PROBLEMS OF THE AGING

The basic difficulties facing older persons today are not new:

1 A funded source of income for retirement.

2 Adequate housing, including facilities for special care.

3 Ability to pay for and receive adequate medical care.

4 Where possible, an opportunity for contribution to society.

The factual problem facing these older people, and their society, is this:

1 Persons over 65 constitute 10% of our population. (17½ million in 1960.) By 1980, there will be in excess of 20 million persons over 65 (Ivan A Nesturzen, Under Secretary, HEW)

2 Those who have reached 65 have an average income, if single, of $1100.00. If married, there income is approximately $2300.00. This income average, which includes Social Security lbenefits, is less than ½ of the per capita average. (See chart book, White House Conference on Aging.) But more dramatically, 57% of those over 65 had income of less than $1000.00 in 1958 and 80% under $2,000.00, including married women dependent on their husbands. One-half of those 65 and older who live alone have an income of $940.00 or less. (Chart Book, opus cit.)

3 The major asset which people over 65 have is their equity in their home. Approximately 3 out of 5 persons over 65 have some form of home ownership with an average equity of $8,000.00. However,

a 29% of the couples over 65 have no liquid assets.

b 17% had from $1.00 to $500 in assets and an additional 21% had from $500 to $2000. Thus, 67% of the couples over 65 have less than $2000 for emergencies (Federal Reserve Board Survey - quoted Gilbert Harrison, New Republic, 4/17/61.)

4 As against the tragic economic squeeze of the members moving into the aging population, hospital and care cost have increased dramatically.

a 9 out of 10 of the aged will be hospitalized one or more times before death.

b Those over 65 admitted to hospitals remain 3 times as long as the younger groups.

c The national average for hospital cost per day is $32.00. This does not include medical costs.

d Persons over 65 spend almost exactly twice as much for medical care as the general population.

e One in every 5 couples over 65 willbe hospitalized during the year, the average cost of such a stay is $700.00, i e over 60% of their average annual income. (Chart Book, opus cit)

As to medical care along, then, the conclusion is inescapable that the vast majority of the aged simply cannot afford sickness requiring hospitalitation yet, 9 out of 10 will necessarily have to meet that experience.

PRIVATE HEALTH INSURANCE

There is no question but what a system of private health insurance for the aging is desirous -- but it is completely impractical.

1 Only 50% of the persons over 65 had any form of health insurance and as to there group, 57% (as learned in a Social Security study) had insurance which paid less than one-half of their total medical bills. Such insurance is useless to those facing a long illness.

2