-day living expenses for all.

Under the present matching formula the States receive less money to provide medical care to the neediest of old-age assistance recipients (OAA) than is provided to them to pay for medical care to recipients who have sufficient resources to meet regular expenses other than med-

ical bills (MAA). This has resulted in a few States providing a more generous program under their MAA program than they do under their medical program for OAA recipients.

The enactment of this amendment will not only help to cure this defect but also enables States to correlate standards and requirements under both OAA and MAA.

(2) Provide that any statement of a claimant for medical assistance for the aged, if made under oath or affirmation and on such form as may be prescribed by the State agency shall, insofar as such statement relates to the financial status of such claimant, be presumed to be factually correct for purposes of determining his immediate eligibility for such assistance. Penalties would be provided for any false statements revealed by subsequent audits.

The welfare aspects of the present program would be overcome by such an amendment. It would also prevent the delay in providing medical care alleged to be due to cumbersome investigation procedures in some of the States.

An amendment on this subject, except for the requirement of post-audits and penalties, has been introduced by Senator Dirksen (S. 305).

(3) Eliminate State family responsibility laws, except for the spouse (applicable in 12 States), provided that provisions for recoupment from the estate of the aged individual (after death of the surviving spouse) are strictly enforced.

This suggestion, if enacted, would make it easier and quicker for the qualified individual 65 and over to obtain needed medical care.

(4) Provide the same matching grant for administration cost as now is provided for the cost of medical care.

At the present time the Federal Government makes grants up to 80 percent for medical care of those 65 and over, and only 50 percent of the cost of administration of the program. The enactment of this amendment will help States with low per capita incomes and encourage them to expand their present medical care programs.

In addition to these proposals to implement the Kerr-Mills Act, we suggest that the income tax provisions of the Internal Revenue Code be amended to permit an income tax deduction for payment of health insurance premiums and medical expenses of persons 65 and over who, but for the support test, would qualify as dependents of the taxpayers making the payments. Such a proposal, if enacted, would encourage children or brothers and sisters to make such payments for the individual 65 and over and thus help to reduce the cost for medical expenses under the MAA program.

The problem of providing adequate medical care to those 65 and over is not solved by placing such care under the social security system. Our reasons for this statement have been presented here and by our testimony at the hearing before the House Ways and Means Committee on January 22, 1964, on H.R. 3920 (pt. 3, p. 1694). Serious problems, as presented by this statement and our prior testimony, would arise by use of the social security system in providing medical care to those 65 and over.

We believe it is far better to reserve the payroll tax for the social security system of retirement, survivorship, and disability benefits which are related to replacement of income. Whatever the Government needs to do in the area of health care for the aged should be supported by 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 by the Kerr-Mills approach will provide for a more equitable distribution of the fiscal load.

I wish to thank you.

(The attachments referred to follow:)

APPENDIX

[Reproduced from Social Security Bulletin, April 1964, published by the Social Security Administration, U.S. Department of Health, Education, and Welfare (p. 26)]

Status of the old-age and survivors insurance and disability insurance trust funds, by specified period, 1937–63

[In thousands]

Period	Receipts		Transfers under financial interchange with railroad retirement account [3]	Expenditures		Assets at end of period		
	Net contribution income and transfers [1]	Net interest received [2]		Benefit payments	Administrative expenses [4]	Invested in U.S. Government securities [5]	Cash balances	Total assets
	Old-age and survivors insurance trust fund							
Cumulative January 1937 to December 1963 [6 7]	$115,928,457	$7,918,332	−$1,804,530	[8]$101,022,350	[6]$2,539,529	$17,153,513	$1,326,867	$18,480,380
Calendar year:								
1940	325,004	42,861		35,354	26,203	2,016,500	14,206	2,030,706
1941	789,298	56,159		88,083	26,158	2,736,400	25,521	2,761,921
1942	1,012,490	72,271		130,675	27,898	3,655,434	32,676	3,688,110
1943	1,239,490	88,250		165,938	29,455	4,778,834	41,624	4,820,458
1944	1,315,680	106,741		208,972	29,201	5,966,834	37,873	6,004,707
1945	1,285,486	134,318		273,885	29,971	7,054,424	66,231	7,120,655
1946	1,295,398	151,592		378,104	39,739	8,078,734	71,067	8,149,801
1947	1,557,911	164,186		466,193	45,561	9,268,481	91,663	9,360,144
1948	1,687,820	281,201		556,174	51,277	10,555,761	165,953	10,721,714
1949	1,669,975	145,662		667,164	54,265	11,727,994	87,928	11,815,922
1950	2,670,771	256,998		961,094	61,330	13,330,649	390,618	13,721,266
1951	3,367,200	417,267		1,885,201	80,798	15,017,325	522,409	15,539,734
1952	3,818,911	365,221		2,194,129	88,019	16,960,377	481,342	17,441,719
1953	3,945,099	414,167		3,006,298	87,732	18,291,238	415,719	18,706,956
1954	5,163,263	446,777	21,146	3,670,162	92,186	19,862,520	713,275	20,575,795
1955	5,713,045	453,612	7,439	4,968,155	118,633	21,101,865	561,238	21,663,104
1956	6,171,931	525,540	5,220	5,714,610	132,031	21,830,552	688,601	22,519,153
1957	6,825,410	555,575	1,588	7,347,347	161,522	21,565,885	826,972	22,392,857
1958	7,565,797	551,666	−124,441	8,326,966	194,491	20,953,408	911,014	21,864,422
1959	8,051,972	532,246	−282,048	9,841,641	184,184	19,151,165	989,602	20,140,766
1960	10,866,294	515,744	−318,389	10,676,628	203,289	19,128,245	1,196,255	20,324,499
1961	11,284,951	548,052	−331,734	11,861,589	238,868	18,404,279	1,321,032	19,725,311
1962	12,058,809	526,228	−360,788	13,356,411	255,883	17,060,022	1,277,243	18,337,265
1963	14,541,451	521,373	−422,523	14,216,567	280,619	17,153,513	1,326,867	18,480,380
1962								
December	525,303	193,454		1,134,064	−33,792	17,060,022	1,277,243	18,337,265
1963								
January	177,438	2,858		1,144,216	32,238	16,178,883	1,162,225	17,341,108
February	1,810,795	18,920		1,156,924	25,525	16,516,145	1,472,229	17,988,374
March	1,190,372	3,520		1,170,866	28,071	16,570,744	1,412,585	17,983,329
April	899,717	20,147		1,185,124	24,114	16,044,311	1,649,644	17,693,954
May	2,717,964	24,610		1,190,585	26,354	17,747,008	1,472,582	19,219,590
June [7]	1,184,358	180,953	−422,523	1,194,631	28,664	17,613,190	1,325,894	18,939,083
July	505,673	2,347		1,191,993	32,417	16,887,393	1,335,163	18,222,556
August	2,183,576	19,731		1,196,212	24,632	17,891,699	1,313,319	19,205,018
October	429,388	20,477		1,196,900	25,494	16,823,802	1,363,422	18,187,224
November	1,507,973	23,980		1,190,[illegible]	[illegible]	[illegible]	[illegible]	[illegible]
December	[illegible]	[illegible]		[illegible]	[illegible]	[illegible]	[illegible]	[illegible]

				1, 186, 212	24, 632	17, 801, 669	1, 313, 319	19, 305, 018
October	429, 388	20, 477		1, 196, 900	25, 494	16, 823, 802	1, 363, 422	18, 187, 224
November	1, 507, 973	23, 980		1, 190, 583	25, 974	17, 076, 208	1, 426, 412	18, 502, 620
December	957, 764	198, 840		1, 201, 729	−22, 886	17, 153, 513	1, 326, 867	18, 480, 380
	Disability insurance trust fund							
Cumulative, January 1957 to December 1963 [7]	$6, 751, 058	$325, 036	−$8, 956	$4, 532, 917	$299, 259	$2, 115, 374	$119, 588	$2, 234, 963
Calendar year:								
1957	701, 566	7, 240		56, 675	2, 783	611, 946	37, 403	649, 349
1958	965, 509	25, 091		248, 958	12, 477	1, 320, 758	57, 756	1, 378, 514
1959	891, 229	40, 201	21, 980	456, 722	49, 995	1, 793, 379	31, 828	1, 825, 206
1960	1, 009, 926	53, 252	4, 851	568, 167	36, 229	2, 179, 930	108, 908	2, 288, 839
1961	1, 038, 020	65, 729	−5, 148	887, 137	63, 686	2, 323, 975	112, 643	2, 436, 617
1962	1, 046, 192	67, 622	−11, 030	1, 105, 050	66, 449	2, 256, 199	111, 704	2, 367, 903
1963	1, 098, 617	65, 902	−19, 609	1, 210, 208	67, 641	2, 115, 374	119, 588	2, 234, 963
1962								
December	46, 539	29, 890		97, 448	63, 242	2, 256, 199	111, 704	2, 367, 903
1963								
January	19, 745	217		98, 887	312	2, 187, 393	101, 273	2, 288, 666
February	139, 937	1, 255		97, 466	291	2, 197, 803	134, 297	2, 332, 100
March	81, 711	268		101, 404	291	2, 195, 842	116, 542	2, 312, 384
April	79, 374	978		99, 360	368	2, 180, 899	112, 109	2, 293, 008
May	197, 724	935		99, 803	308	2, 233, 924	157, 637	2, 391, 561
June [7]	94, 233	30, 206	−19, 609	102, 376	303	2, 277, 244	116, 468	2, 393, 712
July	35, 013	228		99, 588	454	2, 205, 497	123, 408	2, 328, 904
August	158, 729	1, 320		100, 638	298	2, 251, 531	136, 487	2, 388, 018
September	77, 514	342		101, 127	298	2, 247, 938	116, 518	2, 364, 456
October	34, 406	1, 056		104, 636	266	2, 177, 324	117, 692	2, 295, 015
November	110, 676	1, 657		101, 705	303	2, 164, 452	140, 887	2, 305, 339
December	69, 556	27, 440		103, 219	64, 153	2, 115, 374	119, 588	2, 234, 693

[1] January 1937 to June 1940 equals appropriations transferred (estimated net proceeds of taxes after deduction of estimated administrative expenses); July 1940 to December 1950 equals taxes collected; beginning January 1951, equals amounts appropriated (estimated tax collections with suitable subsequent adjustments). Beginning 1951, includes deposits by States under voluntary coverage agreements. For 1947–51 includes amounts appropriated to meet costs of benefits payable to certain veterans' survivors. Beginning 1952 for the old-age and survivors insurance trust fund and 1959 for the disability insurance trust fund, includes deductions for refund of estimated amount of employee tax overpayment.

[2] In addition to interest and profit on investment, includes annual interfund transfer of interest on administrative reimbursed expenses, to the old-age and survivors insurance trust fund from the disability insurance trust fund, 1958 to date (see footnote 4).

[3] The purpose of the financial interchange provision of the Railroad Retirement Act, as amended, is to place the trust funds in the same position in which they would have been, had railroad employment always been covered under the old-age, survivors, and disability insurance systems. Transfers include: interest from railroad retirement account to old-age and survivors insurance trust fund on amount held to the credit of the trust fund, 1954–57; beginning 1958 from old-age and survivors insurance trust fund and 1961 from disability insurance trust fund to railroad retirement account (principal and interest); and from railroad retirement account to disability insurance trust fund, July 1959 and June 1960. Negative figures represent transfers to the railroad retirement account.

[4] Represents net expenditures for administration. Beginning 1951, adjusted for reimbursements to trust fund of small amounts for sales of services. Beginning 1953, includes expenses for central office building construction. Since the January 1957 inception of the disability insurance trust fund, most administrative expenses are paid initially from old-age and survivors insurance trust fund with subsequent reimbursement, plus interest (see footnote 2), from the disability insurance trust fund for the allocated cost of disability insurance operations. The Treasury Department is regularly reimbursed from the appropriate trust fund for its expenses as incurred.

[5] Book value: Includes net unamortized premium and discount, accrued interest purchased, and repayments on account of interest accrued on bonds at the time of purchase.

[6] Includes transactions of predecessor funds, the old-age reserve account, January 1937 to December 1939.

[7] Revised to correspond with Final Statement of Receipts and Expenditures of the U.S. Government, unless otherwise noted.

[8] Total reflects cumulative adjustments made in 1954 as a result of the changeover from "checks paid" to "checks issued" basis in the reporting system of the Treasury Department.

Source: Monthly and Final Statement of Receipts and Expenditures of the U.S. Government and unpublished Treasury reports.

Tax table under the social security system

Year	Employer and employee, each			Maximum primary benefit
	Tax rate (percent)	Wage base	Maximum tax withheld	
1937-49	1.0	$3,000	$30.00	$60.00
1950	1.5	3,000	45.00	80.00
1951	1.5	3,600	54.00	80.00
1952-53	1.5	3,600	54.00	85.00
1954	2.0	3,600	72.00	108.50
1955-56	2.0	4,200	84.00	108.50
1957-58	2.25	4,200	94.50	108.50
1959	2.5	4,800	120.00	116.00
1960-61	3.0	4,800	144.00	120.00
1962	3.125	4,800	150.00	125.00
1963-64	3.625	4,800	174.00	127.00
H.R. 11865 [1]				
1965	3.8	5,400	205.20	133.40
1966-67	4.0	5,400	216.00	133.40
1968-70	4.5	5,400	243.00	133.40
1971 and thereafter	4.8	5,400	259.20	133.40

[1] Proposed tax amendment—present law on $4,800 base:

Year	Tax rate (percent)	Maximum tax withheld	Year	Tax rate (percent)	Maximum tax withheld
1965	3.625	$174	1968-70	4.625	$222
1966-67	4.125	198	1971 and thereafter	4.625	222

The OASDI Trusts Funds and the Pragmatic Political Process

The social security financing method, has been described as developed by a "pragmatic political process." [1] No truer words have been written as will be evident from the following analysis.

A key indicator of one of the sources of the financial strength of social security financing is the ratio of the amount of the trust funds to the current rate of benefit payment. In other words, how many years' payments will the trust funds cover at any time? An official publication, "Financing Your Social Security Benefits," OASI-36, May 1964, states:

"The trust funds serve two important purposes:

"1. The interest income on the invested assets of the funds helps to keep the social security taxes lower than they would have to be if the money in the trust funds were not invested.

"2. They are assets to draw on in temporary situations when current income is less than current outgo."

The degree to which the trust funds are able to fulfill these purposes is indicated by the relation of trust funds to the rate of benefit payments.

As to the benefit of interest income, we may first note that under a fully funded private retirement plan, investment income provides from 40 to 50 percent of the amount required to pay benefits. In the report to the Committee on Ways and Means for the proposed Social Security Amendments of 1964 (H.R. 11865), interest on the existing trust fund is estimated to reduce the "level-cost" (constant tax rate requirement) of 9.80 percent of payrolls by 0.19 percent or only 2 percent. This 0.19 percent is of the same magnitude as the estimated actuarial deficit under the bill of 0.20 percent which is considered so insignificant that the actuarial balance is "well within acceptable limits."

The capacity of the trust funds to meet "temporary situations when current income is less than current outgo" is indicated by the following exhibit of actual and projected ratios of the respective trust funds to yearly rate of benefit payments.

[1] Actuarial study No. 49, app. I, Social Security Administration.

Ratio of trust funds to benefit payments of the year

OASI TRUST FUND

Trustees report	19th (1959)	20th (1960)	21st (1961)	22d (1962)	23d (1963)	24th (1964)	H.R. 11865 report
	Short-term projections						
Year:							
1958	2.6	2.6	2.6	2.6	2.6	2.6	2.6
1959	2.2	2.1	2.1	2.1	2.1	2.1	2.1
1960	2.1	1.9	1.9	1.9	1.9	1.9	1.9
1961	2.0	1.8	1.7	1.7	1.7	1.7	1.7
1962	2.0	1.7	1.6	1.4	1.4	1.4	1.4
1963	2.1	1.7	1.6	1.4	1.3	1.3	1.3
1964		1.8	1.7	1.4	1.2	1.2	1.2
1965			1.7	1.5	1.2	1.2	1.0
1966				1.7	1.2	1.2	1.0
1967					1.3	1.3	1.0
1968						1.4	1.1
1969							1.2
	Long-term projections (intermediate cost estimates)						
1970	3.4	2.9	2.6	2.4	2.6	1.9	1.3
1980	4.7	4.1	3.7	3.5	4.1	3.0	2.4
1990	4.9	4.3	3.9	3.7	4.4	3.3	2.7
2000	5.5	5.1	4.6	4.4	5.2	4.1	3.3

DISABILITY INSURANCE TRUST FUND

	Short-term projections						
Year:							
1958	4.7	7.0	7.0	7.0	7.0	7.0	7.0
1959	3.8	3.6	3.6	3.6	3.6	3.6	3.6
1960	4.8	3.8	3.8	3.8	3.8	3.8	3.8
1961	5.8	4.7	2.8	2.7	2.7	2.7	2.7
1962	5.8	5.3	2.6	2.5	2.2	2.2	2.2
1963	6.7	5.3	2.5	2.3	1.8	1.8	1.8
1964		6.0	2.5	2.1	1.6	1.5	1.4
1965			2.3	2.1	1.5	1.3	1.3
1966				2.1	1.3	1.2	1.3
1967					1.1	.8	1.3
1968						.6	1.2
1969							1.3
	Long-term projections (intermediate cost estimates)						
1970	5.2	10.8	(1) 2.8	2.8	0.2	0.1	1.4
1980	4.9	15.9	1.5	1.5	(2)	(2)	1.1
1990	6.3	26.4	.4	.4	(2)	(2)	1.2
2000	8.3	35.3	(3)	(3)	(2)	(2)	1.4

[1] Benefits extended below age 50.
[2] Exhausted in 1971.
[3] Exhausted in 1993.

These ratios are not published, as such, in the trustees' reports but are computed from actual figures in the reports.

Upon analysis, the most significant feature of this array of ratios is that the successive projected figures steadily decrease. For example, in 1959 the projected

OASI ratio for 1963 was 2.1 and the acutal was 1.3. Also, in 1959 the projected OASI ratio for 1970 was 3.4 and the projected ratio currently (H.R. 11865) drops to 1.3. An extrapolation of the trend of the figures from successive reports to future reports leads one to the conclusion that future actual experience will be materially less than that projected. In other words, one would be justified in being very skeptical as to the validity of all projections and would reasonably expect that the ratios will be less than indicated at any given time. Has the actuary done a poor job? Not necessarily at all. He also taken the benefit and tax provisions as they are at the time of projection with no allowance for future changes. An actuary cannot anticipate what future political actions will be. An excellent professional job has been done. The real culprit is the "pragmatic political process." As periodic amendments are made, the taxes required for added benefits are spread into the future by the very nature of the financing method. On such occasions, the value of additional taxes payable as to present members is usually only a modest fraction of the value of benefits they will receive. In addition to this feature, current benefits may be increased with a deferred tax provision. For example, in 1961, the retirement or work test was liberalized with a resulting substantial increase in current benefit outlays. But the cost of this change was covered by shifting the tax rate effective in 1969 to 1968. Then, under, H.R. 11865, the tax rate for the 5 years 1966 through 1970 is decreased from 9¼ percent to 9 percent (although applicable to a higher wage base) and the year for the ultimate level is shifted from 1968 to 1971 with the rate changed from 9¼ percent to 9.6 percent. Deferments of this kind, which are typical of the political process, account in good part for the lower and lower projections of trust fund growth.

It is evident from the trend of the figures displayed that it is very unlikely that the trust funds will ever become much more than equal to 1 year's benefit payments. Does this provide ample provision to serve the second purpose cited agbvoe

Projections of the dollar amount of the OASI trust fund have some interesting characteristics. Here are the figures for 1970 and 1980 taken from trustees' successive reports.

[In billions]

Report	1970	1980
19th (1959)	$50.3	$98.7
20th (1960)	45.5	88.8
21st (1961)	41.3	81.6
22d (1962)	40.1	79.3
23d (1963)	44.8	96.1
24th (1964)	36.0	75.5
H.R. 11865	27.6	64.6

In the 22d annual report, certain so-called medium-term projections were included based on the assumption that the benefit and tax formulas remain unchanged but that wages would rise. Although the report warned that it was unlikely that the assumptions would be realized, the Social Security Administration put out a booklet "Financing Your Social Security Benefits" (OASI-36 March 1962) that included a chart (with moneybags) indicating that, using these medium-term projections, the OASI trust fund would amount to $53.7 billion in 1970 and $153 billion in 1980. After some criticism of this publication as grossly misleading, the next issue of the booklet (OASI-36 November 1962) omitted the $153 billion figure and its associated moneybag but kept the charted line, now dotted, extending to the same $153 billion point. The latest issue of the booklet for May 1964 omits the chart entirely but with no explanation. Will the Social Security Administration take positive steps to correct the grossly erroneous 1962 booklets? Enactment of H.R. 11865 will require substantial downward adjustment of the figures that appear in this paragraph from the current booklet:

"Income to the program as a hole is expected to exceed outgo over the 5 fiscal years 1964 through 1968 and the combined assets of the funds are estimated to increase by about $5 billion by the end of June 1968. There will be an estimated $6.2 billion increase in the old-age and survivors insurance trust fund and a $1.2 billion decrease in the disability insurance trust fund."

The actual increase will be only about one-half of that indicated. This assumes, of course, no further amendments before 1968.

In summary, the pragmatic political process has produced an essentially pay-as-you-go financing method. The trust funds' interest earning role is so minor that it hardly deserves mention—it value has been greatly exaggerated. The present and prospective magnitude of about 1 year's benefit payments constitutes a modest provision to absorb temporary fluctuations and any substantial economic recession would melt it away very rapidly.

R. M. PETERSON,
Fellow, Society of Actuaries.

JULY 20, 1964.

Senator LONG. Thanks very much. You have given us a lot of good information here.

In your State, have you undertaken to determine just how much the Government is presently spending on medical care?

Mr. EUBANK. No. You mean under the Kerr-Mills Act?

Senator LONG. Under all of them.

Mr. EUBANK. No, I haven't. I have made some estimations on the soundness of the fund. I know a little bit about New York but I don't know generally. I think there was some testimony introduced in the record yesterday that would show, as I recall, around $250 million this year and $450 million the next year. I believe that was introduced specifically in the record yesterday at the request of Senator Smathers.

Senator LONG. Well, I think that if you take a look to see what the Federal Government is spending, for example, starting with your veterans' programs as well as what we are spending on a matching basis, and then adding to that what the States are putting up on a matching basis and what they are putting up to provide care on their own motion in programs in effect long before we ever had any Federal aid, then adding what the cities are doing, I think you will find the figure is extremely large. If you look at what the Federal Government is doing plus what the states are doing in this field, we have not been inactive.

Mr. EUBANK. I have not made a check on that, Senator, but I think it would be a good point to put in some statement at some time.

Senator LONG. It is interesting to notice some of these figures you have about hospital care. In Louisiana, we have a very expensive State hospital system. About 50 percent of all hospital days are spent in our State hospitals.

But I think the figures indicate that the average case stays in there, in these State hospitals, about 50 percent longer than in a private hospital, and the reason appears to be almost entirely human element.

In other words, a person is not paying for it himself, he feels, "Well, while I am here I might as well get the benefit of all these tests and no point in going home and making Mama look after me. If I stay up here a while longer, I won't be a burden on mother and the children when I come back so I will just stay around here until I am ready to go to work."

Mr. EUBANK. In one of the social insurance bulletins recently, and I have it and can show you, it shows the people on public assistance stay longer in hospitals than others do, and it also shows the utilization rate of people who have insurance rates stay longer.

Senator LONG. If a person is really concerned about the expense of it themselves, that the question tends to be "Doctor, can I go home today?"

Now, on the other hand, if someone else is paying for it, oftentimes it is a question of "Doctor, must I go home today, can't I stay a while longer until I am perfectly recovered?"

Mr. EUBANK. It is quite surprising about how people react. Now, my own mother was just the opposite when she was in the hospital. Other people that I know want to get home. They are afraid if they are in the hospital too long they are going to die.

I think you have two reactions in this respect. I believe that if you had free hospitalization there would be a tendency of a person to want to stay a bit longer and you might have a higher utilization rate.

We have another problem on utilization rate, too, Senator, that is just the reverse. There are a large number of proprietary hospitals coming into New York and we had to have legislation passed this year to have them get consent because we found out with proprietary hospitals coming in we had a lower utilization rate than some of the other hospitals, which caused a higher tax rate.

Senator LONG. One of the most expensive economies ever practiced in the Louisiana system at a time when the State was short on money was to eliminate what we called a free ambulance service.

We used to have an ambulance that would go get someone and bring them to the hospital, more often the ambulance was to take them home.

Now, when the State, as an economy measure, undertook to eliminate that ambulance service they found it cost the State a lot of money because you have some of these terminal cases, for example, where if a person is going to die, he is not going to die now, but a terminal case of cancer might hang on for 6 months to a year, and the State would need that hospital bed for somebody that they could cure. But you can't just put those people out on the streets, so for lack of an ambulance the relatives would refuse to come take them home. If you had an ambulance you could take them home and you could explain to them they have to take this person, perhaps their father or mother, and look after them because the State has done all it can do. That being the case, it was time that the relatives had their responsibilities of their father or uncle or whoever the person might be to take them in the home and provide care the best they could.

In other words, it is not just a job for the State. A lot of this is a burden on the individual people who provide medical care for their relatives.

Mr. EUBANK. For their own relatives, I agree with you. I might say there are two things you might be interested in.

One, New York has amended their Kerr-Mills program to pay for transportation to and from the hospital. They found out in doing that they could have care at the hospital and it would avoid them holding off and having high hospitalization.

Also Governor Rockefeller has appointed a committee under the chairmanship of Marion Folsom to study hospital costs in New York State. He has 10 areas of hospitals that he wants to have them look over. If you want a copy of the bulletin covering the Governors' committee, I would be glad to mail you one or several if the rest of the committee would want to read it.

Senator LONG. The point I have in mind is that I don't know whether these estimates take into account our own experience.

If we are going to provide this care at Government expense, you had better expect your costs to be about 50 percent greater than you are anticipating because that is our experience for what we provide in Louisiana, and we do provide a tremendous amount of medical care there.

Mr. EUBANK. I believe that is true and I think the doctors are going to have to work on that. I think they would be more inclined to work with you on the Kerr-Mills approach than under the King-Anderson approach.

Senator BENNETT. Mr. Chairman, that is a live quorum, I have no questions, I have no questions of Mr. Eubank. I think he has given us a lot of good information.

Senator CURTIS. I will be very brief.

Everyone who earns any money has to pay social security tax.

Mr. EUBANK. There are still some people, but generally speaking.

Senator CURTIS. I mean the people who have to work with their hands, do hard work.

Mr. EUBANK. Yes.

Senator CURTIS. And when they apply the social security tax you do not get any $600 exemption for yourself and the members of your family, isn't that correct?

Mr. EUBANK. That is correct.

Senator CURTIS. The poor people who make a few dollars have the social security tax taken out from the first dollar; isn't that correct?

Mr. EUBANK. That is correct.

Senator CURTIS. The blind person, when he learns to do something and work with his hands, is taxed at these high social security rates from the first dollar, isn't that correct?

Mr. EUBANK. That is right.

Senator CURTIS. The physically handicapped man, who pulls himself up to a bench and, with great effort, makes a few dollars has to pay the social security tax on every dollar of it.

Mr. EUBANK. On every nickel; yes, sir.

Senator CURTIS. Yes, sir.

Now, can you find any altruistic reason why those people should be taxed to pay the hospital bill of somebody who is more able to pay it than the person who is paying the social security tax?

Mr. EUBANK. No, sir. That is one of the reasons that I brought out in one of my meetings. I do not believe they should have to pay for the hospital bill of somebody else. We are already paying a lot of subsidization of people who are now retired on their own retirement benefits. I don't think there should be any subsidization in medical care.

Senator CURTIS. I am not critical of any person who has a misunderstanding of King-Anderson. I am critical of the proponents who understand. If they told all the facts about it there won't be many people for it.

Senator LONG. Let me just say this, as one of those who supported and helped sponsor the Kerr-Mills proposal and as one who would like to amend this to make it a better program as we go along, and to provide more adequately for health care: I personally prefer a system of supporting medical care in which you have some regard for ability to pay such as our general revenues are incurred, as compared to what is the most regressive tax that anyone ever levied.

The social security tax, I would say, is as regressive as any tax tha we have, is it not?

Mr. EUBANK. That is true. They would not get any deductio for it. I believe that the best criticism that has been made of the Kerr-Mills Act is that it pays more in matching formula than th OASI program does. This has resulted in some of the States having a better program for those that are not as needy than for the neediest.

This is one of the things that I think should be corrected in the Kerr-Mills Act, because I think this criticism is constructive and it has worked in two States I know and has been one of the vetoes for Kerr-Mills, particularly in Indiana and Missouri.

They said they couldn't correlate the two with two programs and I think this is one of the things we have to correct.

Senator LONG. In States—in areas where the State has had available to it large amounts of money on a matching basis and those States have done nothing about it, would it not seem to you that those States ought to move to match what we have made available in order to provide more adequate care for their people before they come to us asking us to give them a whole new program?

Mr. EUBANK. Well, I think so, too. But there are some of the States that have poor programs, and being fair about the whole thing, and looking at some of the States, their own State budget is very high on education and health, and I think perhaps we ought to help them out a little bit more.

This is going to cost New York money in the long run for those States, but I think our board took a little courage in saying this. They need a little more money now in order to encourage them to have a little better Kerr-Mills program.

Senator LONG. Thank you very much.

The next witness is Mr. Paul D. Hill, International Association of Health Underwriters.

STATEMENT OF PAUL D. HILL, PAST PRESIDENT OF INDIANA STATE AND INDIANAPOLIS ASSOCIATIONS OF HEALTH UNDERWRITERS

Mr. HILL. Mr. Chairman and members of the committee, my name is Paul D. Hill. I am past president of both the Indiana State and the Indianapolis Associations of Health Underwriters. I come before this committee as a representative of the International Association of Health Underwriters, and on behalf of that organization, I wish to thank you, all of you for giving us the opportunity to present our testimony in opposition to compulsory health care for those 65 and over, paid for by social security taxation.

Our organization, the International Association of Health Underwriters, is made up of more than 5,000 members, in over 90 State and local associations all over the country.

It is our members, along with members of the National Association of Life Underwriters and the property-casualty insurance agents, who sell and service health insurance—who every day contact people about their health insurance needs.

Our members are constantly in touch with people in practically every State; our members are constantly in touch with people—our

members have the opportunity to "feel the pulse," as it were, of the American public. And so I would like to talk to you for just a few minutes about the way people around the country feel about this subject.

Before, I do, let's mention just a few statistics, since they are so vital to a subject of this kind. Other organizations will, we know, include others and I have tried to avoid those to avoid duplication.

Today, the total cost of welfare plans at the Federal level is $31 billion per year. In addition, the total cost of welfare plans at the State and local level is $12,700 million. We are already spending, as a nation, almost $45 billion per year on welfare plans. How much more can we afford?

Already, more than 5 million American families are paying more in social security taxes than they are paying in Federal income taxes. This is the point the Senator brought out just a moment ago. That figure was compiled before the latest income tax cuts, so today the figure is undoubtedly even larger.

Under the social security tax law now on the books, the tax rate is 363½ percent of the original tax rate. Under present law, the tax rate from 1968 on will be 462½ percent of the original tax rate. The actual tax paid, for those making $4,800 per year, is now 580 percent of the original maximum social security tax.

These amounts and rates are all based on present law, and do not take into account either the social security legislation of 1964 already passed by the House of Representatives, or any "medicare" benefits.

Under the social security bill passed by the House, after 1970 the tax rate would be 480 percent of the original rate. And the actual tax would be 864 percent of the original tax, for those making the maximum taxable in each instance. Again, the figures are without any provision for "medicare" benefits.

Senator BENNETT. May I stop you at that point, Mr. Hill?

Mr. HILL. Yes, sir.

Senator BENNETT. When you say 480 percent you mean they are just a little less than five times as high?

Mr. HILL. This is right; yes, sir.

Senator BENNETT. Wouldn't it be more clear to say that the figure of 362½ percent is more than 3½ times as high?

Mr. HILL. Yes, sir; this is correct.

Senator BENNETT. And this goes on down?

Mr. HILL. Yes, sir.

Senator BENNETT. And the last figure would say that the actual tax paid would be more than 8½ times as high as the original tax for social security?

Mr. HILL. Yes, sir.

This is under the bill that has been passed by the House.

Senator BENNETT. Thank you.

Mr. HILL. Many economists believe that 10 percent of payroll is about the largest social security tax that can realistically be levied.

The latest social security revisions passed by the House call for an eventual tax of 9.6 percent—very close to that maximum figure again with no consideration given to taxing for the cost of "medicare" benefits.

According to the most recent census, in 1960, 70 percent of families over 65 owned their own homes, completely paid for. Half the

6,200,000 families over 65 at that time had incomes exceeding $3,000 per year. Where the head of the family worked that income was over $5,200.

"Medicare" benefits would involve much larger social security taxes—just how much larger, no one can say for sure. Insurance actuaries, basing their assumptions on billions of cases, say that costs for the "medicare benefits" that have been proposed would be twice what Health, Education, and Welfare experts say they would be.

Social security is supposed to be of greatest benefit to those in lower income brackets. Yet at the present time, 90.9 percent of all social insurance tax contributions are made by people with incomes of less than $10,000 per year.

How about cost projections? In 1949, the estimate was made that social security benefits would reach $12 billion per year in 1999. They reached that amount in 1961, 38 years ahead of schedule. Are projections about the cost of a "medicare" program likely to be much better?

The University of Michigan Survey Research Center completed a survey of the financial condition of older folks in 1962. It showed that people 65 and over are actually better off, financially, than any other age group in our Nation.

Some time ago—I have not given you the exact year there, I am not sure whether it was 1961 or 1962—the Conference of Catholic Charities conducted a survey of the financial condition of older folks among what the conference itself described as "lower middle income" parishes, in St. Louis, Cleveland, and Buffalo.

When asked who would pay for hospitalization if it were necessary, over 80 percent of all those surveyed said they had hospitalization insurance, savings, or potential help from children or other relatives.

I have personally visited with a number of hospital administrators about this problem. And without exception, they report that the age group from which they have the most trouble collecting hospital bills is not older people—but young married people who are in debt for babies, houses, automobiles, TV sets, and so forth.

Now let's talk for just a moment about the thinking of people around the country. First, I would like to mention the surveys taken by your colleagues in the House of Representatives. We know you are already familiar with them, but anything that so closely reflects the thinking of the American people should certainly be included in these hearings.

In 52 polls taken among their constituents by Congressmen in 1961 and 1962, a majority of those replying were against King-Anderson-type legislation in 33 instances; in only 19 instances out of 52 were they in favor.

Through July 30, 1964, single choice, "yes or no" polls taken by members of the 88th Congress totaled 51. In only 9 of the 51 did the largest percentage of those responding favor the social security approach.

In addition, seven "multiple choice" polls, attempting to discover what method people preferred for paying hospital bills for the needy aged, were taken.

In not one did a majority of those responding favor a social security approach. All of you on the Senate Finance Committee are, we recognize, already familiar with these figures.

Senator CURTIS. May I interrupt right there?

Mr. HILL. Yes, sir.

Senator CURTIS. Those polls are in face of the great amount of misinformation that is put out about King-Anderson and similar proposal, isn't that right?

Mr. HILL. Yes, sir; this is true. There was one poll taken in favor by a representative who in his poll asked this question.

He said: "Wouldn't it be nice if you could have all this for a quarter a week?"

And on that particular poll he got a yes.

Senator CURTIS. I am not condemning any person, but the fact remains that there is a very widespread amount of misinformation and lack of information on what the King-Anderson bill will do, who will pay the taxes and what the old folks would get out of it, isn't that correct?

Mr. HILL. I think this is absolutely true, Senator.

Senator CURTIS. Yes.

Mr. HILL. We believe that one other statistic should be mentioned. The Kerr-Mills law is now in operation in 37 States, plus the District of Columbia, Guam, Puerto Rico, and the Virgin Islands. More States are passing laws to implement that program every legislative year.

Just one more poll. When I learned I was coming here, I decided that it might be of benefit to this committee if I brought you the latest thinking of the people of Indiana. So I asked one of the 12 radio stations in Indianapolis to ask the following question on one of their public service programs, with answers to be sent to me.

The question was used on an evening program on Thursday and Friday, August 6 and 7, and on Monday, August 10. To be tabulated, an opinion had to be in the mail on Tuesday, August 11, so that I would have it the next day.

In so short a time, I believe you will agree the number of replies is amazing, particularly when you consider that the question was on radio 3 times on only 1 station out of 12, and that people had to compose their own letters, postcards, and telegrams after hearing the program, and that people acted purely on a voluntary basis. The question was worded in as unbiased a manner as it could be:

Do you favor the present Kerr-Mills law, which is a Federal-State cooperative law which pays all medical bills for people 65 and over who cannot pay their own, or do you favor a compulsory approach under social security which would cover everyone over 65?

People were asked to send their replies directly to me at my home.

The results:

Total number expressing an opinion	325
Total number in favor of King-Anderson-type legislation	3
Total opposed to all social programs or in favor of Kerr-Mills legislation	322
Percent favoring King-Anderson	1
Percent favoring Kerr-Mills	99

I would like to comment here on just two things, I frankly was very much surprised at this. I did not think that the preponderance again would be so great, and secondly, I was amazed at the number of people who, with an opportunity to get their thinking before this committee, who were in favor of medicare under social security did not bother to even write.

I have all of these opinions here with me. I have brought them here in this book, and if I may I would like to turn them over to this committee as a sampling of the people of Indiana on the bill you are now considering, is that permissible?

Senator LONG. We can keep it for the committee files, not for the record.

Mr. HILL. May I turn it in?

Senator LONG. Yes, sir.

(The information referred to will be found in the files of the committee.)

Mr. HILL. I have also included here the thinking of about 200 members of our own association, all over the country who have sent me their thinking and I would like, if I may, to turn this over to the committee, too.

In summary, for some reasons that we, as members of the International Association of Health Underwriters, believe are equally as important as all of the statistics that have been mentioned in this report and elsewhere.

Our members constantly deliver claim checks in practically every hospital in the country. We are thoroughly aware that when a person is hospitalized, the family budget can be wrecked, family finances can suffer a definite setback. And it is unquestioned that when this happens to an individual age 65 or over, particularly if he is retired, his ability to recover by earning money is severely curtailed or even nonexistent.

But health care problems of those 65 and over are problems of individuals—not problems of an age group. There are many millions of older Americans who are perfectly capable of taking care of their own financial needs, be they for hospitalization or otherwise—and who without question prefer to do so.

During the last 4 or so years, it has been my personal privilege to make more than 100 talks on the subject of medicare from groups as small as 30 or 40 to groups as large as 700 or 800, and on radio and television where for practical purposes it is impossible to measure the number who are listening.

It is amazing how many older people attended these meetings, even in inclement weather. I will never forget a night that was 5 below zero in northern Indiana, when the wind was blowing probably 30 miles per hour. I spoke at a meeting that was attended by more than 300 people.

After the meeting, one of the people who came to the front of the room to speak to me told me that she was 84 years old, and that she was unalterably opposed to legislation of this kind. I don't even know her name, but to me she represents the thinking of many of the people over 65 in our country—proud, independent, self-sufficient and self-reliant; who want the feeling of self-satisfaction that comes from knowing that they have taken care of themselves—that they are in debt to no one—that they have not needed a social program to pay for their needs. I have talked personally to hundreds of other Americans just like this lady, and surveys indicate that there are millions more.

Social security taxation is becoming an increasing burden to the younger people of this country. Yet few of them would shirk their obligation to the older people of our country—and such an obligation definitely does exist.

But that obligation is to the people who cannot care for their own needs—it is not to everyone on the automatic event of his or her 65th birthday. The obligation of society is to the people of any and every age who are unable to care for themselves.

In the health care field, we are meeting this obligation to people 65 and over through the Kerr-Mills law and State programs, and to younger people through State and Federal programs of public assistance. These should be maintained at a level that will meet the needs of those less fortunate in our society.

But no law should be passed which will make everyone who does not need a Federal medicare program subject to such a program. We believe that this is the thinking not only of the International Association of Health Underwriters, but also of the majority of the American people.

Thank you for allowing us the privilege of presenting our testimony at this hearing.

Yes, if I may, I would like to add two points that are not on here that had to do with subjects that have been previously discussed this morning.

Is that permissible?

Senator LONG. Yes.

Mr. HILL. Very briefly, one of the questions that Senator Smathers brought up before he left the room was this: The question there has been a lot of misinformation, as Senator Curtis referred to a moment ago, about both social security and the medicare plan, and the question has been asked or the statement has been made whichever way we prefer to look at it, that isn't it a good idea for people to save during their working years in order to pay for things that they want after retirement.

And I think everyone who agrees with the free enterprise system or with individual initiative agrees that this is true.

I would like to point out that this has been represented as being true of both social security and medicare and nothing could be further from the truth.

Just as a specific case in point, I would like to mention, for example, a man who has been under social security since the law first became effective January 1, 1937, who retired January 1, 1964, and who has paid the maximum amount of social security taxes every year since the law was enacted: if he has paid that maximum amount of taxes, he has paid $1,758 in social security taxes.

If he and his wife both live out their actuarially anticipated lifetimes they will draw $36,200 in benefits.

Senator LONG. It seems to me we should recognize that people are saving. You put these figures in the record in your statement, stating that 70 percent of families over 65 own their own homes completely paid for.

If we are going to take out 10 percent of their income for social security taxes it will be 15 percent in the next 10 years. If you are going to take out 15 percent of their income for social security taxes, plus about 20 percent for costs of general government of the United States, let the States get to them for about another 5 or 6 percent, by the time the government gets through with them we take about 50 percent of their income from them in taxes. Then you are not going to have any

70 percent of them who own their own homes by the time they get to be 65 because the government just wouldn't be leaving them that much on which to live.

Mr. HILL. I think that is exactly true.

Senator LONG. So as a practical matter they do have savings and if they fall sick or fall on bad times that is an asset against which they can borrow a very substantial amount of money if they need it, otherwise the home would never have been paid for to begin with.

They would have had the mortgage on the home in the first instance. So, I think it is well to keep in mind that people are providing for these things. They may not be thinking about it that way but when they have a life insurance policy, with cash value, they have a home that is debt free, and they have an automobile and things of that sort, they do have assets or savings which are resources that they can call upon if they need them.

That has been the tradition of this country, at least up until now for the first 200 years of the Nation's existence anyway. We save and provide for our own needs when these things arise.

One thing that does concern me somewhat is this argument that you should not have any needs test in connection with this. It may sound fine, let's not have any needs test, but if you are talking about taxing someone who can't afford to pay in the first instance, some man who has a wife and five or six children to provide for, making $3,000, and taxing him money he can't afford to pay, and taking that to provide medical care for someone who is well able to pay for it, it doesn't quite square with the theory of social justice that when you charge someone to provide a service for someone else, the person who is paying should be the one who is better able to pay than the person who is receiving.

Mr. HILL. This is one thing that has been very confusing to me as to why the needs test has been objected to so strenuously in regard to medicare, as we call it, when most of our other Federal, State, and local programs, Federal programs, contain a needs test for assistance.

Senator BENNETT. I would just comment that earlier in the hearings I put into the record a list of 10 of the major Federal assistance programs which do involve a means test, and I can't find any program except the King-Anderson proposal which does not involve a means test.

We are breaking into new territory on the theory that everything we have done in the past somehow embarrasses and humiliates, those who have received Federal benefits or subsidies apparently just to talk about their medical care means we suddenly are supposedly going to embarrass and humiliate them when we ask them how well they are prepared to either take care of themselves or contribute part of the costs of the program.

Senator CURTIS. In the interest of saving time, I won't say much. You had a very fine paper and gave us a lot of information.

One question: Isn't it true that an individual might be a veteran of many years' combat, if he has ample means to pay his bill in the veterans' hospital he is required to pay it, isn't that true?

Mr. HILL. Yes, sir.

Senator CURTIS. That is all, Mr. Chairman.

Senator LONG. I asked this question and I have been supplied the answer I believe to be the correct answer. Here is a statement of Fed-

eral expenditures for medical and health-related programs on an agency basis. I believe I will have this put in the record at this point. The total net budget expenditures for health in 1963 were, at the Federal level were $4,663,500,000.

Now, the 1964 estimate, and the year is far enough along to know how it would work out, was $5,214 million or an increase of $600 million roughly, and for next year the estimate is $5,408 million, an increase of another $200 million based on estimates.

My guess is we will spend more than that. So we are, at the Federal level, spending a great amount of money on health now.

Senator BENNETT. Isn't all of that subject to a means test?

Senator LONG. Not all of it because part of it comes under the Veterans' Administration, and the Defense Department. But there is most of it would be and there is a tremendous expenditure here.

Thanks so much.

Mr. HILL. Thank you.

Senator LONG. That was page 399 of the budget of the Government of the United States for 1965.

The next witness is John B. O'Day.

STATEMENT OF JOHN B. O'DAY, APPEARING ON BEHALF OF THE INSURANCE ECONOMICS SOCIETY OF AMERICA

Mr. O'DAY. Mr. Chairman, and members of the committee, my name is John B. O'Day, and I am appearing on behalf of the Insurance Economics Society of America, an organization devoted to the study of all forms of social insurance. My home is in Northbrook, Ill.

It is with a deep sense of responsibility we appear before this Senate committee to give testimony in opposition to proposals which would add hospital and nursing services to the already underfunded social security OASDI program.

These proposals are not new. They have been around in one form or another for over two decades. Congress has rejected them time after time, year after year, because they are fiscally unsound; they impose a tax burden on the current wage earner to provide inadequate medical care for all over 65 in order to reach a minority in need; and they have been rejected because of the adverse effect they would have on the American philosophy of life.

That there is a growing and urgent need for this type of legislation proponents have argued for years. But the facts are that the magnitude of the actual need and its urgency have been diminishing rapidly due to the farsighted measures taken by previous Congresses and the demonstrated desire and capability of the private sector to provide the best health care for the entire population, aged included.

There are those who would have the American people believe that the legislative branch is impervious to the need for medical care of our aged—that a congressional deaf ear has been turned to the problem. A review of the legislation which has been passed by this body to alleviate this problem indicates that nothing could be further from the truth.

I refer to the old-age assistance program which provides our indigent aged with not only complete medical care but with food, clothing, and shelter as well.

I refer to the Kerr-Mills Act passed by Congress in 1960. Ker Mills involves local legislation which is designed to fit the realist needs of the aged as determined in their own locale and by local publi officials who are acutely aware of prevailing conditions locally. Th problems of the aged in one area of the country can be as differen from other areas as the climate, topography, economic conditions, an population density are different. Congress recognized these differ ences when it passed Kerr-Mills allowing each State the latitude t tailor its own plan to fit its own needs.

I might add parenthetically that the medical profession and th business community with few dissidents suported this humanitariar legislation.

In providing comprehensive medical care to those aged who hav the financial resources to provide for themselves in every other way except medically, Congress has demonstrated its ability to recognize the basic problem and to solve it expeditiously. The problem was kept in perspective and a logical solution in line with American philosophy was conceived, legislated, and has been and is being further implemented.

While Congress concentrated on solving the problems of those aged who are unable to provide for themselves, the insurance industry has been working on the problems of the majority who are able and willing to provide for their own medical care.

Over 10 million of those over 65 are carrying health insurance under a variety of policies, many of which did not even exist when Congress began to concern itself with the problem. Hospital, surgical, and major medical coverages for those now over 65 have been devised and are readily available to all who apply irrespective of past health history.

To those under 65 a wide variety of health insurance policies are available. Guaranteed lifetime coverage is being offered by more and and more companies. New group insurance concepts include coverage beyond retirement.

With each passing year more and more will enter retirement status with health insurance similar to that which they carried throughout their earning years.

Further, the insurance industry, which has always been alert to the progress constantly being made by the medical profession, can be expected to respond with new coverages to the ever-changing medical needs of all segments of the insuring public.

As in the past, health insurance coverages of the future will evolve under a keen competitive atmosphere with benefits to include every advance in medical treatment for old and young alike.

In a relatively short time tremendous progress in the financing of medical care has been experienced by both the public and private sectors, each in its own domain.

To measure this progress one need only turn the calendar back 10 years to a time before widespread medical care insurance for the aged had even been conceived.

Terms like senior citizen policy, major medical, State 65 plans, and open enrollment were unheard of. During this period, when little insurance coverage for the elderly was available, Congress considered and rejected the idea of social security financed medical care time and time again.

The wisdom of this course of action has been proved by the subsequent phenomenal public response to voluntary health insurance coupled with the enactment of MAA.

If social security financed medical care was considered unsound in the 1940's and 1950's before health insurance was universally available and before MAA was enacted, is it not an even less sound proposition today?

This committee has heard testimony as reflected in the House bill being considered concerning the actuarial imbalance of the OASI trust fund, the inadequacy of the disability fund, the necessity to raise the social security taxable wage base by 12½ percent and the tax rate itself to a degree just short of 10 percent of taxable payroll.

How long could this system, currently lacking in financial stability, stand up under the addition of a proposed medical care trust fund which promises susbtantial deficits from the very outset.

What changes in the tax and the tax structure would be necessary in the future as continuous pressure was placed on Congress to expand the rather limited benefits which have been proposed.

And does anyone seriously contend anything other than once the Government is established as having a responsibility to provide medical care for one segment of the people, it would rapidly extend its responsibility to include all the people.

A study of the history of social security, the periodic expansion of benefits and the continuously increasing taxes clearly marks such a course. One is inclined to ask if a system of compulsory Government health insurance for all is being advocated.

In conclusion, there is one further ominous aspect to a government system of medical care and perhaps American citizens would consider it to be the most compelling argument against such a system. That is, a serious curtailment of individual freedom. An invasion of privacy into an individual's personal health history which has always been held at inviolate as a penitent's confession to his priest or minister.

Proponents of Government medicine discount this argument and even reverse it by promising that individual freedom of choice and privacy would be in fact preserved.

But should this statement stand unchallenged when the truth is that each participating hospital would have to have the approval of the Secretary of Health, Education, and Welfare and that each participating doctor would have to have his approval also. Does not control of the hospital and control of the doctor also means some control of the patient?

There is ample evidence throughout the world that free choice of doctor, hospital, and even the method of treatment cannot long exist under a government health insurance program.

Freedom of choice must give way in any confrontation with government regulation for would it not be far from prudent to allow billions of public funds to be spent without close supervision and regulation by government?

In fact, isn't this what the Supreme Court meant in 1942 when, in an agricultural subsidy case, it ruled "It is hardly lack of due process for the Government to regulate that which it subsidizes."

Mr. Chairman, may we again urge this committee to continue its efforts in helping the aged who are unable to help themselves and to

vote against those proposals which would increase social security taxes for Government-controlled medical care for persons who can provide for themselves.

We thank you for allowing us to testify.

Senator LONG. Thank you,sir.

Any questions?

Senator BENNETT. No questions.

Senator CURTIS. I would like to ask unanimous consent to submit for the record an article on medicare from the Washington Star of May 1, 1964, and another article from the St. Louis Globe-Democrat of April 30, 1964.

Senator LONG. They will be placed in the record.

(The newspaper articles referred to follow:)

[From the Evening Star, May 1, 1964]

MONEY AND POLITICS—DEMOCRATS PUT CASH INTO MEDICARE FIGHT

(By Walter Pincus)

Funds from the Democratic National Committee provide an important source of revenue for the National Senior Citizens Council which, according to its own literature, "has been the acknowledged leader in the national campaign to mobilize public support for a program to finance aged hospital insurance through social security."

In seeking members, the council describes itself, however, as a "nonpartisan organization of independent senior citizens groups and individuals."

The council is holding its annual convention in Washington the weekend of May 8–10 with President Johnson and a group of administration officials scheduled to speak.

SILENT ON RELATIONSHIP

As the medical profession's political action organizations have chosen not to disclose the candidates who will receive the $3 million they plan to distribute this year, so the council and the Democratic National Committee have chosen to remain silent—until now—on their financial relationships.

Records on file with the Clerk of the House, however, show that in the first 2 months of this year, the Democrats contributed $15,000 to the council. Last year, $40,000, or almost one-third of the council's reported budget came from the Democratic National Committee.

SEEN AS VOTING BLOC

The council acts as a political education center for 1,700 affiliated senior citizen clubs with combined memberships of about 1.5 million. Though these affiliated clubs are—for the most part—nonpolitical, the council has sought to involve them in such things as congressional letterwriting campaigns on behalf of medicare and other issues, including increased Federal aid for senior citizen housing, opposition to "fair trade" legislation and support for the proposed National Service Corps.

"The Senior Citizens Council," said a spokesman for the opposition American Medical Political Action Committee (AMPAC) recently, "represents an attempt by the administration to weld senior citizens into a voting bloc." Though the AMPAC man was unaware of the Democrats financial support of the council, he seems to have been fairly accurate in his assessment.

There are some 18 million Americans 65 and over, most of whom are retired. Polls show that this group—which votes more conscientiously than younger groups—tends to be strongly conservative in outlook and thus heavily Republican at election time.

In the 1960 elections, a Senior Citizens for Kennedy Committee was formed to try to make political capital of the medicare issue. The effort was impressive enough to cause the Republicans to set up their own senior citizens division within their national committee.

In August 1961, former Congressman Aime J. Forand—sponsor of the original medicare legislation—and some veterans of the Kennedy campaign group established the Senior Citizens Council. Though the basic effort was to enlist support

of the thousands of old age clubs across the Nation for medicare, there was also the possibility that the senior citizens could be wooed into supporting Democrats rather than Republicans at election time, since the Democratic Party as a whole was more oriented in favor of Federal support for senior citizens legislation.

FIGURES ARE DISPUTED

Through a monthly newspaper, mass rallies, petition campaigns, and education workshops, the council has kept the medicare issue in the public eye. One of its brochures also lists "supported Congressmen and Senators who supported medicare" as one of its activities.

The election support referred to, however, is strictly educational. The AFL–CIO and some affiliated unions—particularly the Steelworkers—have been handling the direct financial contributions to promedicare Congressmen through COPE and the United Steelworkers of America Voluntary Political Action Fund.

AMPAC Director Joe Miller told a business audience in January, 1963, that in the 1962 congressional elections, COPE sent financial aid to 42 marginal House candidates. Of these, Mr. Miller went on to say, AMPAC contributed to 30 candidates on the other side. The result, according to Mr. Miller, was victory for 25 of the doctor-supported men. Union leaders dispute his figures.

There is little doubt that with AMPAC studying 77 congressional districts for contributions, they again will be squaring off directly against COPE candidates during this fall's election.

Along with the Democratic National Committee, the Senior Citizens Council depends upon labor unions for both financial and administrative assistance. For example, at least 4 of 13 council field representatives primarily represent labor unions in their particular cities.

CONTRIBUTIONS LACKING

Clubs affiliated with the council are supposed to contribute $10 apiece for membership, but council officials admit not all of them do. "The old folks just don't have money to spend this way," a council spokesman said recently.

Asked about the propriety of the Democratic Party contributions to his organization, Council Information Director William Hutton said the money was used partially to cover costs of printing pamphlets on social security and writing Congressmen. Mr. Hutton noted that a Republican, Dr. Arthur Larson, former Eisenhower administration official, was on the council's board of directors. He added, the council would accept funds from the GOP National Committee if they were offered.

[From the St. Louis Globe-Democrat, Apr. 30, 1964]

DEMOCRATIC PARTY AIDS MEDICARE UNIT

NATIONAL TREASURY GAVE $15,000 THIS YEAR TO SENIOR CITIZENS' GROUP

(By Edward W. O'Brien)

WASHINGTON.—The National Council of Senior Citizens, which describes itself as the voice of 2 million elderly people who favor the medicare health proposal, is in reality receiving a sizable portion of its financial support from the Democratic National Committee.

In the first 2 months of this year, the Democratic Party's national treasury contributed $15,000 to the council, according to a report filed with Congress by the Democratic committee.

The contributions were in $5,000 checks January 3, 22, and February 14.

The Senior Citizens Council's budget for the entire year for funds from all sources is $150,000, Information Director William Hutton said.

In 1963, the Democratic National Committee's contributions to the Senior Citizens Council totaled $41,000, represented by checks February 1, June 4, and July 23.

$5,000 TO START

In 1962, when the council was getting started, it received a check for $5,000 from the Democratic treasury. This was March 30.

The Senior Citizens Council had its founding convention in May 1962. It had been organized on a temporray basis in August 1961.

Though the council's support of medical care for the elderly financed by social security has been its reason for being from the start, the council's financial tie to the Democratic National Committee has been much less obvious.

In a press release last January 10, the council's self-description was that the group "includes more than 1,700 affiliated older peoples' clubs in nearly all States, with a combined membership approaching 2 million older people."

"Its prime goal," the press release continued, "has been to build support for and understanding of social security-financed health care for older Americans."

PUSH FOR MEDICARE

The big push for medicare was launched by President Kennedy and is being continued by President Johnson. The proposal is opposed by most Republican Congressmen and by organized medicine through the American Medical Association.

In an interview, Mr. Hutton, the Senior Citizen's Council spokesman, said he could not give a breakdown of his group's sources of income.

He said that not all of the Golden Age Clubs are able to pay a $10-a-year charter fee to the national group here, many individual members give $1 for a golden card, he said.

Supporting groups also help, he said, and they include some church groups, labor unions, and some political groups.

Asked about the political groups, he said the Democratic National Committee helped last year in paying for promedicare information kits for high school debaters.

Asked about the 1964 gifts from the Democratic treasury Mrs. Hutton said that money is being used to update a promedicare film called "For All the Rest of Your Life." The film is being changed to include a talk by President Johnson.

He described the council as nonpartisan and as not taking any political side, though it announced in 1962 it would support all political candidates who will support medicare.

"We seem to have carried the ball more than anyone else on medicare," Mr. Hutton said.

The national council will hold its annual convention here next week. The acting president is John W. Edelman, former legislative representative of the Textile Workers Union. The first president, former Rhode Island Democratic Representative Aime J. Forand, has relinquished the position because of poor health.

One of the council's major efforts was the countrywide series of promedicare rallies around the country in the summer of 1962. They were billed as a grassroots mobilization of medicare support.

Though the rallies were listed as sponsored by the National Senior Citizens group and its local affiliates, much of the work was done by Federal Government personnel, some of them hired specially for the purpose.

Senator LONG. The next witness will be Mrs. Bessie Gottlieb, National Council of Senior Citizens. We are pleased to have you here today.

Would you identify the young lady who accompanies you, Mrs. Gottlieb?

STATEMENT OF MRS. BESSIE GOTTLIEB, VICE PRESIDENT, CHICAGO AREA SENIOR CITIZENS ASSOCIATION OF CHICAGO, ILL.; ACCOMPANIED BY DEBORAH GOTTLIEB

Mrs. GOTTLIEB. This is my granddaughter, and she is very active in civic problems and so I thought I would bring her with me so she could know how ways and means people conduct their programs, and so forth.

Senator BENNETT. Mrs. Gottlieb, I think we should honor her by having her name in the official record.

Mrs. GOTTLIEB. Her name is Deborah Gottlieb.

Senator BENNETT. How old are you, Deborah?

Miss GOTTLIEB. Well, I am 11.

Senator CURTIS. I want to say, Mr. Chairman, we are delighted to have Deborah; and, Mrs. Gottlieb, before you start, the full title of your group is the National Council of Senior Citizens?

Mrs. GOTTLIEB. Yes, I represent them, and I also represent the Chicago area of Senior Citizens, which comprises of about 110 small clubs with a membership of about 3,500. Then I am honorary president of the President's Council of the Jewish Community Center. They have about 22 senior adult clubs comprising about 2,500.

Senator CURTIS. Are you familiar with the name of Mr. William Hutton?

Mrs. GOTTLIEB. What is that?

Senator CURTIS. Are you acquainted with the name of Mr. William Hutton?

Mrs. GOTTLIEB. Hutton?

Senator CURTIS. Yes. He is assistant director of the Senior Citizens.

Mrs. GOTTLIEB. Of the National Council.

Senator LONG. Mrs. Gottlieb you can proceed as you would care to and then we could have questions if it would be satisfactory.

Mrs. GOTTLIEB. May I.

Mr. Chairman and members of the Senate Finance Committee, as I told you before, I am vice president of the Chicago area association of the senior citizens, consisting of 100 clubs in all with a membership of about 3,500, and I am also honorary president of the President's Council of the Jewish Community Center with 22 clubs throughout the metropolitan area of Chicago consisting of about 2,500 members.

In addition, I am also the national vice president of the National Council of Senior Citizens. I have been working on my own here in Washington interviewing Congressmen and Senators for the past 7 years. I have been very active.

Why have I been so active for medicare? Because coming in contact with so many of the older people, seeing their poverty and their needs, gave me the incentive to work for this medicare bill.

Many of them have absolutely no assets at all. Some of them are not even under social security, and have to look to their children for maintenance.

The children themselves are hard pressed, too. Many older people do not have children or anyone else to turn to. In speaking to one of your Congressmen, I will not mention his name, and I suppose I am not allowed to, he asked me when I interviewed him. He asked me: "Mrs. Gottlieb, how come that the older people did not provide for their senior years, or for their retirement?"

And this is what I told him: "Perhaps you do not remember that we older people went through two wars, depressions, and recessions. They did not want to stand in the breadlines or the soup kitchens so they used up their finances."

I would like to tell you about my own case history.

When the First World War broke out, naturally I wasn't married then until 1917. My first child came, was born in 1918. We had saved a little money. When he was 5 years of age, he had a mastoid operation, $1,100. I did not have that much. I had to borrow some.

That was paid back. I am of a very independent nature and I did not want to go to my family. Most of them have their own troubles.

Then the Second World War came. We could not have insurance because my husband was a diabetic.

I managed to save some money. Then in 1945, I had surgery. In 1951, I was operated on again.

In 1956 again, and in 1961, there was more surgery. You would be surprised if I tell you this, seeing that I am so active, that two of these illnesses were cancer. The doctors tell me that when I have passed the 5-year point, I will live a long time.

Now they do not guarantee that I am free entirely. I get checked by four doctors on account of the surgery that I had.

My case is somewhat similar to the people I represent. Today I live only on my social security. I have absolutely no other assets or financial income. I am an independent spirit. I do not like to go to neighbors or to friends. If you want to lose friends, just go to a friend and try to borrow money.

So you see, for 17 years I have been a widow, and managed to get along on the little I had until that was spent.

I would like to tell you about this. In June of 1947 my husband took sick with a heart attack. It was so bad he could not be removed to the hospital. For 3 weeks I had oxygen every single day at $17 a day. I had to have two nurses around the clock. By the time I paid the doctor's bill and paid all the bills relative to his sickness, there was very little left.

I did have a nest egg of $3,000. But deduct all these bills that I had to pay, feeding two nurses and all, there was very little left.

Now then, should another illness occur, I would have to ask my family. They have children of their own and today bringing up children is a very expensive proposition.

When my children were born, the only time I had a doctor for them was when they were sick, but today children get checkups practically every month for all kinds of allergy, sicknesses, smallpox, polio, and so forth, that is an expense to an average family.

Besides that, the administration stresses the fact, keep the children in college, they need more doctors, scientists, and so forth.

Now, who are these young people to take care of first, their own children or a father and mother, and you must not forget that some children have two sets of parents, the husband's parents, and the wife's parents to look after.

A story was—I want to read this to you—a story was carried in the Chicago Daily News and other papers by W. M. Newman on July 27, 28, and 29 this year concerning foreign visitors at a Chicago supermarket. They noticed several men loading grocery carts with cat and dog food. One of them asked, "For your pets, they must eat a lot."

The man replied, "No, it's for us. It's all we can afford."

The clerk in the store indicated they had quite a few who can only afford cat and dog food. The article went on to say that more money is being spent on food for the animals in our zoo in Chicago than older people receive from public assistance and minimum social security. I would like to insert this series of articles in the record, because

it reflects the problems we of Chicago face. I am sure other cities have similar problems.

This small social security increase you have been considering isn't the answer and you know it. A dollar a week raise for the increased cost of living is nothing compared with the $144-a-week raise you gave yourselves.

We tell you frankly we would rather have medicare, the King-Anderson-Javits type, which is worth more than $180 a year if purchased as a private insurance policy. Many of us couldn't qualify to buy such insurance even if we had the money. As hospital costs keep going up medicare will be worth a lot more, and the cash or private insurance a lot less.

You are leaving out millions of people if you simply pass the Mills bill. The retired railroaders who will get nothing unless you pass the medicare bill, and many retired people on State and local civil service, teachers on pensions, a number of persons on private pensions and those on public assistance will simply have the 5-percent social security increase deducted from their other pensions or benefits and will receive no increase at all.

I can tell you committee members that it is most difficult to meet hospital and doctor bills when you have only income from social security. And it's even worse to have to become a pauper in order to secure help when you do not have the necessary money for these expenses.

It's a known fact that many who are eligible for social security and who receive same, will go on living with our illnesses rather than take the pauper's oath. It will no doubt shorten the lives of many. It is my honest belief that if this measure passes, it will allow many people, who today are suffering from various illnesses to get medical attention.

In this connection I would like to submit for the record one of the most dramatic cases showing the need for hospital care legislation that we have encountered so far. The facts of this case appeared last year in a letter to the editor in a Peoria, Ill., newspaper. The case described in this article occurred in Peoria, a city of 110,000 people. The letter is as follows:

On Thursday August 8 1963 I played a political football game with a man's life. Yes this is no joke. The man was 69 years old and his eyes were set. He was cold and clammy feeling. He lives on what he receives from his old-age pension (which most of us couldn't start to live on). He had been sick for 3 days and had nothing to eat in that period of time.

He was so weak he couldn't walk under his own power. He had stayed in his own room all during this time for he didn't want anyone to worry about him. What at last he came out, it was for help. But where is a man in his condition supposed to get help? The old-age pension, naturally.

Oh, no. We called them and told them he was sick. They said to send him to the emergency room at the hospital. He was left there, thinking he would get help. He waited in the hall for 45 minutes to an hour.

The first thing they asked was did he have a doctor or did he have insurance. No, he had neither. What transpired between the hospital and old-age pension then is beyond me. All I know is they sent this man, too weak, home in a cab, not knowing if someone was there to help him or not. We paid the cab.

We then decided to call the relief office and see if we could get some assistance there. After telling Zack Monroe the details, he said he would call back if he found a solution. He never called back.

Looking at this old man, I realized he needed medical attention fast or it would be too late. My only solution was the State hospital in Bartonville. This was suggested by the old-age pension. I took him over there, with the assistance of another man since I couldn't handle him by myself. We had to support all of his weight. Upon being admitted to the admitting office, I was told they only took mental patients. To this I replied: "If nothing else, I'll say he's crazy. He needs a doctor." They asked if I were a relative. No, I'm just a friend. Many questions kept coming.

I pleaded for them to take him. I waited in the hall for the doctor to talk to me. When he finally came, he went out to the car with me, took one look at him and said: "We'll take him." I'm not a religious person but I stood in the heat and thanked God for finally finding a place for this old man.

People of Peoria, what are we supposed to do with our old people? We take in babies and we take in puppy dogs, but we kick the old people out. We have a humane society for dogs but what do we have for old people? Are we supposed to just sit back and let them die without even trying to help?

I'm 26 years old and the mother of six wonderful children. I thank God for this blessing and pray that my children won't have as much trouble getting help if I ever need it as bad as this man.

I was over to see my old friend Saturday afternoon and again today. It was his birthday. The only present I had for him was his life. No one else seemed to care about it.

MRS. THELMA YARBROUGH.

Mrs. Yarbrough called our field representative, Mr. Ken Johnston, in Peoria after this letter appeared in the press. She authorized Mr. Johnston to give her letter the widest publicity. She urged the national council to exert the most terrific efforts to pass a medicare bill.

Before I conclude, I have forgotten to mention about 4 years ago, I believe it was, I interviewed another Congressman.

He asked me how old I was and I told him, and he says, "Well, I am 78, and I am going to tell you something, Mrs. Gottlieb, I do not believe"—at that time it was the Aime Forand bill—"I don't believe in it because it is socialized medicine," and he tells me a story that his aunt had met with an accident. She had had trouble with her hip, they had to put in a plate, and he says, "By the time I got through paying her hospital, doctors, and medicines it came to close to $2,000."

And I looked at the Congressman and I says, "Now, weren't you pleased that you had that money. What are we to do with our people when they get sick, just let them lay there until they die?"

And this was his answer: "That is your problem and not mine."

This Congressman is retired now, and I guess you can about guess who he is. At that time he was 78 years old.

So, you see, it is not just my case or the case that I have just read to you, it is the case of so many older people that I have come in contact with, and you will wonder why am I doing this. I am doing this because I want to forget what has happened to me and what might happen to me in the future, because every ache or pain that I get there is something in my mind. Maybe, maybe.

So, I get up in the morning and I go out and see what I can do; spread a little cheer to those that haven't got the means. Some of our people are really desperate, and to go again if this Congress goes through, I don't know if any of you know what a pauper's test means, it is practically degrading.

Don't forget that our older people have helped in their small way to build this glorious country of ours, and I think that they are entitled to be taken care of.

In conclusion, I do want to say this: I know the desperate situation in which many of our older people find themselves. These are the people, like I have said, who have built America, and who have made it great. We did not expect to live so long, and I do not see how we could have predicted the fantastic cost of hospital care.

For us there is only one thing that will let us sleep comfortably at night and that is to know for sure that our hospital bills will be paid if we have to go to the hospital. Kerr-Mills will not do that. Private insurance will not do that. Only medicare can do that. I plead with you to help those of us who are retired, and especially for those of us who are widowed * * * please pass a medicare bill.

Won't you please let us live in the dignity and respect that I think America owes us.

(The attachments referred to follow:)

CONDENSED SUMMARY OF INCOME STATUS OF OLDER AMERICANS

In 1961, 45 percent of the single persons over age 65 had less than $1,000 a year cash income from all sources, two-thirds had less than $1,500 a year, three-fourths had less than $2,000 a year, and only 1.2 percent had more than $10,000 a year cash income from all sources.

In 1961, in the families whose head was over age 65, one-third had income of less than $900 per person in the family, 40 percent had less than $1,000 per person, two-thirds had $1,750 or less, and only 1.2 percent had more than $4,800 per person per year.

(Source: U.S. Census, February 1963, series P–60, No. 39.)

What widows and other single persons over age 65 who live alone get per day to live on according to the 1960 census

(The includes all moneys from whatever source, including social security, public welfare, veterans' benefits, employment, pensions, etc. It would be even less if employed people over age 65 were left out.)

	Average yearly income	Average daily income		Average yearly income	Average daily income
All States	$863	$2.36	Missouri	$767	$2.10
			Montana	1,058	2.90
Alabama	607	1.66	Nebraska	858	2.35
Alaska	1,250	3.42	Nevada	1,237	3.53
Arizona	900	2.47	New Hampshire	863	2.36
Arkansas	637	1.75	New Jersey	854	2.34
California	1,260	3.45	New Mexico	786	2.15
Colorado	1,400	3.84	New York	871	2.39
Connecticut	964	2.64	North Carolina	642	1.76
Delaware	830	2.27	North Dakota	853	2.34
District of Columbia	1,287	3.53	Ohio	834	2.28
Florida	849	2.33	Oklahoma	776	2.13
Georgia	647	1.77	Oregon	958	2.62
Hawaii	745	2.04	Pennsylvania	824	2.26
Idaho	955	2.62	Rhode Island	829	2.27
Illinois	865	2.37	South Carolina	629	1.73
Indiana	799	2.19	South Dakota	798	2.19
Iowa	866	2.37	Tennessee	639	1.75
Kansas	851	2.33	Texas	703	1.93
Kentucky	681	1.87	Utah	828	2.27
Louisiana	742	2.03	Vermont	823	2.26
Maine	836	2.29	Virginia	718	1.97
Maryland	798	2.19	Washington	1,151	3.15
Massachusetts	995	2.73	West Virginia	701	1.93
Michigan	840	2.03	Wisconsin	832	2.28
Minnesota	852	2.33	Wyoming	1,116	3.06
Mississippi	606	1.66			

Source: Social Security Bulletin O January 1963.

TABLE 4.—*Money income of single persons aged 65 and over*

[Annual median money income of widows, widowers, and other single persons over 65]

State	All single	Men	Women	Living alone or with non-relative	Living with relatives
Alabama	$566	$687	$530	$661	$516
Alaska	1,115	1,310	805	1,327	715
Arizona	863	1,184	723	1,100	624
Arkansas	572	690	526	657	491
California	1,185	1,373	1,108	1,314	953
Colorado	1,237	1,333	1,190	1,287	1,156
Connecticut	967	1,424	768	1,323	738
Delaware	768	1,186	628	1,014	599
District of Columbia	1,298	1,712	1,144	1,923	784
Florida	804	1,206	670	1,001	608
Georgia	584	709	550	692	525
Hawaii	620	944	374	1,020	447
Idaho	945	1,185	823	1,082	696
Illinois	835	1,323	674	1,037	669
Indiana	747	1,148	634	886	599
Iowa	838	1,179	728	967	679
Kansas	817	1,116	729	934	654
Kentucky	602	793	533	694	533
Louisiana	708	897	652	793	650
Maine	811	1,045	713	1,009	637
Maryland	721	1,176	581	966	585
Massachusetts	993	1,382	830	1,244	760
Michigan	802	1,218	648	1,008	615
Minnesota	824	1,121	709	972	670
Mississippi	554	643	521	631	508
Missouri	719	964	641	818	604
Montana	1,053	1,311	868	1,169	789
Nebraska	827	1,126	732	952	652
Nevada	1,190	1,458	930	1,351	844
New Hampshire	835	1,197	718	1,030	677
New Jersey	806	1,342	624	1,132	624
New Mexico	695	937	593	925	502
New York	826	1,323	649	1,140	590
North Carolina	518	692	462	703	433
North Dakota	818	1,135	667	978	644
Ohio	799	1,235	659	986	643
Oklahoma	732	900	680	830	599
Oregon	956	1,244	822	1,122	692
Pennsylvania	760	1,290	582	994	609
Rhode Island	784	1,204	650	1,000	641
South Carolina	513	666	470	642	447
South Dakota	746	957	653	858	605
Tennessee	517	703	455	661	431
Texas	641	814	589	752	541
Utah	791	1,236	669	879	644
Vermont	805	1,016	730	1,022	648
Virginia	575	859	479	845	435
Washington	1,101	1,280	1,005	1,217	784
West Virginia	599	912	490	743	502
Wisconsin	808	1,153	683	961	676
Wyoming	1,090	1,388	904	1,229	787

NOTE.—Singles over 65 constitute about ⅓ of persons over 65.

Source: U.S. Census of Population, 1960, "Income of the Elderly Population."

[From the Philadelphia Inquirer, July 27, 1964]

PLIGHT OF THE ELDERLY—GOLDEN YEARS ARE TARNISHED

"To old to live, too young to die * * *."

That's the bitter refrain of many forgotten Americans in youth-oriented America. Millions of persons over 65 have become outcasts, put on the shelf before their time, or dreading the day when it will happen. Often they struggle along in retirement years on small fixed incomes while prices rise, and they are battered by illness, loneliness, and feelings of uselessness.

Here is the first of a series of four articles outlining their problems and progress.

(By M. W. Newman, special to the Inquirer and Chicago Daily News)

CHICAGO.—A German tourist visiting a Chicago supermarket noticed several elderly men loading their grocery carts with cat and dog food. "For your pets?" the visitor asked with a smile. "They must eat a lot."

"No, for us," one of the men said after an awkward pause. "It's all we can afford."

The stunned German turned to a salesgirl in disbelief. "Oh, yes, we have quite a few who do that," she said.

And so the indignant tourist complained to the U.S. State Department about America's barbaric treatment of its needy old folk.

The State Department referred him to Paul Ertel, director of the Mayor's Commission on Senior Citizens in Chicago. And Ertel listened sadly—because he knew that the visitors' complaint was in good part true, both for Chicago and for other parts of this Nation.

Millions of "senior citizens" in the world's richest country must spend their declining years dogged by poverty, outright hunger at times, ill health, idleness, and anxiety. For them the golden years are tarnished with misery.

While by no means all of America's 18 million oldsters are up against it in this way, enough of them are. The problems of our shelved and neglected grandmothers and grandfathers have become a national calamity, despite progress made in combating its worst effects.

Most of our over-65 citizens, according to the National Conference on Economic Progress, live mired in poverty. It defines poverty as anything less than $4,000 a year for a family, and $2,000 for an individual.

Poverty? To thousands of the elderly, these figures represent high living. They can tell you what bottom-of-the-barrel poverty really is.

Take the 26,000 aged here who subsist on public old-age assistance (relief). Even dog food may be a luxury for them at times. Their food budgets were cut back about 16 to 21 percent last November in a State of Illinois economy wave.

Their average monthly allotments for everything—food, clothing, shelter, personal needs—are around $93. They get less than any other group of people on relief.

"I never thought I would come to this," one bent, white-haired widow said between sobs. "It seems I never have enough to eat anymore."

And an 80-year-old housewife wept when a reporter and county welfare case-worker visited her recently. "We skip lunch to make do," she said. "We eat twice a day, and not much at that. We're hungry."

Her 87-year-old husband, almost apologetically, rattled off relief figures memorized during the long, sad days. "We are supposed to spend an average of 24 cents a meal," he said, "but we find we can't spend less than 42 cents, no matter how hard we try. They tell us to eat a balanced diet. Tell me how."

A balanced diet * * * such as is fed to sea lions in tax-supported Lincoln Park Zoo, for instance. It takes about $5.81 a week to keep a sea lion sleek and well nourished.

That works out to more than the State grants old-age relief clients in Chicago. Their food budget is programed at 78 cents a day if they live alone—and still less if two or more are in the household.

Tigers in the zoo do a lot better ($16.58 a week). Sinbad the gorilla ($41.61 a week) gets lots of fresh fruit and vegetables with a vitamin and mineral supplement. As Sinbad sees it, hunger is for the birds * * * or humans.

But the zoo animals and most of America's human old folk, well fed or not, have one thing in common anyway: they must depend for their upkeep on some public program.

In the case of people, it is usually social security retirement benefits. These average $76 a month nationally for a retired worker, $66 for a widow, $129 for a couple, and are earned by taxes paid during the working years.

About 16 percent of those over 65 have no income at all, however. Eight million have less than $1,000 a year. And half of the older couples, according to the President's Council on Aging, have incomes of less than $2,350 a year, including whatever they have in addition to social security.

They need at least $3,010, says the U.S. Bureau of Labor Statistics, to live even modestly.

Overcoats and movies are never-never wonders to the creaky couples whose taste for 42-cent meals limits them to two helpings a day. Their budget provides for $14 a month for everything after food and rent bills are paid.

"We hardly have bus fare to go anywhere and no money for clothes," said the woman, voicing a common complaint of the elderly. "In church, I cover up my old shoes with galoshes. We have one daughter, but she can't help us. Her husband is an unemployed dishwasher."

The elderly pair live in a cramped, cluttered two-room flat in a jungle district. When the electric lights are turned off, the first-floor flat is pitch dark. It costs the taxpayers $52 a month rent for this slum dump.

Here these ailing old folk have clung for 11 years, stubbornly refusing to die.

You may say that they are an extreme example of poverty, and perhaps they are although there are all too many like them. They may be "poor managers," hard-core reliefers * * * but after you've said that, then what?

Faith and memories—they keep many going. There's the 93-year-old childless widow living on the third floor of a neat apartment building. "Every day I thank God for the glorious light," she said. "I thank Him for the day, for my meal * * *."

For here, memories are bittersweet. She was married for more than 60 years. "And in this very room my husband spoke his last words to me."

Call her Mrs. A. Slim, white haired, amazingly active, she is an excellent manager and says she gets enough to eat.

She makes do on a monthly pinpoint budget that provides $23.40 for food, $3 for laundry, $2.85 for electricity, $4.35 for telephone, $4.65 for clothing, $1.90 for household expenses. A roomer contributes $42 a month to her income and "the welfare" rounds it out.

But for those who cannot manage as well as she does, life on a tiny budget is a terrible drag. Said an 84-year-old blind man living in a hovel:

"I could eat more. My assistance budget was cut $8 a month, and it had to come out of my food. Where else could it come from?"

Some manage cheerily, like the 79-year-old widow living in a basement flat. You enter her apartment through the boiler room.

She gets along on $85.50 a month ($45,50 from public aid, $40 from social security). There's no money in her budget for carfare, so she walks. "I learned to get by on little money during the depression," she explained.

Tuesday: "I cry every time I have to take money from my children."

[From the Philadelphia Inquirer, July 28, 1964]

PLIGHT OF THE ELDERLY—EACH DAY MEANS A STRUGGLE

The story of the plight of the forgotten Americans—our shelved and neglected senior citizens—is continued in the second of a series of four articles of what it is like to be old and broke, sick and lonely.

(By M. W. Newman, Special to the Inquirer and Chicago Daily News)

CHICAGO.—"I cry every time I take money from my daughter," said a woman of 64, nervously tightening a scarf about her head. "It means that she must deprive her kids of something. But what can I do? My husband is too sick to work and I'm sick myself.

"Our social security income is barely enough to pay our rent and medicine bills. Without my daughter's help I'd go hungry.

"It's no good living this way, it's no good * * *"

Her body swung back and forth as she sat, her fingers plucked at her faded dress. She spoke the same words again and again, as if living on a treadmill.

For many of the elderly each day dawns the same * * * a struggle. As a rule, they don't want to take help from their children, and often they try bravely not to do so. But just as often, a huge medical bill or series of them comes along, wiping them out. And then they must find help where they can, pride or no pride.

This is the weary story told by many retirees on small, fixed incomes—and not merely those unfortunates on the relief rolls.

Most of the retired elderly must depend in large part on social security old-age benefits. In Illinois these average $81.82 a month for an individual.

Only 17.6 percent of the recipients in this Sate are in the top bracket—$115 to $127 a month—and yet that's far more than in most States.

Social security is earned by taxes paid during the working years. It keeps many from the poorhouse, and they bless it.

But when you go into places where old folks meet—parks, hobby centers, cafeterias, small hotels, clinics—they tell you soon enough that social security doesn't stretch far enough.

Those who lack an extra income to pad it out talk like a man of 80 who sat wearily in a senior center. He was bent by years and worry.

He and his wife have $150 a month in social security benefits—plus a "little help" from a son and daughter.

"For many years I was a salesman," the old man recalled. "I had $4,000 in the bank when I retired 15 years ago. Well, it should have been more, but that's all I could get together.

"My wife and I have lived carefully ever since—how carefully you can guess, because it took us all these years to use up the $4,000. Most of it went a few years ago when I needed two operations. Just the other day, I took the last $50 from the bank."

"Now we have nothing," he said heavily.

"I guess we look well-fixed, but sometimes we don't have the $12 a month my wife needs for drugs for her heart condition. She went without it for a few weeks until the doctor screamed."

"I had to give up our life insurance long ago because I couldn't pay the premiums," he added after an unhappy silence.

"For our Blue Cross health insurance, we must go to my daughter—$50 every 2 months for the two of us. Our rent is $95. A year ago, we applied for a 'project' (low-rent public housing), but we're still waiting. We seldom go anywhere because the carfare is so high."

A large number of the elderly are widows—among them Mrs. C., who didn't want to "bother" her children for help. She figured they had all they could do to make ends meet.

With about $80 a month social security income as her bulwark against life, she moved into a cheap hotel in a slum area. The place was a fleabag—full of deadbeats and down-and-outers—and other poor, old people like herself.

Most of her fellow seniors were living on spaghetti and crackers to stretch their pennies, and she did, too. By the time her family learned the truth, the old woman had become anemic. She finally was placed in a charity home for the aged, after signing over all her "assets" to the institution—the $80 a month social security.

Then there was the shook-up couple in their sixties, in a Jewish community center. They came there because "staying home and thinking drives us crazy."

A white-haired husband, a chronic invalid too sick to work, nervously ran his tongue against toothless gums. His wife was bedeviled by heart trouble and diabetes.

Social security provides them with $123.80 a month. They took the option of starting it at age 62, instead of age 65, when it would have been somewhat more.

Rent is $77 for this ailing couple. Medicine bills run around $40 a month. Their life is marked by long rides to hospital clinics where "they treat us fine, but every extra test costs 25 cents."

"The 'welfare' offered us $20 a month and free medical treatment," said the woman. "But it's not enough and they wouldn't give more because we have four children—three daughters and a son, all married.

"They tell us 'You've got children. They're buying homes. They can support you.'

"But my kids all have a struggle and there are 10 grandchildren to feed and clothe, too."

Needy oldsters are proud of staying off relief, like a once-prosperous shopkeeper and his wife. Time was when she bought I. Miller shoes and high-fashion gowns on Michigan Avenue. Now she looks for $4 bargins in cheaper areas.

These two get along on less than $200 a month and live in low-rent public housing. Their medical bills keep them broke.

"Sometimes I think we'd rather be on relief," said the woman. "That way at least we'd get free medical care. But we've never yet accepted a penny in public help."

Like many of the elderly, she wants higher social security monthly payments plus medical and hospital bill coverage.

Talking to the aged, a reporter concluded that two can barely scrape by for $225 a month—provided big medical bills or other emergencies don't hit and their

housing costs are moderate. About $250 or $275 is better. But even that is hard, grinding poverty living, when you figure today's costs.

Many of the elderly are sufficiently well-fixed to get by. Many have savings or private pensions. A number retire with no money worries.

But one out of four Americans is still not even eligible for social security.

"I'm lucky," said one aged widower, a former business executive. "I have $250 a month coming in from investments, plus social security. It usually costs me $250 to $275 a month to live. I'm not stingy, but I'm not extravagant.

"But if I had to depend on social security alone, it would be very hard."

[From the Philadelphia Inquirer, July 29, 1964]

PLIGHT OF THE ELDERLY—MANY FLUNG ON "JUNKPILE" AT 50

(By M. W. Newman, special to the Inquirer and Chicago Daily News)

CHICAGO.—The question—when does a man become old at his job?

The answer—when he has lost it and can't find another. This bitterly true definition comes from Hobart Rowen, a magazine business editor who addressed the National Council on the Aging in Chicago.

It could come as well from thousands of oldsters who find themselves dumped on the junkpile, too "old" to appeal to employers.

Old? It doesn't mean 60 or 70 or 80 any more, by today's employment standards.

Maybe it really never did. Many years ago, Carl Sandburg wrote about steelworkers in their forties who were adjudged too old to work every time seasonal layoffs hit the industry.

In any event, "old" today begins at 45, or even earlier when you're out of work and lack a needed skill. In fact, "old" may start at 35. Some employers won't hire file clerks over that age, figuring they're too stiff and creaky to bend easily.

In this day of pushbutton automation, when machines and business mergers are wiping out thousands of jobs, many middle-aged are being shelved in the prime of life.

They're joining the 60-and-over army of rejects and retirees on the sidelines, while life slides by.

Example: The woman office worker, 48. Attractive but slightly graying (could it be she was too primly honest to tint her hair?), she talked to a reporter, at an employment office.

"It's demoralizing and frightening," she said. "If you're over 40, most companies don't want you. I have been out of work for months."

There also was the bookkeeper, 50, "automated" out of her job last October and unemployed ever since.

"What are we supposed to do—go out to pasture?" she asked. "I can do as good a job as ever, but when I go looking for work, all I hear is that they want someone 20, 30, or 40 at the most.

"When I say, 'What about 50'—that's it."

And still another woman, a business machine operator:

"I'm 55 but I look much younger. So I get work, when I can, by taking 10 or more years off my life. You have to lie. It's bad, but what can you do?"

And what if you're a man supporting a family?

"They're hiring men from 30 on down," said a husky Negro laborer and maintenance man, 53. "They look at me and they don't say I'm too old but I don't get the job. I've been out of work 9 months and living on relief and, believe me, the eating isn't too good."

It's rough and cruel and it doesn't make sense. But that's the way things are, particularly for workers without special skills in a fast-changing society.

Despite record employment, 4,500,000 are out of work. And millions of impatient youths are crowding in, seeking the available jobs. As a result, shelved workers in their forties and fifties aren't even getting a chance to earn adequate social security credits for their later years.

And so the middle-aged begin stacking up on the reject shelf, where millions of senior citizens already languish.

About 17 percent of those over 65 still are working. Many more would like to be, particularly a number of those retired against their will at a time when the lifespan is increasing. But the jobs just aren't there. Few of the elderly bother to seek them. They're not even listed as "unemployed."

And yet the average older worker in good health, given a chance, does as good a job as the younger one, studies seem to show.

There have been many such surveys, conducted by the U.S. Labor Department, the University of Illinois, the National Association of Manufacturers, Temple University, the National Office Management Association, among others.

These findings debunk employer myths beyond reasonable doubt, according to Charles E. O'Dell of Detroit, former special assistant in the Labor Department.

They show that on the whole older workers stack up favorably in terms of job output, absenteeism, safety, turnover rates. And when the seniors slow down, they tend to make up for it with greater accuracy and attention to detail.

The more flexible among them can be retrained for other work, too. But some find it harder than others to adjust to new jobs or lower salaries. It's not easy for them to pull up roots and move.

And for those pinned to the long wheel of habit, there's tragedy when it stops spinning.

"There still are old Studebaker employees in South Bend, long after the plant closed for good, who think that it will reopen again," Odell said.

The effects of aging vary so greatly, one set of experts found, that each worker must be judged separately—on ability rather than on his age in years. One man may be old at 50 and another young at 70.

Many companies, Odell found, like to have older workers on the job—but won't hire any new ones.

In explanation, the employers often cite allegedly higher insurance or workmen's compensation cost associated with older workers.

Many private pension plans—and they now cover 25 million workers—require at least 10 or 15 years of employment before payments begin. Thus, an employee hired at 50 might get no pension at all when he retires, or a tiny one at best.

Companies regard this as bad for employee morale and their public image, and as a result shy away from hiring older workers.

Only a few firms go out of their way to employ senior citizens. One such firm is the Belden Manufacturing Co., Chicago wiremakers and it reports good results.

"Sometimes we place people in their seventies," said Mrs. Etta Veal of the Illinois State Employment Service. "One firm hired a 71-year-old design engineer. A 57-year-old art teacher got a good job."

But it is significant that these are skilled people with college degrees. The well-educated under 65 are likely have jobs, "old" or not, found Hobart Rowen, of Newsweek magazine.

In the 45- to 54-year bracket, he reported, only 1 out of 100 college graduates was unemployed. But among those with less than 5 years of schooling, it was 1 out of 10.

Said an ISES official: "The big problem is finding jobs for the unskilled or for people who have been at one job for a long time and whose special skill is no longer needed."

This is where job retraining is supposed to come in. The U.S. Government has a special program here, operated by ISES.

But it too runs into the bogey of employer myth about aging.

ISES, according to its critics, views the old workers as an albatross around its neck and isn't geared to do much for them. It operates as a central job exchange rather than an agency specializing in finding jobs for the "hard-to-place" worker.

And so the army of unemployed recruits the middle aged. They are "old" in a youth-struck society where, says Rowen, "you can go from baccalaureate degree to banishment in a bit over 20 years."

(Thursday: Medical bills jolt the elderly.)

[From the Philadelphia Inquirer, July 30, 1964]

PLIGHT OF THE ELDERLY—MEDICAL COSTS ARE STAGGERING

(By M. W. Newman, special to the Inquirer and Chicago Daily News)

CHICAGO.

A man of 76 drooped in his bed in a hospital for the chronically ill. He had only one leg. Gangrene claimed the other. He suffered from diabetes and his world was a big, bleak ward.

"Why am I here?" he asked with a shrug. "Before this, I was in a private hosptial where my hospital insurance paid $1,500 but my bill cost me $5,000 more.

"When I had nothing more to spend I told them, 'call the police. I can't pay any more money. Throw me out.'"

He was removed to a county hospital where his bill is $185 a month—and public relief pays it.

Here he sits out his last years emptily * * * another of the army of older Americans broken by medical costs in their later years, or forced to become a public charge.

Major illnesses and accompanying major medical bills jolt the elderly at the very time of life when their incomes have dwindled.

It's a dismal picture despite all the gains made in fighting disease and lengthening life. Old folks' illness has taken on all kinds of personal, social, economic, and political overtones in the world's richest Nation.

If the cost problem is to be met, more public subsidy seems inevitable. And yet public programs such as relief spending, veterans spending, aid to the "medically indigent" already pay more than $1 in every $4 for medical care for older Americans.

And just around the corner, possibly is the controversial "medicare," or some new formula for meeting medical bills for elderly citizens.

The simple fact is that as people get older, they tend to get sick more often and for longer periods, and need more hospital care.

Of every 100 persons over 65, says the President's Council on Aging, 80 have some kind of chronic ailment. Many don't get the care they need because they don't want to burden their families or are too proud to take outside help.

The crushing medical bills for the elderly frequently fall on relatives ill equipped to pay.

One debt-ridden housewife, in her middle fifties, told a harrowing story of the burden thrown on her and her husband. Her aged mother and father receive only $90 a month social security between them, and the bills have been staggering.

"My parents have grown sicker and embittered and the toll upon my marriage and the life of my child has been irreparable," she said.

On top of all this; medical costs—particularly for drugs and hospital bills—have skyrocketed. And while more than half of the elderly now carry prepaid hospital insurance—launched with fanfare a few years ago for those over 65—it doesn't go far, as a rule.

The President's Council figures that this insurance meets only one-sixth of the total medical costs of even those elderly who are covered. Most of them can't afford the premiums for broader, more adequate insurance.

Even on a nonprofit basis, these higher cost premiums come to about $400 a year—"one-sixth of the total income of an average (older) couple."

The Blue Cross-Blue Shield standard over-65 plan in Chicago charges $300 a year for a couple, $150 for an individual. It provides for 30 days of benefits, with a 90-day wait before renewed eligibility.

Semiprivate room costs are paid in full, except for "cooperative payments" of $5 a day.

Many of the private policies provide very limited benefits—both in dollars and duration. "A $10-a-day payment for hospital board and room is typical," said a director of the county's aid to the medically needy.

This figure is less than half of the usual charge in hospitals.

What's more, a number of underwriters have suffered losses in their over-65 insurance programs, forcing them either to increase their rates or slash benefits.

A Senate subcommittee found that only 4,500,000 of the country's 18 million aged have "reasonably adequate" hospital insurance, covering at least 75 percent of the bill.

These figures are challenged by the Republican minority on the subcommittee, Senator Barry Goldwater among them. They hold that private insurance coverage of the elderly is expanding and should be given the chance to do the job.

Blue Cross has given the aged the best protection for the premium charged, the subcommittee majority report said. But it added that "Blue Cross and its older subscribers are in very serious trouble" and that the policies meet only a dwindling part of the average bill.

A few nonprofit groups, like the American Association of Retired Persons, have come up with their own group insurance and discount drug service.

But for most older Americans, the question is: What now?

The Kennedy and Johnson administrations have been pushing for hospital care for the aged. This is prepaid hospital insurance for those over 65, to be paid from a ½-percent boost in everyone's social security taxes.

In turn, the potent American Medical Association and its supporters have bitterly fought back, labeling this proposal a step toward Government-controlled medicine. The plan at the moment remains shelved in a House committee, its future dubious.

But the battle goes on. The hospital care plan's chances—or at least some version of medical care—probably will improve as the years pile up, simply because the army of elderly is mounting.

In 1960, a stop-hospital-care movement came up with the Kerr-Mills Act, embraced by the AMA. Kerr-Mills is designed to pay hospital and other medical bills of the "medically indigent" over 65—defined as people above the public relief level, but still too broke to pay their own bills.

Kerr-Mills is in operation in Illinois in a rather small way, and does pay some people's bills—surprisingly large ones, at times. But the whole program operates rather obscurely.

To qualify for Kerr-Mills, a single person can have up to $1,800 in the bank plus $1,800 annual income. The figure is $2,400 for a couple. But some can have more than that, depending on the size of the bill.

In one instance, the program paid $12,000 to cover the hospital bill of a woman whose income was $60 a month. In another case, a Chicagoan with an income of $294 a month was hit with a hospital bill for $2,243 for his wife. Kerr-Mills paid $900.

A man of 77, with a $900-a-year veteran's pension, was hospitalized for 6 days. The bill was $160, and Kerr-Mills paid everything over the first $155 of the bill.

But Kerr-Mills achievements are debatable, at best. A Senate subcommittee in 1963 concluded that the program was "ineffective" and "piecemeal" and had a pauper's oath taint. It found that benefits didn't amount to much except in a few States.

Senator LONG. Thank you for your statement, Mrs. Gottlieb.

I think we have as liberal a program in Louisiana——

Mrs. GOTTLIEB. I can't quite hear you.

Senator LONG. I believe we perhaps have as liberal a program in Louisiana as almost any State in the Union. We have a 2-percent sales tax, practically all of it goes to our welfare department.

We then match that with Federal money and the Federal Government putting up more than we put up so the amount derived there would be about the equivalent of a 5½- to 6-percent sales tax, and then we spend all that on our welfare program.

So, we have about 58 percent of our aged people drawing pensions from the State, and we have a very liberal program on hospitalization. More than half the hospital days in Louisiana are spent in our State hospitals and no charge for the people there.

But the one question that does bother me about that sort of thing, has to do with these people who are all well able to pay for themselves.

Now, my own mother might be an example. She is, I would say, reasonably well-fixed financially. She will leave a considerable estate to her children at such time as the good Lord may call her to her reward, and she is well able to take care of her expenses. She is the strong one of the family, not only hereself, the rest of her family, too. If they fall on bad times she will look after them, too. Why should someone pay taxes to provide for my mother who is well able to pay for herself, not just for herself, but for all the rest of the family too, in the event any of them fall on bad times. Why should that burden be imposed on someone who can't afford to pay it, that is, someone with a wife and eight children to feed with $2,000 income to

support my mother who may have an income, let's say of in excess of $70,000 a year, why should they tax that poor person to provide for her?

Mrs. GOTTLIEB. Don't you think that is to be human. If a private person, say, there is a plague of some kind, and we have to have inoculations, and they come to the board of health, would the board of health say to them, "No, you have money, you go to your doctor." That wouldn't be fair, would it? Don't you think that he should have gotten that injection of whatever serum or whatever they give them?

Senator LONG. Well, of course——

Mrs. GOTTLIEB. Say some people at the present time have a nestegg, but if they go to a hospital, and you don't know what some of their bills amount to when they are through, and they go home, what are they to live on after? Then they have to resort to welfare, then they have to go back to welfare again, and the State has to pay for that, the Government has to pay for that.

If a person has $3,000 or $4,000 in the bank, and a serious illness comes, and if they have insurance, a little insurance, that doesn't pay the entire bill or the doctor's bill. Blue Cross, Blue Shield, the most they pay for major surgery is about $250, but if the doctor charges $500, where is that $250 going to come from? All these are deducted from their little nestegg. By the time, Senator, he is 65, by the time he is 70, he has to use up that nestegg. Social security will not provide it all.

My social security of $76.86 per month, what does this give me? Only last month, one doctor, in his office is $10, I had a blood test, $19. The gynecologist, $10; my eye doctor, $10; the one that performed my cancer operation is another $10.

This money, I get checked up sometimes from some once a year when I go and they say come and see me in 6 months or in 3 months, and that is where I use my social security for.

Senator LONG. Do you have any questions?

Senator BENNETT. I have no questions, but I do have one comment.

I am greatly disturbed by this story of Mrs. Yarbrough. It looks to me as though she was trying to find out whether she could get the man in the hospital, and the first thing I would have done in her place would be to call my family doctor and say, "Here is a sick man, what can I do about it?"

But she never called a doctor, according to her story.

Mrs. GOTTLIEB. Well, I don't know whether she did or not, but I had a case in my—they have no family doctor. I called my doctor and he says, "Mrs. Gottlieb, I can't come. I have an emergency case, call some other doctor."

Perhaps that is what happened in her case. Perhaps she called the family doctor and he wasn't home or couldn't be reached. I can't vouch for Mrs. Yarbrough. I can only tell you what I read in the paper.

Senator BENNETT. Her story says she called first the old age pension office.

Mrs. GOTTLIEB. Well, maybe she herself hasn't got a doctor, maybe this man didn't. There are a lot of people, 65 and over, that haven't got a family doctor. They just wait until they get sick and some friend or so on will call the doctor.

Senator BENNETT. This story sounds very much to me like a situation which was carried out to provide a newspaper story to test not the ability of the community to take care of this man, but to test the reaction of various agencies none of which were a medical agency until they got all the way out to the insane asylum in another city.

I can't believe that the doctors in Peoria, would all have refused service for a man in this condition or that medical service would have been refused if somebody had attempted to find it. She never attempted to find medical service. She was just testing the pension offices to see what their reaction would be.

Mrs. GOTTLIEB. Well, of course, I wasn't there. I don't know. Perhaps this woman didn't have the ability to do this for the moment. She was just concerned about this poor man that was sick, and many times I don't know, many times there are occasions when something happens when you just lose your perception.

You just can't know, what should I do at this moment.

Senator LONG. You know, Mrs. Gottlieb, I suppose the country is getting so big that in some respects in large cities people get so impersonal that they just chase the mighty dollar without following some of the fine traditions that this country had in years gone by.

One of my cousins is a very good doctor. His father, who was a doctor before him, told him that a doctor should never charge his relatives, which incidentally has caused me to have quite a lot of free medical services.

Senator BENNETT. I thought it was a rule that a doctor should never treat his relatives.

Senator LONG. A doctor should never charge his relatives, for treating his relatives, and that anyone who came to him who was sick and couldn't pay he should take care of them. So his tradition in which he grew up was he would figure on about 50 percent of his practice being work that he was not getting paid for and he would make his living on the other 50 percent.

Now, of course, in doing so, in charging his fees he would try to charge someone who could afford to pay a bigger price than he could charge someone who had very modest means.

STATEMENT OF HON. SEYMOUR HALPERN, A U.S. CONGRESSMAN FROM THE SIXTH DISTRICT OF THE STATE OF NEW YORK

Mr. HALPERN. Senator, if you will forgive that little informality, Senators, I regret that a quorum call prevented my appearance a little while ago in order to personally fulfill what I think is one of the nicest privileges I have had or would have had as a Member of this Congress.

But knowing Aunt Bessie as I do, I am sure that she didn't need me or anyone else to introduce her or to present her case any more effectively than I am sure she has.

Mr. Chairman, my feelings this morning are intermingled. I feel pleased and I feel privileged and I feel proud. I am pleased that these hearings are being held; that there has been this opportunity for the proponents and opponents, of medical care, for health insurance for the elderly, whatever you call it, to present their cases. It is commendable and I am glad before this session adjourns that this oppor-

tunity has been given, and it is my sincere hope that the committee will act favorably and, of course, I as an advocate, strongly hope that there will be a strong, effective, and meaningful program adopted at this session.

I am privileged to be identified, Mr. Chairman, as a sponsor of legislation to provide medical care for the elderly under the social security system.

I am privileged to do so, if I may, as a member of the Republican Party in the other House.

I am proud. I said I was proud, well, I am proud, proud of the previous witness. Here is a woman, Mr. Chairman, Senator Bennett, who has been a typical mother, a housewife, and a grandmother, who, in her later years, a widow I should add, in later years decided that she just couldn't go on and not give her all, not give everything she has to a good cause, and she has dedicated herself these past years to helping her fellow citizens, her fellow senior citizens in their cause—namely, medical care for the aged.

She has been active on a local level in Illinois, and in Chicago on a State and National level, and if ever a Senator or a Representative in Congress has had an effective advocate of a cause, come to them to plead that cause, it has been Aunt Bessie, my dear father's sister.

I was amazed as a Member of this House to have her come calling to my own office because at that point I had no idea of her role, and she came in and I must say did a very effective job in convincing me I was right on this subject, and I believe that my good aunt should be complimented.

I certainly, as I said before, am proud to have such a dedicated, wonderful aunt as my dear Aunt Bessie. I want to thank you for giving me this privilege to at least say amen to what she said, and an opportunity to make up for not being here to properly and formally present her. But as I said I know she did a creditable job.

Thank you very much, Mr. Chairman. [Applause.]

Senator LONG. May I just say as the chairman of this, acting chairman, I must warn the audience we do not permit demonstrations in our committee meetings any more than on the floor of the Senate.

I would like to say to you, Mrs. Gottlieb, you made a fine statement here, and I hope that you and those for whom you speak are not as much in need of medical care.

Right now, some of us in this committee, our chairman, Senator Byrd, has got a bad knee, suffering I believe from arthritis in his knee, and just last night I hurt my back in the lumbosacral area so I suppose this committee needs more medical care than some of those for whom you are speaking.

Thank you very much for your statement.

Mr. HALPERN. Mr. Chairman, if I may as part of my introductory remarks I was going to ask unanimous consent of the committee to submit a statement of my own covering this subject, if I may.

Senator LONG. We will print it in the record.

(The statement of Representative Halpern follows:)

STATEMENT OF CONGRESSMAN SEYMOUR HALPERN, REPUBLICAN, OF NEW YORK

Mr. Chairman and distinguished members of the committee, the following statement which I offer to this committee is the presentation I have given to the Ways and Means Committee on this subject and which I would like to include

as part of this committee's hearings. I am grateful for the opportunity to appear today on behalf of legislation authorizing health care for the aged under the social security system. I have stanchly advocated and consistently supported such legislation ever since I first came to Congress, and I am proud to say that I am a cosponsor of the measure known as the King-Anderson bill. I am also the sponsor of H.R. 4029, the House version of Senator Javits' bill, S. 849, which is faithful to the fundamental principles of the social security system but widely broadens the opportunity for health insurance by coordinating the basic contributory social insurance and voluntary private insurance.

I introduced both of these measures this session because of my determination to do everything I possibly can as a Member of this House to help bring about the strongest, most effective, and workable health care bill. I believe both of these bills complement one another and that the dual approach, Government and private, is further buttressed by the report last week of the National Committee on Health Care of the Aged, which I heartily commend and which I will discuss briefly further in my testimony.

But, first, in order to judge my concern with this subject, it might be useful to describe my efforts on behalf of adequate health care for the aged. In the 86th Congress I had the privilege of introducing a companion measure to H.R. 4700, the bill devised by our distinguished former colleague, the Honorable Aime J. Forand. My bill, H.R. 5000, was one of the first introduced in this field.

The bill I sponsored in the 87th Congress, H.R. 4111, while similar to my earlier bill, initiated a new concept by providing insurance coverage for those folks who, through no fault of their own, were not covered under social security. This concept has since been generally accepted and is now provided in H.R. 3820 and its companion measures.

I feel the inclusion of this earlier omission in the bill is a vast improvement. And the committee could well consider the further liberalization of the program as offered in H.R. 4029, my bill which I mentioned earlier. This bill, I might point out, is along the lines of the plan accepted by the senior Senator from New Mexico, Senator Anderson, the other half of the King-Anderson team, as an amendment to his health care bill on the floor of the other body last year. Although the bill itself was defeated, the amendment was adopted, thus broadening the scope of the Senate bill at that time to include participation by private insurance.

Now, along the lines of this amendment and carrying out the principles of S. 849 and my bill, H.R. 4029, comes the plan proposed by the National Committee on Health Care of the Aged. This commendable and most welcome report was released only last week after considerable study by a special citizens committee, known as the National Committee on Health Care of the Aged, headed by the distinguished former Secretary of Health, Education, and Welfare, Dr. Arthur Flemming. Other members of the Committee are among the most distinguished members of the medical profession, hospitals, Blue Cross, insurance, and business authorities.

Laudable as the King-Anderson bill is for financing hospitalization, nursing home care, and outpatient diagnosis, it deals with only a part of the total problem. I, as one of its sponsors, must concede that this measure deals with only part of a total problem. The report of the National Committee on Health Care of the Aged still strongly upholds the social security principle; it offers effective means of administration and it recommends that Congress encourage private insurance companies to develop low-cost, nonprofit policies on a national basis to cover other major medical expenses of the aged. The encouragement would come in the form of possible tax exemption and, in order to permit companies to pool their resources, a possible waiver of antitrust agreements which now bar such agreements.

I am glad to note from Secretary Celebrezze's testimony the other day that he believes that a coordination of basic contributory social insurance, private voluntary insurance and public assistance would work well in coping with the overall problem of financial protection for the aged.

I understand that former Secretary Flemming and other expert witnesses from the National Committee on Health Care of the Aged will appear before this committee early next week to discuss this new proposal in detail. I urge you to give every consideration to the report of this Committee and the views of its able spokesmen, as the possible means of ending the stalemate on this issue and of providing a meaningful, effective program to meet the total health needs of our elderly citizens.

The importance of finding the most effective program in this field is undeniable.

Mr. Chairman, no one can doubt that there is a serious problem in the field of medical care for the aged. Even those individuals and groups who oppose any change in the status quo in this area admit that the aged don't obtain adequate medical attention at all times. Perhaps the majority of the aged get "subsistence" care, which means that they are not left to die on the streets and the community does provide some free hospital beds—but is this adequate care, proper treatment for those citizens who have been the bulwark of our Nation in former years? I say it is not fair, and furthermore, that private charity and group insurance schemes can never provide adequate care for the elderly without placing too great a burden on the rest of the population.

Careful consideration of a few statistics will illustrate the dimensions of the problem. Only 22.5 percent of those aged 65 and over have no chronic medical conditions. This means that the other 88 percent, and that is a very high proportion, need at least a minimal amount of medical supervisions. 28.2 percent of those with chronic conditions have partial activity limitation and 15.2 percent are completely disabled. The last percentage, that of complete activity restriction (suggesting a need for constant care) jumps from 15.2 percent to 24 percent for those individuals aged 75 and over. The aged have an average of 38 days of sickness during the year; this is more than 2½ times more days of disability than a younger person would have. Figures show that the lower the income, the greater are the number of disability days. This is partly because the elderly, who have few financial resources, cannot afford proper medical care. Medical care is a very large slice of their budget. In 1957–58 per capita medical expenses for those 65 and over totaled $177, compared to $86 for those under 65—28 percent of this amount went for hospital care and 24 percent for drugs.

When an aged person becomes seriously ill his financial problems increase. Hospital costs have more than tripled in the past 15 years, from a 1946 average cost per day of $9.39 to 1960's average cost per day of $32.28, and they are now approaching $35. This has a heavy impact on every one of us who needs hospital care, but it is especially hard for the aged, whose income does not rise with inflation or increased national productivity but falls drastically as the years go by. They are the group who can least afford medical expenses, and they are the group most heavily burdened.

A few facts on the yearly income of the aged will illustrate their need for comprehensive hospital and nursing home insurance. In 1960, 27.1 percent of the men and 73.0 percent of the women had an income of between $1,000 and $2,000; 45 percent of those over 65 had an income of $1,499 or less. By no stretch of the imagination can this kind of an income be considered adequate to cover medical expenses that are anything but minimal. Not only do the aged have small incomes compared to the rest of the population, but they have fewer financial resources available in case of emergency. One-half of social security beneficiaries had no significant regular additional income. Of aged couples who had a joint income of less than $2,500—and this is the neediest group when it comes to medical care—one-third had no liquid assets at all (nothing they could readily convert into cash to pay medical bills) and one-half had less than $500 in assets. Even if an elderly individual or couple does have a small nest egg, it usually totals far less than would pay for major illness in these days of soaring medical costs. And with the first emergency, the first serious illness, the small measure of financial security a couple or individual has built up through the years disappears.

Health insurance benefits are a necessary part of income protection is retirement. No other program, State or Federal, can give the elderly the care they need without tying bonds of financial dependence around them. This country has a traditional love of independence, from which we derive our self-respect; it is contrary to our ideals to force those who have contributed many long years to our prosperity to beg payments which should be theirs of right.

Kerr-Mills although helpful, is not enough. The recent report of the Senate Special Committee on Aging shows that even after 3 years in operation the plan for medical care for the aged is not yet a smoothly working national program. Some of the criticisms of Kerr-Mills obviously stem from impatience, because such a complicated program as this, which depends on detailed action from 50 States and 4 territories, will take some time to develop efficiently. I am sure that in the future many more than 28 States will organize useful programs under Kerr-Mills. However, some of the weaknesses of Kerr-Mills cannot be

removed simply by improving the program. It can never fulfill the objective of "fair" medical care for all the aged. Under Kerr-Mills the elderly citizen obtains widely differing care depending on his State of residence. The duration, level, and type of benefit available varies widely from State to State. Only Hawaii, Massachusetts, New York, and North Dakota have what are considered comprehensive programs. If an elderly person is unfortunate enough to live in a State which does not offer adequate benefits (often through no fault of the State, which may be poor and have many other vital uses for the tax dollars available), he may not get the care he needs and deserves. The Senate report details other inequities in the administration of Kerr-Mills. Wealthy States, which can best afford proper care of the elderly, have received the major part of Federal matching funds to date. This is partly because they can afford to spend more on Kerr-Mills programs than can a very poor State where the need might be greater.

Kerr-Mills is an open-ended program; there is no indication that the amount of funds needed will decrease, and if medical costs keep rising it is certain that the costs of Kerr-Mills will rise. If medical care for the aged under Kerr-Mills is expanded to cover a major share of the elderly's medical expenses, the drain on State treasuries will be fantastic. And it has been shown that some of the States, judging by their actions under Kerr-Mills as it is now, can ill afford even a limited medical care program.

Kerr-Mills, as implemented by many States, does not cover the medically indigent. Instead, many people have simply been transferred from the rolls of old-age assistance to those of medical assistance. The recent Senate committee report, "Medical Assistance for the Aged," on Kerr-Mills, states that probably over one-half of all applications approved for medical assistance for the aged through September 1962 were on behalf of people already eligible for medical aid under other public programs. Those retired persons who cannot afford proper medical attention in some States are still left without recourse, unless they can show dire distress.

The most convincing objections to Kerr-Mills as the final solution to the medical problems of the elderly lies in the means test as interpreted by the various States involved. There are many situations where the means test is necessary and useful, but it is not a good method of determining whether one of our aged citizens should get the medical care he needs. We know how expensive hospitals and drugs are today, and we know that the aged need comparatively more care than the rest of the population. Under Kerr-Mills the elderly are subjected to what easily becomes, to them, a degrading experience. In many States, all members of the applicant's family over 18 must undergo investigation, and the applicant himself must fill out form after form and explain in great detail any financial transactions for at least the past 2 years. Many people pauperize themselves, out of desperation, before subjecting their families to this process. The annual income ceiling for Kerr-Mills aid in my own State of New York is $1,800 or less for an individual and only $2,600—$800 more—for couples. Such a low ceiling does not begin to cover all the elderly who need assistance in times of health emergency.

An indication that Kerr-Mills is not fulfilling its goal of aid to the "medically indigent" is that in at least 14 States, which are listed on page 35 of the Senate Kerr-Mills report, income restrictions are more rigid than those used to determine eligibility under old-age assistance. Medical assistance for the aged, in contrast to the insurance provisions under the present bill, is made available only after the applicant has reached a dependent level. Is this what we want for our elderly citizen? Kerr-Mills will become a useful supplement to health insurance under social security, alone, it is neither fair nor adequate.

Although private insurance companies have worked tirelessly in recent years to offer the elderly comprehensive health insurance at a reasonable cost they have not succeeded. If the aged are covered by community plans, the younger members of the community pay proportionately higher premiums and the elderly must still scrimp to afford the lower payments. It is not possible, without penalizing someone, to offer low priced insurance to this aged group which will use the benefits most frequently and is judged by underwriters to be the highest risks. Many States, working with insurance companies, have made thoughtful attempts to organize insurance plans for the elderly which will not be too expensive. Connecticut 65 is such a plan. It provides two types of major medical coverage, varying in costs and maximum benefits. The premiums are kept reasonably low. During the hearings which were held on the King-Anderson bill in 1961, Mr. William Seery, vice president of Travelers Insurance Co., spoke of the

plan in these terms: "The Connecticut 65 program is designed to help people provide for their own medical care through insurance. To the extent that it is successful it will keep people from being medically indigent and will help to relieve the strain on taxpayers."

There are recent indications that Connecticut 65 is not going to prove successful. A few weeks ago it was announced that premiums for this plan may be increased because the plan is proving to be more costly than underwriters had estimated. How high a premium can the elderly, a low income group, afford to pay?

Opponents of health care under social security argue that private charity supplements Kerr-Mills and old-age assistance so well that no elderly are left in need. This may be true, in case of obvious, desperate need; but the free services that hospitals and doctors give make medical costs for other people soar even farther and faster. This is not the sensible way to deal with the problem; once again the whole community suffers.

Mr. Chairman, there is no question but that the need for remedial action is urgent and grows in magnitude as our elderly population grows and medical costs increase. The simplest and most equitable answer as far as hospital and nursing home care, nursing care in the home and outpatient diagnostic services is concerned lies in the financing of such insurance under social security. There are ample guarantees in the bill to avoid Federal interference in the operation of hospitals. This is far from socialized medicine. It is simply an efficient, relatively inexpensive way of dealing with a problem which yearly grows more acute for the aged citizens who remain in need of help. Such legislation would remove the fear of catastrophic hospital and nursing home costs from the minds of the elderly, and promote earlier utilization of health services. This will in turn decrease the burden on hospitals of long-stay patients who do not enter until their condition is critical. Such measure will help private insurance carriers to give even better service to the community, since they will be relieved from the heavy burden of providing basic medical insurance for the elderly. Most importantly, such legislation will restore dignity and self-respect to one of the most deserving sections of the community.

As I stated earlier, I also introduced, this year, H.R. 4029. This measure differs from my companion bill to the King-Anderson proposal in that it provides an option to beneficiaries to continue their private health insurance protection. Payments would be made to eligible carriers under an approved plan with respect to services. An individual would be able to elect this option within 3 months after he became entitled to health insurance benefits. This option would cover group and union-management plans, and would give the individual even broader and more extensive coverage as well as more freedom of choice than under the program limited only to the social security plan.

The report of the National Committee on Health Care of the Aged to which I referred earlier is certainly an important contribution in this field. In its report the Committee strongly emphasized the basic need for the social security approach to hospital care needs of our elderly citizens and it further points up the need for private insurance for the risk of health care above the basic minimum hospital and nursing home care. The report of the National Committee on Health Care of the Aged sets as its basic thesis that the health needs of the aged can be met best through complementary, but separate, Government and private insurance which can work together harmoniously in meeting the health needs of our elderly citizens.

I presently am pursuing the impact of the recommendations of this National Committee on my own bills, H.R. 4029 and H.R. 8052, with a view toward determining how this legislation can be improved and what new legislation I can draft and introduce in order to keep abreast with this latest blueprint for a comprehensive plan to meet the maximum health needs of the elderly.

Mr. Chairman, I heartily recommend early action by your committee on health care legislation using the principle of the King-Anderson as a base, and urge the committee to consider complementing it on the basis of H.R. 4029 and the recommendations of the National Committee on Health Care of the Aged which, as I pointed out, could well serve as the basis for new legislation.

I strongly urge that you consider all avenues to come up with a strong workable bill and that such a bill be forthcoming during this 88th Congress. In reporting such a bill you will be making the greatest advance ever undertaken in meeting one of the most vital problems of society, the health needs of our elderly.

I commend the chairman and the committee for their patience, their fairness and determination to hear and probe every aspect of this subject. I trust it will result in the approval of a broad, equitable program. The entire Nation will owe the committee its thanks if such is the result.

Senator LONG. The committee will stand in recess until 2:30.

Mrs. GOTTLIEB. Thank you very much and I will look forward, and I want that bill passed. Please vote for it.

Senator LONG. Dr. Caldwell B. Esselstyn will be the first witness at 2:30.

(Whereupon, at 12:25 p.m., the committee recessed, to reconvene at 2:30 p.m., the same day.)

AFTERNOON SESSION

Senator BENNETT (presiding). The committee will come to order. We will continue with the testimony of Dr. Esselstyn.

STATEMENT OF DR. CALDWELL B. ESSELSTYN, CHAIRMAN, PHYSICIANS COMMITTEE FOR HEALTH CARE FOR THE AGED THROUGH SOCIAL SECURITY

Dr. ESSELSTYN. For brevity, it might be well if we could put this statement in the record.

Senator BENNETT. Yes; and if you and I could have a conversation, if you could summarize it, that would be well. You may put your entire statement in the record.

Dr. ESSELSTYN. My name is Caldwell Blakeman Esselstyn, and I am a practicing surgeon in a rural part of the country.

The purpose of this statement is, in general, to talk about principle, and not to talk about a lot of detail.

The committee that I represent, which is the Committee for Financing Care of the Aged through Social Security, is very deeply indebted for this opportunity to present this statement before the Senate Finance Committee.

We are a committee of 35 physicians who represent different specialties and who come from different parts of the country. We represent both political parties, and we do feel that the most practical method of financing care of the aged is through a payroll tax, and we also feel this is a moral issue rather than a political issue.

In addition to our committee, it might be said that there are many doctors throughout the country who are in favor of this mechanism. Among are some 1,000 who have been in touch with us, the entire membership of a separate but fairly large membership of the Physician's Forum.

I think it is interesting to note that in the poll taken at random by the magazine known as Modern Medicine, some 10 percent of the sample that was taken of the physicians in the country, were in favor of financing the care of the aged through social security.

We have been working here for the last 7 years since the establishment of the Forand bill, and during this time there are several things that have happened that I am sure you are aware of.

The over-65 population is certainly growing out of proportion to the rest of the segments; and the proportion of people over 65, who are over

75, it is also increasing, and this is the segment which, obviously, has the greatest need and also has the lowest percentage of coverage of insurance.

We also know that the people over 65 have less insurance than the other segments of society, and that the insurance that they do have covers less of the total bill.

In spite of that, during this time, the Consumer Price Index has gone up to 123 if we use from 1947 to 1959 as 100 percent, and I think one of the most striking figures is the fact that a hospital day, a day of hospital care in 1951, which cost $17, in 1964 is costing $40.

Blue Cross premiums, as we know, have gone up some 83 percent in the last 12 years, and there are many programs around the country today which are asking for increases in substantial amounts, between 20 to 32 percent.

The burden of paying for the care of the aged continues to threaten the life of Blue Cross which, in 1962 collected some $200 million in premiums, and was obliged to pay out some $375 million in benefits for the same group.

Blue Cross, as you know, feels that it has to have extra financing if it is going to be able to continue.

The other thing is, I think, to realize that the over-65 programs which have been started are all in trouble and need more premiums because——

Senator BENNETT. Wouldn't you think, Doctor, we could expect the same thing to happen to the King-Anderson program if it is adopted?

Dr. ESSELSTYN. I think the broader the baseline, the less opportunity there is for this to happen. I think the over-65 programs are denying the very basic principles of insurance which, after all, are simply things to spread the risk, and if we are going to spread——

Senator BENNETT. You heard the discussion this morning, I think. This is not insurance, this is a tax, plus an unrelated program of benefits. I have been on this committee for 11 years, and I have watched the committee regularly every 2 years increase the benefits without actually being sure that it was covering the cost by increasing the taxes.

Dr. ESSELSTYN. Let us say that it is a mechanism for spreading the risk, and it is a mechanism for enlisting the force of numbers in the aid of the individual. This, I think, we all admit is true.

Senator BENNETT. There are a lot of us who feel that this program, the whole social security program, has its limit, too, and that as we approach 10 percent of payroll we are approaching the limit.

Dr. ESSELSTYN. I think we would all admit that.

Senator BENNETT. Now, you are starting this new program as we approach the limit. You are not starting it from scratch, you are starting it at a point where we are just about to bump our heads against the ceiling or at least the theoretical ceiling, of the total cost of this type of social benefit.

Dr. ESSELSTYN. Our committee has never held that this should be the only source of financing. We feel that part of the source of financing should come through the social security mechanism for reasons I would like to outline later.

Senator BENNETT. When you say the social security mechanism and then say the social security mechanism should not be the only source of financing, aren't you contradicting yourself?

Dr. ESSELSTYN. I did not say it should not be. It does not necessarily have to be.

Senator BENNETT. Where else would you get further financing?

Dr. ESSELSTYN. From the general tax revenue.

Senator BENNETT. And yet—well, go ahead. In other words, you are more or less agreeing with me that at this point there is some doubt, at least, that the social security mechanism will finance the program.

Dr. ESSELSTYN. If it is corrected, the social security mechanism should for some reason pass 10 percent, and on the baseline on which it is levied should pass its present limits, then I think it is obvious to all of us that somewhere along the line there must be additional financing.

Senator BENNETT. And yet the proponents of the King-Anderson approach insist they are going to finance it through social security in order not be a burden on the general revenue.

Dr. ESSELSTYN. But not solely, but not solely. Those who are for King-Anderson, such as our committee, have never said that we should have King-Anderson to the exclusion of Kerr-Mills, for instance. This is another mechanism.

Senator BENNETT. You want Kerr-Mills to come along and pick up the problem that King-Anderson cannot finance?

Dr. ESSELSTYN. We have always maintained this very strongly.

Senator BENNETT. You feel that it is humiliating or, as Mrs. Gottlieb said this morning, degrading, for people to be required to face a means test?

Dr. ESSELSTYN. I think to ask people at any time in life, people who have been hard working and diligent, and then because of something which is unpredictable and unpreventable, to have to have these people admit inadequacy, I think in the later years of their life, is a very, very unfortunate method.

Senator BENNETT. Then you are now saying again that you want King-Anderson, but it has got to be backed up by Kerr-Mills which has the means test. You cannot avoid the means test, can you?

Dr. ESSELSTYN. I think we can have medicine as a right with no means test attached.

Senator BENNETT. Then we should eliminate the means test in Kerr-Mills.

Dr. ESSELSTYN. I think there are a great many people who would go along with this.

Senator BENNETT. Then there is no limit.

Dr. ESSELSTYN. One of which is the New York State Medical Society.

Senator BENNETT. There is no limit then to the drain on the Public Treasury that Kerr-Mills could produce?

Dr. ESSELSTYN. As it now stands, I think it is an unlimited program, and I think it is a very dangerous program.

Senator BENNETT. It is limited by the willingness of the States and by the regulations that the States make.

Dr. ESSELSTYN. That is right.

Senator BENNETT. So what you are saying, in effect, is that you think there should be complete medical care either through one system or the other, with no restrictions on it, so that anybody could present himself at the door of a hospital and say "I want to be taken care of," and be taken care of.

Dr. ESSELSTYN. We are talking about the people over 65.

Senator BENNETT. Over 65.

Dr. ESSELSTYN. Right.

Senator BENNETT. No limits on the rights of people over 65 to get any kind of hospital care for any duration.

Dr. ESSELSTYN. That they need.

Senator BENNETT. Well, who is going to decide whether they need it or not?

Dr. ESSELSTYN. The same person who is going to decide whether they go to the hospital and are admitted.

Senator BENNETT. You heard the lady this morning, I guess, Mrs. Gottlieb, give us the sad story reported by the woman who didn't go to a doctor, she just took the patient in her car and went around the agencies and said, "Will you take care of this person?"

Do you think that was the right way to take care of that person?

Dr. ESSELSTYN. I think there is only one person who can admit a patient to a hospital, and that is a State physician.

Senator BENNETT. I am sorry, I did not realize that when I was questioning her this morning, and I am glad to get that in the record this afternoon. You do not take a publicity-seeking individual who goes from one agency to another trying to get help for a sick person and never goes to the doctor in the first place.

Excuse me. I am using you to straighten the record out. I should have straightened it out with Mrs. Gottlieb this morning.

Go ahead.

Dr. ESSELSTYN. Well, I just want to make the point, as I have made it here, that the pioneering Kerr-Mills program, while still helpful for the present, and needed for the future—and we may have always said this right from the start, and I want to emphasize it in case you do not feel that we have before this—we do not want King-Anderson instead of, but in addition to.

Senator BENNETT. But you want Kerr-Mills modified so that there is no means test?

Dr. ESSELSTYN. Right.

Senator BENNETT. So this means——

Dr. ESSELSTYN. The Kerr-Mills program, as you know, has been ineffective, and I have listed the reasons here, and I do not think we have to go over them. I am sure you have heard that many times.

Senator BENNETT. That is right.

Dr. ESSELSTYN. However, I think that we have got to realize that in spite of all this today the No. 1 cause of dependency is still disability, and for this reason, I think we have got to pay more and more attention to it.

During the past years the opposition has come from the sources that you are well aware of, and I would like to mention some of these.

A major element in the AMA's campaign has been an attempt to instill in the older people of this Nation the fear that the social security system is about to go bankrupt, totally ignoring all of the evidence to the contrary, including the most recent report of the Advisory Council on Social Security.

Then we suddenly find the AMA in the role of speaking for labor, and we see the old arguments come up about its being socialized medicine, and that there is a threat of the doctor-patient relationship, and

there is a threat of the Government getting into medicine, and there is the element of compulsion.

Well, I think all of these things should be faced very squarely. First of all, when it comes to who speaks for the AMA, I think it is important for your committee to realize that within the AMA that democracy stops at the county level, and beyond this there is no two-party system, and there is no minority report, and there is no effective platform from which the minority may speak.

This is one of the reasons why our committee was formed. I think the result is that people feel that the president of the AMA speaks for the AMA, which is a monolithic kind of a structure.

I would draw your attention to the fact that in the New York State Medical Society, when a study was made 3 years ago, it was found that 18,000 out of the 26,000 doctors in New York State belonged to the AMA, and at this point, membership was made compulsory, but this same kind of a figure applies to Massachusetts, and I am told it applies to many States around the country, although I do not have the figures. So the AMA does not represent all other doctors of the country by any manner of means, and it does not speak for all of the doctors who are members of the AMA.

Regardless of that, speaking about the inequitable burden, it seems to me that labor is in a position to speak for itself. The thought that, perhaps, somebody might say you did not have to pay, I think, is a very, very limited argument simply because of the fact that only three-tenths of 1 percent have incomes of over $50,000, and only 3 percent have incomes of over $10,000.

About the question of socialized medicine, I am sure that this committee is sophisticated enough to realize the extent to which the Government participates in our medical programs today, and at whatever level it is we have the United States in medical care, is largely due, thanks to, what Government participation we have and, as I say here, I feel the time has come when we can no longer have the great force of private enterprise in mortal combat with the resources of the Government. I think the good of society demands that the antagonism be replaced by synergism in an integrated program which alone can achieve the best in medical care for the American people.

And, this business about the change in the doctor-patient relationship because the bill that made the pay from social security, it seems to me depends entirely on what you consider the doctor-patient relationship to be.

But whether the bill is paid for by the person himself or out of his savings, or from his Blue Cross or insurance company or mortgage on the farm or borrowing from relatives, it still, it seems to me, does not interfere with the basic ingredient of what it is that constitutes a doctor-patient relationship which, after all, is the willingness and the ability of the doctor not only to give of his knowledge and of his time but of himself. This is not in any way, it seems to me, interfered by the source of payment of the hospital bill.

Senator BENNETT. Well, I would agree with you with respect to the King-Anderson bill because that does not give any assistance to the person who only needs medical care in his home and for whom it is not necessary to arrange for hospital treatment.

But I think it is not too unreasonable to suspect that this is just the opening step, and when people find they cannot get Federal assistance

if they do not go to a hospital, then we are going to have demands for amendments to the King-Anderson bill which would provide funds to pay doctors directly outside of situations where hospitalization is involved.

Do you think that is likely to come?

Dr. ESSELSTYN. I am not adept at looking into the crystal ball, but I think that historically if and when in the judgment of society there has been a disparity between the cost of medical care and the ability of a segment of society to pay for that care the Government has stepped into that vacuum, and I think we see that in the fact that the Government today takes care of the tuberculosis, takes care of those with mental illness, takes care of those with drug addiction. I mean you can go through a whole long list of illnesses, and then you can go through a whole long list of categories of classifications of people such as the indigents and the migrant workers and the Indians and the Members of Congress, and the Cabinet, and the President, categories of people as well as categories of disease.

These, I think, are things which may happen in the future if there is a need, and if in the judgment of society this need is great enough to have the Government move in.

Senator BENNETT. Don't you see that when you get into those fields that it is the Government that selects the doctor and not the patient?

Dr. ESSELSTYN. Not necessarily.

Senator BENNETT. Well, we have medical service for the Members of Congress. We do not select the doctors. If we want to use their services we go to the doctor that someone else has selected or we do not use him.

Dr. ESSELSTYN. It is my understanding that you have a choice of doctors who have been already preselected by other doctors, which is a great protection, it seems to me, and a very fortunate thing to be able to do.

Senator BENNETT. I would question that. Our doctors are selected from the ranks of the Navy, and I have never been given any indication that I had any choice or any relationship to their selection. In fact, we do not know who they are until they show up, and we do not know when they are transferred to other naval assignments. They are here for our service if we want to use them, but we have absolutely nothing to do, nothing to say, about who they are.

Dr. ESSELSTYN. Let me say something more about our need for medical care. I believe there is some question sometimes in the mind of some people whether or not there are unmet needs. I just want to remind you what Luther Terry, our Surgeon General, said 2 or 3 years ago, when he said that 150,000 lives would be lost, and over 1 million disabilities take place because of the failure to apply principles and knowledge which were already known.

I think this is extremely important, and I think, if necessary, you can document lists and lists beyond any doubt to make us realize that there are unmet needs in this country. Not only are there unmet needs in this country, but I think one of the very sad things is the fact that within our country the amount of health a person enjoys is directly related to his social or economic status.

We have as much as a 400-percent difference in maternal mortality and infant mortality between various categories of our society. In

other words, health is directly related to a person's ability to purchase. This is not true in some of the other countries.

Senator BENNETT. I would agree with you that it is partially related. But if you insist that it is directly related, then those, and I say those of us because everybody knows the salary of a Member of Congress, we should always be healthy. We should never have any physical problem, so this is not a complete relationship, is it?

Dr. ESSELSTYN. We would hope that you would not——

Senator BENNETT. Well, you know as well as I do that this——

Dr. ESSELSTYN. It would be greater if your salaries were not as large. Your morbidity rate would be greater if your salaries were not as large. This can be documented.

Senator BENNETT. I think you show a relationship, but I am not sure that it is really an overriding relationship.

Dr. ESSELSTYN. Another thing I think we want to bear in mind, and that is we are not the country in the world that has, for instance, the greatest longevity. We are not the country with the lowest maternal mortality, and during these 7 years while we have been talking about how to implement this payment, our infant mortality statistics have gone from 7 in line until today we are in 11th place among the other nations of the world in infant mortality, which our biostatistical friends tell us is the most accurate way of appraising the general health of a community.

I think these are things which we have got to keep in mind.

I think we have to keep in mind what is going on in the rest of the world, in the other industrial countries. The most recent evidence of changing standards of values on the international scene is the health charter for Canadians recently presented in Ottawa to the Parliament by the Royal Commission on Health Services.

The report stated, and I quote:

> Achievement of the highest possible health standards for all our people must become a primary objective of national policy and the cohesive factor contributing to national unity involving individual and community responsibilities and actions.

Then the Commission goes on to spell out its basic philosophy which I think can be summarized as follows:

> That Canada's human resources, men, women, and children are worth the price that must be paid in taxes in insuring that all Canadians may enjoy the best health possible in this era of scientific advancement, and that Canada can afford that price.

I think this is interesting here from our neighbors to the north whose economic status is certainly not as favorable as that of the United States.

In the light of what has gone on in the past 7 years, and in light of the lives which have been needlessly lost over this period of time, to say nothing of the disabilities which are accumulating unnecessarily each day, I feel I can speak for each member of our committee in saying that we are profoundly disappointed in the failure of Congress to enact legislation along the lines of the Anderson-King bill.

Such legislation is necessary and should be enacted without further delay in order (1) that payment toward the cost of medical care may be financed through the social security system; (2) that financing may be handled by a single existing experienced nationwide agency;

(3) that there may be uniform benefits to all regardless of place of residence; (4) that there may be no necessity to publicly confess to inadequacy; (5) that the burden on existing tax structures be minimized; (6) that the financial load on existing welfare plans may be lightened; (7) that Blue Cross may be restored to their competitive position by removing the intolerable burden of the over-65 group; (8) that medical indigency may be prevented.

In short, in order that the people in the last of life for which the first was made, may enjoy some protection toward the costs of their medical care which they themselves will have earned.

(The prepared statement of Dr. Esselstyn follows:)

STATEMENT BY CALDWELL B. ESSELSTYN, M.D., CHAIRMAN, PHYSICIANS COMMITTEE FOR HEALTH CARE FOR THE AGED THROUGH SOCIAL SECURITY

My name is Caldwell Blakeman Esselstyn. I am a practicing surgeon in a rural (Columbia) county in upstate New York. I am here as a member of the Physicians Committee for Health Care for the Aged through social security. On behalf of this committee, I want to thank you for this opportunity to testify before the Senate Finance Committee.

I want to preface my statement by saying that I will confine my remarks as much as possible to matters of principle and not attempt to further deluge this committee with a mass of statistics to which I know you have already been exposed.

Our committee consists of 35 physicians representing different specialties, living in areas that are scattered throughout the entire country. Our membership includes physicians from both political parties. We have a common belief that the most practical method of financing care of the aged is through a payroll tax and feel this is a moral, and not a political issue.

In addition, there are more than a thousand physicians who have indicated to us directly their support of the principle we endorse. It is heartening further to know of the support of this principle by approximately 5,000 physician members of the National Medical Association, and to study the opinion of the conservative magazine Modern Medicine, which showed, by way of a random sample of over 27,000 M.D.'s, that approximately 10 percent of physicians favored the King-Anderson bill. A separate, unrelated organization, the Physicians Forum, representing several thousand more physicians is in favor of financing the care of the aged through social security. It is also interesting to learn of the wholehearted support of the medical profession of the recent opportunity for independent physicians to participate in the social security system.

Our support of financing the care of the aged through social security is in keeping with the traditional pattern of the evolution of health care services, not only in the United States but in other countries throughout the world where advances have been made only after a great deal of argument, with the majority of the medical profession playing the role of reactionary conservatism and an active minority attempting to awaken the public conscience and stimulate political action.

Seven years ago a first step was taken in Congress when the Forand bill was introduced. Unfortunately, today, 7 years later, the House of Representatives has not had an opportunity to vote upon this important issue. While these precious years have gone by, several changes have taken place.

1. The over-65 population is growing at a greater rate than other segments.

2. The proportion of persons within this population who are over 75 is increasing. Needless to say, these are the people with the highest needs and the least amount of insurance.

It has been statistically proved to the satisfaction of all that the need for hospitalization of the over-65 population and the utilization of hospitalization for the over-65 population tops every category such as the number of admissions per thousand, the number of days per thousand, and the length of hospital stay per illness.

3. It is a fact that the over-65 group has less sickness insurance than those under 65.

4. It is also a fact that the insurance that they have covers considerably less of the costs of their illnesses.

5. During the past 7 years the Consumers Price Index of medical care has risen to approximately 120 percent, using 1947–59 as 100 percent. Reliable authorities predict a continued minimal rise of between 5 and 7½ percent annually for the next 10 years.

6. The cost of Blue Cross premiums alone have increased 83 percent in the last 12 years and substantial requests for increases of 22 to 32 percent are pending before many State insurance commissioners at the present time.

7. The burden of paying for the care of the aged continues to threaten the very life of Blue Cross which admits that some outside source of financing is necessary. In 1962 alone, Blue Cross collected $200 million in premiums from the over-65 group, while paying out $375 million for their care.

8. Without exception, the nonprofit over-65 interagency pool plans in New York, Connecticut, and Massachusetts are already finding it necessary to increase premiums even though they are relatively high cost, low benefit stopgaps.

9. The pioneering Kerr-Mills program, while still helpful for the present and needed for the future, is developing many serious defects, some of which will only be intensified rather than cured by time. For example—

(*a*) The marked disparity in benefits among States causing the degree of relief (if any) to the needy to be dependent on place of residence, rather than seriousness of illness;

(*b*) The disappointing number of States which, in 3 years, have not enacted any program at all. This inequity is magnified when it is realized that even people in States with no program are contributing to the general revenues of the Government from which the Federal part of Kerr-Mills is financed;

(*c*) The exorbitant cost of administration, due in part to the need for exhaustive investigation of income and assets, not only of the beneficiaries but of their children as well;

(*d*) The continuing abuse of the intent of the program by many States which have swelled the MAA ranks by transfer from other public assistance programs because of a more favorable extent of Federal participation;

(*e*) The facts that the bill does nothing to prevent financial problems but depends on dependency for its activation;

(*f*) The fact that help from the program requires recipients to be on the welfare rolls, which automatically in most instances means that for inhospital services, he has no free choice of physician;

(*g*) The necessity for an individual, no matter how thrifty or diligent he may have been throughout his life, to be forced to publicly acknowledge inadequacy before becoming eligible for help; and

(*h*) The growing realization that under Kerr-Mills, which is no more nor less than an expansion of the welfare state, all but the extremely wealthy must live under the constant fear that an unpredictable and unpreventable medical disaster may strike and financially ruin not only them, but their children as well.

During the past years, the insurance interests, the drug interests, the National Association of Manufacturers, and the National Chamber of Commerce have been stepping up their campaign in opposition to the social security approach. The past president of the AMA has become the image and the mouthpiece of the group. His approach by this time is well known to us all.

1. A major element in the AMA's campaign has been the attempt to instill in the older people of the Nation the fear that the social security system is going to go bankrupt, totally ignoring all the evidence to the contrary, including the most recent report of the Advisory Council on Social Security.

2. Then we suddenly find the AMA cast in the role of concern for labor, which under social security must contribute a higher percentage of income than the people living on Park Avenue, New York, who do not need any help. They suggest that working people are unwilling to make the additional contribution toward health benefits proposed in the Anderson-King bill.

3. Although it has been worn very thin, there always remains the argument about the threat of socialized medicine.

4. Then there is the suggestion of the threat of the loss of the doctor-patient relationship and the disintegration of the quality of medical care which the free enterprise system in the United States has made the best in the world.

5. There is the threat that the Government will be getting into the practice of medicine and looking over the doctor's shoulder.

6. There is the element of compulsion, which they suggest is un-American.

I would like to comment directly to your committee on some of these allegations. First of all, you must realize that within the AMA democracy stops at the county level. Beyond this, there is no two-party system, no proportional representation, no minority leader, no minority report, and no effective platform from which the minority opinion may be expressed.

The result is the mistaken impression held by many people that the AMA is a monolithic structure and that the utterances of its president, for whom only members of the house of delegates are given the privilege of voting are subscribed to by all. The increasing number of States in which membership in the AMA is becoming compulsory is a slight measure of the growing dissatisfaction of the physicians of America with AMA's political activities. The increase in the proportion of dues (formerly $1.3 million) going toward more active public relations, is particularly objectionable.

Regarding the inequitable burden upon working people which the social security approach would inflict, may I suggest that labor, which represents the best organized, the most articulate, and the most knowledgeable segment of society regarding the value of the medical dollar, is quite capable of transmitting their attitude about financing the care of the aged through social security without the unwanted interference of the president of the AMA.

Regarding the folks on Park Avenue, it might be noted that three-tenths of 1 percent of people over 65 have incomes of $50,000 or more and only 3 percent, incomes of $10,000 or more.

Regarding the question of socialized medicine, I am sure that this sophisticated committee appreciates the fact that our present level of medical care in this country could never have been achieved without the very substantial amount of Government participation which we have been fortunate enough to enjoy. I am sure you all realize that parts of our medical care program are totally socialized; other parts are partially socialized. In fact, there is almost no part which is not socialized to some degree. Nevertheless, it remains our American system today. I believe our greatest responsibility lies in further developing cooperative endeavors combining the exploitation of the great resources of Government with the wealth and talent we have in our free enterprise system. The time has come when we can no longer afford to have either of these great potentials dissipating their strengths in mortal combat. The good of society demands that antagonism be replaced by synergism in an integrated program which alone can achieve the best in health and medical care for the American people.

Whether there is indeed a threat to the doctor-patient relationship in social security health insurance depends upon what kind of a relationship this is considered to be. It is hard to understand how the source of payment of a hospital bill whether from mortgage on the farm, from relatives, friends, savings or social security, will modify the ability of a doctor to convince a patient of his interest, or to command the patient's respect or to give what constitutes the essence of a doctor-patient relationship—to give; namely, not only of his time or even his knowledge, but of himself.

A word about the quality of our medical care in relation to the contention of the AMA that we have the best in the world. Relatively recently, Dr. Luther Terry, the Surgeon General, stated that 150,000 lives were being lost annually because of lack of application of techniques already known; and 1 million disabilities were occurring each year which were preventable. The report of a study of chronic illness in a rural area made possible some time ago by the commonwealth fund revealed an amazing number of existing unmet needs. In Hunterdon County, some 60 miles southwest of New York City, medical care was needed by 79 percent of the sample population—47 percent received it; drug or diet therapy was required by 49 percent of the sample—15 percent received it; surgery was needed by 21 percent—4 percent had surgery; dental care was needed by 17 percent—3 percent had it; psychiatric care was needed by 3 percent—0.5 percent had it; bedside nursing for one or more days was needed by 15 percent, but only 6 percent received it; a home nursing visit should have been made at least once to 13 percent of the sample, but only 1 percent were visited.

Nor do we find solace in a review of recent international vital statistics.

It is Norway—where diseases are recognized as being socially disruptive and where there is considered to be no relation between the value of life, health, and happiness and the wealth of the individual—that has the greatest longevity, not the United States.

We are not the country with the lowest maternal mortality. Only recently we slipped to 11th among nations in infant mortality.

These statistics are all based on comparable criteria according to World Health Organization standards.

It is provocative to compare these representative vital statistics of our country, served by a medical profession that is supposed to rally to the AMA's battle call of "help the needy, not the greedy," with the vital statistics of other countries—in which to a large extent the power to heal has been removed from the marketplace, and people are not penalized financially for illness. It gives us insight into the disquieting fact that in our country, morbidity is related in indirect proportion to socioeconomic status, that infant death rates and maternal mortality in our own country vary as much as 400 percent between certain categories of peoples.

In regard to the Government taking a greater interest in medicine, I can only say it is none too early. As larger sums of money become available for medical care, enforcement of standards becomes more essential. While it is true that efforts have been made by the profession to control certain abuses in accredited hospitals, the overall picture is discouraging. As long as welfare continues to pay for substandard care in substandard facilities, these facilities will be encouraged to continue in their pattern of providing inadequate care.

As long as Blue Cross continues to make payments to hospitals across the country without regard for the fact that only 67 percent of the 3,579 voluntary, and 18 percent of the 982 proprietary hospitals have met even the minimum requirements of accreditation, the existence of substandard hospitals will be encouraged.

Commercial insurance companies continue to pay for physicians' services regardless of any evidence that the doctor is competent to render the service. Perhaps saddest of all, Blue Shield, the so-called doctors' plan, still insists on paying any licensed physician for any service he renders to any patient.

It is apparent that the providers of medical service have not been able to police themselves. The time is long overdue when some branch of Government, hopefully the Public Health Service, will become involved in the development and enforcement of standards in the field of medical care, especially for the aged and chronically ill.

In answer to the question of compulsion, may I say that although none of us enjoy it, there is abundant precedent. After all, it is our compulsory insurance against ignorance and illiteracy, which for many years has formed the basis of our public school system.

These are a few reasons why we are in disagreement with the spokesmen of the bitter opposition to hospital insurance under social security which the AMA has been leading.

It is a great tragedy that during these past 7 years while we have been debating the question of how to make it possible for our senior citizens to enjoy a measure of security against unpredictable and unpreventable medical disaster, other industrial countries in the world have taken the power to heal out of the marketplace and no longer penalize their citizens financially for unpreventable sickness and infirmities. The responsibility for the worsening relative health position of the citizens of the United States as represented by our decreasing standards in infant mortality and our increasing disparity of health within our own socioeconomic classes, must be attributable, at least in part, to the lack of governmental action. I am sure this is due in some measure to the failure to appreciate the extent of the Nation's unmet needs.

The most recent evidence of changing standards of values on the international scene is the health charter for Canadians recently presented in Ottawa to the Parliament by the Royal Commission on Health Services. The report stated that "achievement of the highest possible health standards for all our people must become a primary objective of national policy and the cohesive factor contributing to national unity involving individual and community responsibilities and actions." The Commission goes on to spell out its basic philosophy which may be summarized as follows: "That Canada's human resources, men, women, and children are worth the price that must be paid in taxes in insuring that all Canadians may enjoy the best health possible in this era of scientific advancement, and that Canada can afford that price."

In the light of what has gone on in the past 7 years and in the light of the lives which have been needlessly lost over this period of time, to say nothing of the disabilities which are accumulating unnecessarily each day, I feel I can speak for each member of our committee in saying that we are profoundly disappointed in the failure of the Congress to enact legislation along the lines of

the King-Anderson bill. Such legislation is necessary and should be enacted without further delay in order—

That payment toward the cost of medical care may be financed through the social security system;

That financing may be handled by a single existing experienced nationwide agency;

That there may be uniform benefits to all regardless of place of residence;

That there may be no necessity to publicly confess to inadequacy;

That the burden on existing tax structures be minimized;

That the financial load on existing welfare plans may be lightened;

That Blue Cross may be restored to a competitive position by removing the intolerable burden of the over-65 group;

That medical indigency may be prevent.

In short, in order that people in the last of life, for which the first was made, may enjoy with dignity some protection toward the cost of their medical care which they, themselves, will have earned.

Senator BENNETT. I have enjoyed my visit with you, Dr. Esselstyn. I am sure the committee appreciates your appearance here today.

Dr. ESSELSTYN. Well, it has been a pleasure, and I thank you.

Senator BENNETT. Thank you.

Mr. William E. Beaumont, Jr., the American Nursing Home Association.

STATEMENT OF WILLIAM E. BEAUMONT, JR., PRESIDENT OF THE AMERICAN NURSING HOME ASSOCIATION; ACCOMPANIED BY ALFRED S. ERCOLANO, EXECUTIVE DIRECTOR, AMERICAN NURSING HOME ASSOCIATION

Mr. BEAUMONT. Mr. Chairman, I am William E. Beaumont, Jr., president of the American Nursing Home Association, whose offices are located at 1346 Connecticut Avenue NW., Washington, D.C. I am also past president of the Arkansas Nursing Home Association and owner-administrator of a 47-bed nursing home in Little Rock, Ark. I have with me today, Mr. Alfred S. Ercolano, the executive director of the American Nursing Home Association.

The American Nursing Home Association has a membership of over 4,300 nursing homes and 47 affiliated State nursing home associations. Our membership represents over 170,000 beds of both proprietary and voluntary nonprofit homes.

We who must deal with the problems of caring for our aged and chronically ill on a day-to-day basis, appreciate this opportunity afforded by the committee to present our views on H.R. 11865, the "Social Security Amendments of 1964." It is our position that the proposed amendments to the social security system to provide an increase in benefits, among other purposes, is a sound piece of legislation which is sorely needed to offset the growing demands upon the present social security checks of our aged population.

There is little doubt in anyone's mind as to the intent of this legislation: to provide our aged with additional revenues to help meet their daily expenses.

Since this measure is so important to the some 20 million persons receiving social security payments, we would oppose any additional amendments which would imperil passage of this bill before the end of this session.

It is our contention that any amendment, involving medical care to the aged under the social security system, attached to this bill would

seriously jeopardize, for this session, the passage of this much-needed increase. We support H.R. 11865 because we feel it is in the spirit of the social security concept and in the spirit of individual responsibility.

The benefits embodied in H.R. 11865 allow the recipients to choose freely the area where their additional income will help most. It is our thought that the primary aim of the Congress should be to disencumber this important legislation of elements, such as medical care under social security, which would in any way impair speedy passage and promulgation of this justifiable increase in cash payments.

Since its beginnings in 1949, the American Nursing Home Association and its predecessor organizations have provided leadership in improving nursing home facilities and standards of care in nursing homes throughout the country. We have worked diligently with other organizations in the medical and paramedical fields in meeting the health problems of the aged.

We also cooperate with governmental agencies at National, State, and local levels to raise the standards of care in nursing homes and to bring about realistic laws regulating and licensing nursing homes. While only five States had licensure laws in 1950, today all States require licenses for nursing homes. The American Nursing Home Association membership includes only licensed nursing homes.

We, for many years, have worked to establish an accreditation program which goes beyond licensing standards and encourages a greater degree of professionalism in personnel and in methods of care and rehabilitation. Where such accreditation programs were effected, resultant improvements in standards of care were phenomenal. Last year, we were instrumental in establishing a national accreditation program.

As of April of last year, our association joined with the American Medical Association in the joint sponsorship of the National Council for Accreditation of Nursing Homes. The national council officially opened its new offices in Chicago last September under the direction of Dr. Henry H. Holle, former public health officer from the State of Texas.

There were some 23,000 nursing homes and related facilities with a bed capacity of nearly 600,000 in 196-. Of this number 9,700 were skilled nursing homes under Public Health Service definition, with a bed capacity of nearly 600,000 in 1961. Of this number 9,700 were professional or licensed practical nurses, or both, on their staffs.

The number of skilled nursing home beds has nearly doubled since 1954. I might point out to you at this time that 72 percent of skilled nursing home beds are in private or proprietary homes and 16 percent in nonprofit homes. Publicly operated homes accounted for only 4.5 percent of the homes and 12 percent of the beds.

Government programs such as the mortgage loan insurance programs of the Federal Housing Administration, the nursing home program under the Small Business Administration, and the Hill-Burton nonprofit nursing home grant program, without a doubt, have provided the impetus for the rapid construction of nursing homes and resultant improvements in facilities. Under the FHA program, 453 loans involving 41,887 beds and a total mortgage amount of $284.4 million had been insured as of last June 30.

As of December 31, 1962, Hill-Burton grants of $143 million had been made to 234 chronic disease hospitals and 439 nursing home projects involving a total of 42,639 long-term care beds. Under the SBA loan program 337 loans amounting to $23.4 million had been approved for nursing homes.

The average age of our patients is 80. Most spend at least a year with us and one-third are with us 2 or more years. Many return to their own homes. About 77 percent of those 65 and over and 83 percent of those 75 and older have one or more chronic illnesses. Two out of three suffer from a cardiovascular disease and one in four suffers from some degrees of senility although more than half have periods of disorientation.

The American Nursing Home Association is opposed to any program of medical care to the aged under the social security system because:

1. It seeks to provide medical payments to all the aged regardless of the financial ability of individual; the real need is among only a minority of our population and that figure is diminishing. Today there are only about 2 million persons over 65 who do not qualify for some program of medical assistance under either private policies or public medical care assistance programs. This bill, which is inadequate in its total scope, would have the impact of measurably weakening the equitable and sound programs already in effect.

2. The bill provides nothing which is not presently available, and in many cases more adequately available, from the various private and voluntary programs for aged. Its scope of care is limited, its mechanics are cumbersome, its benefits are inequitable, and, in many instances, duplications of other programs.

3. The proposed legislation is procrustean in concept. It attempts to fit the total scheme of medical care for the aged into a totally inadequate and ill-conceived pattern. It creates a good many unnecessary problems which merely confuse the total health care insurance picture by adding another incomplete program which would have to be supplemented by other programs. The logic involved in this idea of piecemeal legislation is questionable. Certainly it would be to our advantage and to the advantage of those to be covered to improve upon existing programs such as the Kerr-Mills legislation which has met with such widespread support from the various groups who deal constantly with the problems of the aging.

4. Private associations and purveyors of medical services have been continually seeking more expanded methods for dealing with the problems of medical care to the aged. We have constantly sought to increase communication with private insurance companies that they might expand their coverage to include more nursing home facilities and services, and this is being done.

5. The proposed legislation does not take into account the wide range of differences that exist from region to region, from State to State, from county to county, and form individual to individual. Only a program which provides for tailoring to the needs of each specific case, and which apportions the costs according to the needs, could really begin to meet the problem head on and eventually bring about a positive and efficient solution.

6. The legislation in question has risen out of a misapprehension of the total needs of our aged population. Obviously there is some ques-

tion as to the validity of statistics of the various groups who have proposed and opposed such measures. But in this variation there lies the source of our problem: the range of variation is too great to be encompassed in such legislation. The only feasible solution is to prepare a program aimed at meeting the needs as close to each individual case as possible. This obviously can be done best on the local levels through programs similar to MAA.

7. The program is out of focus with the actual health care picture of today. In a goodly number of cases, it would force aged persons to enter a hospital before they could qualify for nursing home care. Yet many require only nursing home care and not more costly hospital service.

8. This type of legislation exempts a person with tuberculosis and the mentally ill. This is wholly unjustifiable since the concept is now being advanced that nursing homes might be a more suitable environment for many mentally ill patients. At the present time, the American Nursing Home Association is conducting a study for the Public Health Service on the feasibility of transferring certain mental patients to nursing homes. This just points up part of the inadequacy of such legislation now pending.

9. The bill discriminates against a vast majority of nursing homes which are not hospital affiliated. Many of these homes have, however, provided many years of care to a large segment of the chronically ill and aged when others were ignoring the problem. There are many of these homes that would be eliminated from the care program simply because an area hospital might not be willing to sign an agreement with the Department of Health, Education, and Welfare and/or the nursing home. The number of formal affiliation agreements between hospitals and nursing homes is insignificant. Probably less than 2 percent of America's nursing homes have such agreements.

10. The legislation does not provide payment for actual costs of care, but only for payment of what the Secretary deems as "reasonable costs." On that basis, if a uniform rate is applied throughout the Nation, it cannot reflect the various cost differences which prevail from area to area, thereby revealing another point in which the program proves unrealistic and inequitable. Failure to pay actual costs would mean a double burden on private pay patients who would be paying the deficit costs of service.

11. The financial condition of America's population aged 65 and over has improved tremendously in the last few years and the prospects ahead are even brighter. Surveys have indicated that about one-half of the patients in nursing homes either paid their own way or their cost of care was borne by their families. The President's Council on Aging in a report issued earlier this year noted that in 1950 there were 12.3 million Americans 65 and older with incomes totaling $15 billion; in 1961 there were 17 million elderly, an increase of 40 percent, with incomes of $15 billion, an increase of 130 percent. Significantly, the report added—

> in addition the people who retire during the next 10 years will receive higher payments, on the average, than the benefits being paid today * * *. Private pensions will also play a bigger role in providing economic security for the people retiring during the next 10 years.

12. Private and voluntary health insurers are continually expanding their coverage of the over-65 age group so that today some 60 per-

cent are covered. The insurers are also extending their coverage to include nursing home care. Figures from the Health Insurance Association of America indicate that 10.3 million persons 65 and over were protected in 1962 by some form of private health insurance. This figure has increased tremendously in the last few years as I am sure the committee realizes. At the same time, we are told by the Social Security Administration that 14 percent of the aged are receiving old-age assistance benefits and are therefore eligible to obtain Government help in meeting health care costs. In other words, at least three-fourths of the Nation's aged have available a means of meeting health care costs without including those who receive aid under the MAA, or Kerr-Mills program. Private insurance coverage companies are expanding their coverage to include nursing home care, and at the end of 1962 more than half of the Blue Cross plans provided nursing home coverage in their benefits.

13. The aid to those financially unable to meet not only health costs, but the costs of everyday living is a joint responsibility of National, State, and local governments and administration of these programs is best done at the State and local level.

The American Nursing Home Association has supported much in the way of legislation which we consider to be to the benefit of our many senior citizens. In opposing or supporting any legislation in this area, we have carefully studied the considerations before assuming a position. So we come here today not without a serious question as to the necessity of this additional program and not without serious question as to the orthodoxy of housing such a program in the framework of social security.

It is our contention that there is now an avenue which is open through which we can take immediate and special action to provide adequate health care for our aged who are in need. This avenue is the present MAA and OAA programs.

It is our position that the real need lies in the development of strong and sincere leadership from the Department of Health, Education, and Welfare to promote the implementation and liberalization of MAA systems and to improve the payments for services in OAA cases.

We feel strongly that this leadership is necessary in many areas of the Nation. Roughly half of our nursing home patients receive some sort of public assistance. In many States the programs are working well, but in some they lag. Health, Education, and Welfare is in a strong position, with its vast network of personnel and resources to provide strong and valuable leadership in these weaker areas. There is, unfortunately, a feeling rampant throughout our field that Health, Education, and Welfare would like to see Kerr-Mills fail of adequacy in order to create an outcry for legislation of this type.

In summary, we support H.R. 11865 and oppose any amendment which is foreign to the intent of this legislation and which could abate the changes of speedy passage of it.

Thank you, Mr. Chairman, for the opportunity of presenting our statement.

Senator BENNETT. Thank you very much, Mr. Beaumont. We appreciate your coming here, and we appreciate your patience in waiting for us this afternoon.

Mr. BEAUMONT. If there is any additional information which we can furnish the committee we would be happy to do so.

Senator BENNETT. Thank you.

(At the request of the chairman, the following are made a part of the record:)

STATEMENT OF THE AMERICAN NURSES' ASSOCIATION ON H.R. 11865, AUGUST 10, 1964

The American Nurses' Association is the professional organization of registered nurses in 54 constituent State and territorial associations. We are one of the professional groups deeply concerned with providing health care for the American people and are the largest single group of professional persons giving that care.

The American Nurses' Association has supported the provisions of the Social Security Act and extensions and improvements of the system since its adoption. We support the amendments to the act passed this year by the House of Representatives.

In 1958, the highest policymaking body of the association, its house of delegates, voted to support the principle of extending the social security program to include health insurance for recipients of old age, survivors, and disability insurance. The house of delegates reaffirmed this position in 1960 and in 1962. We therefore welcome the opportunity to give our views on further extending the act to include health insurance for the aged.

Our primary reason for support is stated succinctly in the following resolution adopted in 1958 and reaffirmed at the two subsequent conventions:

"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 services, including nursing care in the home, be included as a benefit of any prepaid health insurance program."

The association further believes that using the social security mechanism as a means of solving the problem of financing health care for the aged is more dignified and appealing to the people of this country than an approach through public assistance programs.

In taking this position in support of the extension of social security to include health insurance coverage, the association indicated its concern for the health needs of millions of Americans who are faced with the problem of financing health care at a time when income is lowest and potential disability at its highest.

Because of their own economic situation, nurses identify with those facing retirement on a limited income. In 1963, the average weekly salary of general duty staff nurses in non-Federal general hospitals was $86.50 per week. The salary range was $55 to $100. This group of nurses comprises over 60 percent of those in practice.[1] Private duty nurses, who are independent contractors, are the next largest group. During January 1962, they earned a median monthly salary of $320. The median number of days worked during the month was 18. These nurses have no paid sick leave, no retirement program other than social security for which they pay the entire tax, no paid vacation leave or other benefits commonly available to employed workers.[2] The third largest group of practicing nurses are employed in physicians' and dentists' offices. Their median monthly salary in July 1962, when ANA last surveyed their employment conditions, was $360. Only 20 percent reported hospitalization coverage and 5 percent retirement plans other than social security. According to law, office nurses are covered by the Social Security Act.[3]

These three groups comprise over 80 percent of all practicing nurses. On retirement they will be faced with the problem of maintaining a decent standard

[1] "Facts About Nursing," American Nurses' Association, 1964 ed., p. 138.
[2] Ibid., p. 148.
[3] Ibid., p. 175.

of living and securing needed health services. On their present salaries it is impossible to save any substantial amount toward retirement, nor will they, on present salaries, be eligible to receive the maximum retirement income under social security.

In previous testimony before the House Ways and Means Committee, we made several suggestions regarding the provisions of nursing services and the role of professional nursing in establishing policies and executing them in a skilled nursing facility and a home health agency. The major continuing service furnished by these facilities is nursing. Nursing care should be given by or under the supervision of a registered professional nurse and policymaking bodies of the institution should include registered professional nurses.

We have been concerned with the care available in many nursing homes in this country where there is minimal medical and professional nursing service. We believe payments from the social security fund should not be used to support and perpetuate substandard care. We further believe that if skilled nursing facilities are to be eligible to participate in the proposed program they should meet requirements for accreditation set by a multidisciplinary committee or commission. Such a multi-disciplinary accrediting body does not now exist. Efforts to establish a division for accrediting inpatient facilities other than hospitals under the Joint Commission on the Accreditation of Hospitals have not been successful to date. However, several associations, including the American Nurses' Association, continue to explore ways of implementing this multidisciplinary approach.

The American Nurses' Association has supported the Kerr-Mills Act (medical assistance for the aged) by encouraging its constituent State nurses' associations to support necessary enabling legislation to activate the program. On principle the association does not approve of the means test and it questions how much freedom of choice recipients of MAA actually have. Recent studies of the program appear to indicate it has limited value. A few of the more wealthy States have comprehensive programs and receive most of the Federal funds allocated under MAA. In the past, these same States have had fairly liberal public assistance medical care programs, indicating not only ability to finance a program but also a greater than average concern for the less fortunate of their citizens. It would appear, therefore, that the success of MAA is dependent on the resources of an individual State and its commitment to proposals contained in the law.[4]

For all these reasons, the American Nurses' Association supports proposals to extend the social security system to include health insurance for recipients of OASDI, and we urge the committee to give favorable consideration to the principle of financing health care through the Social Security Act.

VERMONT NURSING HOME ASSOCIATION,
March 23, 1964.

Senator GEORGE D. AIKEN,
Washington, D.C.

DEAR SENATOR AIKEN: At a meeting of the Vermont Nursing Home Association, March 12, 1964, the membership resolved that "the Vermont Nursing Home Association is opposed to H.R. 3920 or any other legislation which provides for medical care of the aged under the social security system without regard to the financial needs of the patient."

We are writing to you to express the feelings of the association which represents the better nursing homes throughout the State and a large percentage of the total nursing home bed capacity. We feel there are many reasons why this bill is unrealistic:

The bill seeks to provide medical benefits to all the aged regardless of means and the problem rests only with a minority who require assistance. The bill is unrealistic in that it is hospital oriented and out of focus with the actual health care picture today. It would force aged persons to enter a hospital before they could qualify for nursing home care when many require only nursing home care and not more costly hospital service. The bill fails to meet actual costs of care, providing only for payment of what the Secretary of HEW prescribes as reasonable. The financial condition of America's population age 65 and over has improved tremendously in the last few years and the prospects ahead are even

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[4] Medical assistance for the aged—the Kerr-Mills program, 1960–63, Subcommittee on Health of the Elderly, Special Committee on Aging, U.S. Senate.

brighter. Private and voluntary health insurance is constantly expanding coverage of the over-65 age group.

We hope that you will vote against the passage of this bill and we believe that the real need is for improvements in the Old Age Assistance Act and the Medical Assistance Act program to meet the problems of those who truly cannot afford the cost of major medical expenses.

Sincerely yours,

RAYMOND GOBELL, *President.*

NEW YORK STATE NURSING HOME ASSOCIATION, INC.,
Syracuse, N.Y., August 10, 1964.

Hon. HARRY F. BYRD,
New Senate Office Building,
Washington, D.C.

DEAR SENATOR BYRD: The New York State Nursing Home Association wishes to record its support for H.R. 11865. We also wish to register our opposition to amendment 1163 (Senator Javits' amendment) to H.R. 11865.

Very truly yours,

FREDERICK C. PFISTERER, *President.*

OKLAHOMA STATE NURSING HOME ASSOCIATION, INC.,
Oklahoma City, Okla., August 10, 1964.

Hon. HARRY F. BYRD,
U.S. Senator, Committee on Finance,
New Senate Office Building, Washington, D.C.

DEAR SIR: We have just studied Senator Javits' amendment No. 1163 to H.R. 11865.

As you may know, our Oklahoma State Nursing Home Association and the American Nursing Home Association have already gone on record in support of H.R. 11865. We cannot, however, support amendment No. 1163.

We, therefore, respectfully request that you do all within your power to defeat amendment No. 1163 to H.R. 11865.

Mr. William E. Beaumont, Jr., president of American Nursing Home Association, is scheduled to testify before your Senate Finance Committee on Friday, August 14, in opposition to the amendment proposed by Senator Javits. He will support H.R. 11865. His statement will further explain our position.

Thank you in advance for your consideration of this request.

Respectfully yours,

ED WALKER, *President.*

Senator BENNETT. Dr. Buhler of the College of American Pathologists.

Dr. Buhler, will you identify the gentleman who is with you.

STATEMENT OF DR. VICTOR B. BUHLER, PRESIDENT, COLLEGE OF AMERICAN PATHOLOGISTS; ACCOMPANIED BY DR. OSCAR B. HUNTER, JR., MEMBER OF THE BOARD OF GOVERNORS

Dr. BUHLER. Mr. Chairman, I am Dr. Victor B. Buhler of Kansas City, Mo., president of the College of American Pathologists. I am accompanied by Dr. Oscar B. Hunter, Jr., of Washington, D.C., a member of the board of governors and committee on national legislation of the college.

The College of American Pathologists is a professional society representing over 4,000 doctors of medicine practicing the medical specialty of pathology in hospitals, medical schools, and private offices throughout the country. I appear before you today representing these physicians in opposition to the amendments to H.R. 11865 now before you for consideration which seek to finance certain health benefits for the aged through the social security mechanism.

First, I would like to emphasize that pathologists are doctors of medicine. After an individual graduates from medical school he must spend at least 5 additional years in intensive training in order that he may be certified to practice the medical specialty of pathology.

Mr. Chairman, despite the disclaimer in the various amendments before you that—

> Nothing in this title shall be construed to authorize any Federal officer or employee to exercise any supervision or control over the practice of medicine or the manner in which medical services are provided * * *.

The practice of laboratory medicine and the manner in which such medical services are provided would be specifically regulated were these amendments to be adopted.

The services of over 6,000 doctors of medicine practicing pathology are specifically included under the provisions of these amendments which define the medical practice of pathology as an inpatient hospital service. As physicians engaged in the practice of this specialty, we disagree with and resist the implied classification of the art and science of medicine as practiced by us as a "hospital service."

Make no mistake about it, tens of thousands of medical doctors' services are specifically controlled and regulated by the proposed legislation due to the inclusion of the medical specialties of pathology, radiology, physiatry, and anesthesiology as a "hospital service" under the provisions of these proposals.

Laboratory medicine is just that—medicine. It requires the services of a highly trained medical doctor. Although many pathologists carry on their medical practice as directors of hospital laboratories, this situation does not alter the fact that these physicians are practicing medicine and that their practice would be controlled, supervised, and regulated were these amendments to be enacted into law.

In addition to those pathologists practicing in hospitals and other institutions, a substantial number of the pathologists in this country maintain private offices where they conduct the practice of laboratory medicine as a service to the other medical practioners in private practice and their patients in the communities which they serve. The enactment of this legislation would result in paying for certain laboratory services were they to be provided by the hospital and not to pay for identical services were they to be performed in the private offices of a pathologist.

What about the cost of pathology examinations? Those aged recipients of benefits under these proposed amendments would have great incentive to seek the shelter of hospital and institutional care for diagnostic examinations which could be provided more inexpensively in private physicians' laboratories. Pathology services provided as hospital outpatient services, in general, must reflect, in addition to the professional services involved, various hospital administrative and overhead charges which are more costly to the patient.

When diagnostic services are provided as hospital services—where the primary reason for hospitalization is a diagnostic workup—the cost differential becomes greater because to the cost of pathology services must be added room, board, nursing care, and hospital administration costs which are completely unnecessary for most pathology examinations. Consequently, we feel this bill would not only be destructive of good medical care but costly both to the taxpayers and to the patient.

On behalf of the membership of the college I would like to speak to you now as a physician and voice some of the concerns and objections which are common to all of us who have dedicated our lives to the art and science of medicine and the care and healing of the sick, aged, and infirm.

We are concerned over the effects of Government intervention on this Nation's unsurpassed standards of health care. We also question the financial necessity of a Federal Government program providing medical care as a matter of right to all those over 65 years of age regardless of their need for governmental assistance.

Our observations also indicate that as a group over 65, Americans are self-reliant and independent and are in control of their economic destiny. In general, they are in good health and most of them are now adequately protected through insurance or other governmental programs with localized control from the costs of serious illness.

The members of the College of American Pathologists, like most other physicians, endorse limited governmental programs where they are locally administered and related to the need of the ill individual for assistance from taxpayer funds. Like most other thinking taxpayers, we voice our strenuous opposition to proposals such as the pending legislation which call for the expenditure of taxpayers' funds without any relation to the need of the recipients for Government assistance.

In this connection I would certainly be remiss if I did not once again call to the committee's attention the outstanding success of the Kerr-Mills law enacted by the Congress in 1960 to provide medical care for the needy and near-needy aged. I am sure the members of this committee are more knowledgeable than I am on the rapidity of acceptance of previously enacted Federal grant-in-aid programs. However, from our observations it appears that the Kerr-Mills program has been implemented by the States at least as fast as any other Federal grant-in-aid program in the history of this country.

This is not a federally operated bureaucratic program but may be tailor made to the needs of the various States and localities in the United States. It offers a very promising vehicle for meeting the medical needs of those over 65 who are economically unable to bear the brunt of long-term illness but who have adequate funds to meet ordinary everyday living costs including routine medical bills.

I would also be remiss if I did not mention, in passing, the great strides which have been made by private health insurance and prepayment plans. An industry which was in its infancy a little more than a decade ago now prognosticates that by 1970 (a scant 6 years away) more than 80 percent of those over 65 who need and want health insurance will have it. It should be obvious that with a booming growing industry meeting the needs of most aged individuals for a prepayment mechanism to assist them in times of illness that there is no impelling necessity now for a compulsory Federal system encompassing all who have attained the magic age of 65.

We pathologists see week to week, month to month, and year to year an ever-increasing number of our patients able to discharge their obligations in full from the proceeds of private health insurance and voluntary prepayment mechanisms. Let me emphasize from our experience, in our practice of medicine, health insurance and prepayment mechanisms and the Kerr-Mills program are paying most of the medical bills of most of the individuals we serve over the age of 65.

In conclusion, Mr. Chairman, the members of the College of American Pathologists are, in my opinion, legitimately concerned over the effect that enactment of these amendments would have on the practice of pathology and the practice of medicine in general. Our colleagues in Europe, in England, in other countries of this world which have experimented with government medicine tell us in all sincerity that government financing of medical care without reference to need invariably results in poorer, not better, medical care.

As practitioners of one of the four medical specialties which are specifically included in this legislation, we feel that we have a particular stake in your deliberations. I say to you with conviction and without equivocation that we believe that the control of laboratory medicine by a Government bureau would not be in the best interest of our patients or of good laboratory medicine.

We sincerely believe voluntary programs—private insurance and prepayment plans—coupled with limited Government participation based on the needs of our elder citizens for tax funds to assist them is the proper cooperative approach between Government, private enterprise, and the professions toward achieving and maintaining the best possible medical care for all Americans.

I realize that the responsibility which you gentlemen have in passing on this legislative proposal is not undertaken by you lightly. I can only sincerely urge on behalf of our membership that you seriously consider the sweeping effect of the step which you would take toward total Government regulation of medicine should you favorably report to the Senate the proposed amendments now before you.

I urge your thoughful rejection of these amendments and all similar proposals seeking to finance health care for the aged under the social security mechanism and other legislation designed to federally finance health care for a segment of our population without reference to need for Government assistance.

Thank you, Mr. Chairman, for the opportunity that you have afforded the College of American Pathologists to make their views known to you on this important legislation.

Senator BENNETT. Thank you very much, Dr. Buhler.

You have heard, if you have been in several of these hearings, many witnesses challenge the right of the American Medical Association to speak for doctors generally on the ground that it is not a democratic organization, and that the house of delegates is so chosen that many doctors are deprived of an opportunity to express a contrary opinion.

Do you have any—do you know of the existence of any—strong minority in your association that would oppose the statement you have just made?

Dr. BUHLER. No, sir. Our organization is democratically organized by representatives based on the number of pathologists practicing in the State; or elected to an assembly, who meet, who discuss policy, and policy is formulated by our board of governors who are elected by vote of the membership.

I am sure that, as in any organization, there may be a few who would not agree with these views. But these views are those of the overwhelming majority of the pathologists belonging to the college.

Senator BENNETT. Thank you very much. I appreciate your being here, and we are happy to have Dr. Hunter with us.

Dr. BUHLER. Thank you.

Senator BENNETT. Thank you.

The last witness is Dr. Malcom Phelps, of the American Academy of General Practice.

STATEMENT OF DR. MALCOM E. PHELPS, PAST PRESIDENT OF THE AMERICAN ACADEMY OF GENERAL PRACTICE

Dr. PHELPS. Mr. Chairman, I am Dr. Malcolm Phelps, of El Reno, Okla. I have been engaged in the general practice of medicine and surgery for more than 30 years. I am also a past president of the American Academy of General Practice, the Nation's second largest medical association. The academy has more than 28,000 family doctor members in 50 State chapters, the District of Columbia, and Puerto Rico. I speak today as both a private practitioner and as the official representative of these 28,000 physicians.

As is true of all academy members, I am in daily contact with my patients. I know each of them as a person—as a man, a woman, or a child who needs medical attention. I know them as individuals—and as members of a family. If you are familiar with the term "ivory tower medicine," please understand that I am far removed from any related endeavor.

Let me stress that I am in the general practice of medicine and surgery by choice—not default. I believe, with all my heart, that the family doctor has always been, and will always strive to be, the backbone of any sensible health care effort.

I will direct my comments today to the health care of the aged as it is related to social security health care proposals. My concern, quite properly I believe, lies entirely with my patients and their personal health care problems.

I have been baffled, in recent years, by efforts to isolate the aged, to treat them as biologic phenomena, biosocially unrelated to their children. Let me assure you that medicine does not hold with arbitrary standards expressed solely as a function of chronologic age. I have 40-year-old patients who are functionally decrepit; I have 60-year-old patients who are incredibly healthy. Why, then, do we assume that a man, having reached age 65, is either unable to work or unable to play a dynamic role in our society? Why do we similarly assume that he must become a medical ward of the State, possibly surrendering his last vestige of pride and dignity? I submit that the mere act of assigning a "moment of eligibility" has a detrimental effect on these fine people.

On many occasions, my over-age-65 patients have told me that they are opposed to compulsory health insurance plans. These people don't want to be hoisted up on a health care shelf and treated like human antiques. They are proud and purposeful people and it is a distinct privilege to serve as their family physician.

Why, then, do proponents of most health care legislation view these people as though they were physically and mentally senile? You would perhaps be amazed to discover how many men and women, turned out to pasture at age 65, die within a year. They don't die because they are 66 years old, they die because they have been forced to climb up on a sociologic shelf and gather someone else's dust. This is sad—and I can't envision being a party to any related social travesty.

No one denies that some people, over age 65, need medical care and are not in a position to pay the bills they may incur. The same, let

me stress, can be said of some people who are 21, 42, 54½. I urge you to understand that nothing happens to the human body, upon reaching age 65, that has not been happening for 65 years. Health is not inflexibly tied to age. No great and debilitating organic change takes place at three score and five years. If such a change does take place, I argue that it is imposed more by the dictates of society than by the will of God.

This, I implore you, in terms of health care needs—not in terms of a birthday cake with 65 candles—grant unto these people the same rights and privileges that you insist are your own. Don't, in the name of social progress, treat them as aged lumps of humanity or as people who need help on their way to the grave.

It has taken those of us with an interest in humanity years and decades to dispel or dilute the idea that a person, at age 65, is a sedentary has-been. If the good Lord is willing, I will be taking care of people until I am 112 years old. I am told that the physician's average retirement age is 72 but I know countless able and active men who can barely remember back that far.

I am talking, then, about need—not years. Name me a profession, other than the clergy, more concerned with human needs than the medical profession. Ask me how many patients I have treated without charge and I will tell you I have not the remotest idea.

Senator BENNETT. May I stop you at that point. Were you here this morning?

Dr. PHELPS. Yes, sir.

Senator BENNETT. Do you remember the letter that Mrs. Gottlieb put in her testimony?

Dr. PHELPS. I do.

Senator BENNETT. Would you refuse, would you hang up on that woman, if she called and said she had found a man in the need of medical care?

Dr. PHELPS. I have never know any doctor in my community to do such a thing. I never heard of it happening.

Senator BENNETT. If you were in such a position that you could not go yourself, what would you have done?

Dr. PHELPS. I would have had one of my associates go or one of my colleagues in the community. We do that very frequently when one of us is busy and an emergency comes.

Senator BENNETT. But you would have assured that medical care was provided for the man before you dropped the situation?

Dr. PHELPS. We certainly would; we always have.

Senator BENNETT. Thank you.

Dr. PHELPS. I have read news items about the number of hours doctors devote to the care of the indigent—and I am neither surprised nor concerned. This is implicit in the medicine and a contrary attitude is to be deplored.

I ask you now if we have existed in a legislative vacuum. Is there truly a great and pandemic need for additional health care legislation? Distinguish, if you will, between a down-to-earth need and an emotional demand. I have patients who demand a drug for which there is absolutely no indication or need and I ask you to make a similar distinction. We give it to them only if we think they need it.

Senator BENNETT. Don't they usually develop that demand because one of their friends is using it?

Dr. PHELPS. Some neighbor.

Senator BENNETT. Yes.

Dr. PHELPS. That is correct.

Time after time, in recent years, State and county medical societies have run newspaper ads that belie this need. These ads have attempted to locate people who, being in need of medical care, have sought such care and not received it. To the best of my knowledge, no one has ever come forth with a legitimate reply. No one has yet said: "I needed medical care, sought medical care—and was unable to obtain it."

Bear in mind, please, that these people were not offered perfunctory or second-class care. Visit our finest medical centers and see, for yourselves, the number of patients who are utilizing the finest talents and equipment we can offer—and are not paying a penny or being asked to mortgage their homes. Others, more fortunate, can afford this kind of care—thanks, in great measure, to voluntary health insurance.

I mentioned earlier that my patients are individuals—not stereotyped samples of humanity. As such, their health care needs and their health insurance needs vary from individual to individual and from community to community. The moment you enact legislation that provides specific benefits for one, you will automatically neglect the needs of many.

If indeed there exists any reason for a Government-subsidized health care plan, then have the wisdom and vision to retain an element of flexibility, the courage and commonsense to provide for those who need help and not for those who are clearly able to pay. Such a program, perhaps more often than you realize, would take from those who have not and give to those who have.

Without trying to establish myself as an expert on legislative matters, I would like to suggest that further and continuing consideration be given to appropriate income tax deductions. Such a plan would let the individual tailor a health insurance program to his own needs and those of his family, would encourage regular and routine physical examinations and would give most people the satisfaction of knowing that they paid their own way.

I have spoken here today largely in terms of older people and the very real concern that we in medicine feel for them. Now, I would like to say a word about our younger citizens.

The legislation approved by the House calls for bringing physicians under social security. I know I speak for most of my colleagues when I tell you we are against this proposal—have always been against it.

Only a minority of physicians retire at 65. Our years of practice, as I have noted, go on to 72 and beyond. With the supply of doctors what it is today in our rapidly expanding population, we shouldn't be encouraged to retire as long as we are capable of serving and our services are desired by those who have grown used to depending on us over a great many years.

But beyond these considerations, there is the deeper feeling among doctors that they do not want to be in the position of receiving Government benefits that represent a burden, however small, on younger people who are paying these taxes while they have to find the money to raise families, buy homes, educate their children, and, yes, pay their doctor and hospital bills.

The plain fact is, after you have spent a lifetime caring for the needs of others, you cannot lightly discard a feeling of responsibility for them.

I will take up no more of your valuable time. I thank you very much for the privilege of appearing here today. You gentlemen have urgent matters to consider, and I have patients to take care of.

Thank you very much.

Senator BENNETT. I appreciate your presence here, Dr. Phelps, and I am sure that the other members of the committee do.

It seems I have now reached the magic age of 65. I particularly appreciated what you said in the middle of your statement against the idea that those of us who have reached this point should automatically become subject to being put on a shelf. Fortunately in the Senate we are elected for a definite term, so I cannot be suddenly sawed off just because my 65th birthday has passed.

Well, thank you very much.

Dr. PHELPS. May I say a word about a question you asksd the last doctor?

Senator BENNETT. Yes.

Dr. PHELPS. Since I have been rather active in the American Medical Association, and one witness testified that there was no place for a minority report, I assure you, sir, if he made that statement he has never been to the house of delegates or any of our meetings because I have been one of those who have filed minority reports on many occasions, and I have always been heard, and any doctor can be heard.

Senator BENNETT. I appreciate that comment. I have been sitting in on hearings like this now for 14 years, and I have discovered that some of my colleagues, whenever a representative of an association appears to testify in opposition to their position, they immediately challenge the legality of the testimony on the ground that he cannot possibly be speaking for every member of the association.

I think if the situation were reversed and these men were hearing testimony that they wanted, they would never raise that particular question.

Dr. PHELPS. I am sure they would not.

Senator BENNETT. Ladies and gentlemen, this brings us to the end of the scheduled hearings.

The committee will attempt to begin its study of the bill next Monday, so it will be impossible for us to accept any statements after the close of these hearings.

We hope to have the printed record of the hearings for the use of the committee by Monday or Tuesday, so unless there is anyone present who has a statement to offer for the record, we will call the hearings adjourned, the record closed, and we thank you for your interest.

(By direction of the chairman, the following is made a part of the record:)

STATEMENT OF D. P. LOOMIS, PRESIDENT OF THE ASSOCIATION OF AMERICAN RAILROADS

Mr. Chairman and members of the committee, my name is Daniel P. Loomis. I appear here on behalf of the Association of American Railroads, which is an unincorporated association of substantially all of the class I railroads of the United States. It is a voluntary, nonprofit organization. Its members operate more than 95 percent of the total railroad mileage in the United States and have operating revenues of approximately 98 percent of the total railroad operating revenues of all railroads in the United States.

The Association of American Railroads is opposed to amendment 1213 to H.R. 11865. That amendment was offered by Senator Douglas, of Illinois, on August 11, 1964. The amendment is one of a long series of measures supported by the railway labor organizations which, rather than promoting the soundness

of the railroad retirement system, add to the annual deficit in the railroad retirement account. The railroad retirement system is now running at an annual deficit of about $19 million and the Douglas amendment would add about $6.5 million a year to that deficit, leaving the system in a substantially poorer financial situation than it is at the present time. The railroads oppose any measure providing for such deficit financing of the railroad retirement system in which, of course, they are vitally interested.

The financial condition of the railroad retirement system has, for a long period of time, been of concern not only to the railroads but to others. Over the years the labor organizations have repeatedly sponsored and supported legislation that would have resulted in benefit payments under the system exceeding tax income, both benefits and taxes being calculated on a level cost basis, and some of such legislation has been enacted. As a result of the passage of a number of such measures the deficit in the railroad retirement account grew and grew until in 1961 it had reached the staggering total of more than $70 million a year. It was at this point that the President of the United States entered the picture. On September 22, 1961, he signed S. 2395, a bill amending the Railroad Retirement Act to permit early retirement on a reduced annuity by male railroad workers. In his statement with respect to S. 2395, the President pointed out that the bill added a relatively small but significant additional burden on the system, the sum of $2 million a year, on top of the existing deficit. He said that the railroad retirement system was already in serious financial trouble and that since 1959 the actuarial deficit of that system had risen to $73 million a year. He then urged the Congress to take appropriate action in its next session to restore the retirement system to healthy financial self-sufficiency.

As I have said, the railroads have always been vitally interested in maintaining the railroad retirement system in a sound financial condition. At the instance of the carriers, representatives of the railroads and of the standard railway organizations had a number of conferences aimed at substantially reducing the retirement system's actuarial deficit, which by 1963 had risen to $77 million a year. Management and labor were finally able to agree on a bill that made a number of amendments to the retirement system. That bill was introduced on both the House and Senate sides, was passed by both Houses and signed by the President on October 5, to become effective November 1, 1963, as Public Law 88133.

This new 1963 law increased the tax income of the system, half of which is paid by the employers and half by the employees, by $71 million. Of that amount $40 million goes to pay increased benefits by reason of the fact that the creditable compensation base from $400 to $450 a month was increased. In other words, the employers' taxes amounted to $35.5 million a year on a level cost basis, and the employees taxes were the same. The employees' additional benefits, also on a level cost basis, amounted to $40 million, or something more than their additional tax contributions. Other changes in the law further reduced the deficit until, as has been stated above, it is now running at about $19 million a year.

When Senator Douglas introduced his amendment on the floor of the Senate on August 11, he pointed out that his amendment would increase taxes by $11.2 million, this again would be equally divided by the employers and the employees, and that the benefit expenditures resulting from his bill would amount to $21.7 million. In other words, under Senator Douglas' amendment, benefits would exceed taxes by about $10.5 million a year. Passage of this type of legislation, and on more than one occasion, led eventually to the staggering deficit in effect in 1961 and prompted the President of the United States to express his deep concern over the financial condition of the retirement system. Enactment of Senator Douglas' amendment 1213 would very definitely be a step in the wrong direction.

Mr. Leighty, in his statement, admits that the amendment proposed by Senator Douglas would increase the existing deficit in the railroad retirement account. He fails to point out that if H.R. 11865 is enacted in the form in which it has been referred to your committee the financial condition of the railroad retirement system would be improved to the extent of $4.1 million a year. I shall explain how this would come about. As Mr. Leighty says in his statement, section 5(k)(2) of the Railroad Retirement Act provides that the social security trust funds are to remain in the same financial condition in which they would have been had railroad employees been covered by the social security system rather than the railroad retirement system. The financial interchange provision between the two systems works in the following way: The railroad retirement account is charged with the taxes that would have been paid by railroad

employers and employees to support the social security system if such employers and employees had been covered by that system and such taxes are paid over to the Social Security Administration. In addition, and this is important, the benefits that would have been paid from the social security funds had railroads and their workers been covered under the social security system, are in turn paid by the Social Security Administration to the Railroad Retirement Board. The necessary transfers between the Railroad Retirement Board and the Social Security Administration, in order to carry out this provision, are made annually. Mr. Leighty points out that H.R. 11865, while increasing the social security tax rates, would not increase the railroad retirement tax rates and that the majority of the Board (the member representing the public and the member representing the labor organizations), and presumably Mr. Leighty, are of the view that this would have a "serious adverse effect" on the railroad retirement system because of this financial interchange provision. Mr. Leighty would be correct in his contention if H.R. 11865 only provided for social security tax increases but did not provide for an increase in social security benefits. Of course, the bill does provide for substantial increases in benefits under the social security system. The actuary of the Railroad Retirement Board has estimated that if H.R. 11865 is passed without amendment the railroads will have to pay to the Social Security Administration $42.4 million a year, this resulting from the additional social security taxes provided in the bill. On the other hand, by reason of the increased social security benefits provided in H.R. 11865, the Social Security Administration will have to pay the Railroad Retirement Board $52.5 million annualy, or slightly in excess of $10 million more than the Board will pay it. The result is that, from the standpoint of financial interchange, rather than having the "serious adverse effect" on the railroad retirement system referred to by Mr. Leighty, H.R. 11865, without amendment, would have a very beneficial affect on the railroad system.

In dealing with the need for additional benefits for railroad members, Mr. Leighty calls attention to the provision of the existing Railroad Retirement Act that provides that if a beneficiary, under that act, is entitled only to the minimum benefits provided in the act, that beneficiary is entitled to 110 percent of the social security minimum. He then states that in order to maintain this relationship it is essential to amend H.R. 11865 by adding amendments to the Railroad Retirement Act that retain the 110 percent ratio. It is true that if the Railroad Retirement Act changes proposed in Senator Douglas' amendment are not enacted, the railroad retirement beneficiary, whose annuity is based on the minimum provisions of the Social Security Act, will not receive 110 percent of the social security minimum. He will, however, continue to receive more than the social security minimum; that is, 105 percent rather than 110 percent of that amount.

The railroad retirement system provides much more generous benefits than does the social security system. This will continue to be the case even if H.R. 11865 is enacted without the increased benefits suggested by Senator Douglas' amendment. In addition, the taxes paid by the railroad employers and employees are very substantially greater than those paid by social security employers and employees and will continue to be so even if H.R. 11865 is enacted without the Douglas amendment. At the present time, the social security tax rate paid by employers and employees is 3.625 percent on $4,800 a year, and is scheduled to reach 4.625 on that same amount in 1971. H.R. 11865 would increase the present social security tax rate to 3.8 percent on $5,400 a year and eventually, in 1971, the rate would go to 4.8 percent on that amount. Without any change in the tax rates, the railroad rate, now at 8.125, paid each by employers and employees on $450 a month ($5,400 a year) is scheduled to reach 9.125 percent on that amount in 1971. The Douglas amendment would further increase the taxes imposed on railroad employers and employees.

Railroad employees have much more generous benefits than social security employees and the taxes paid under the railroad system are substantially greater than the social security taxes paid either at the present time or as proposed under H.R. 11865. Additionally the railroads see no occasion to increase railroad taxes and benefits: (1) since railroad taxes and benefits were greatly increased less than a year ago and (2) the Douglas amendment would add to the existing deficit in the railroad retirement account.

(Whereupon, at 2:40 p.m., the committee was adjourned, to reconvene subject to call of the Chair.)

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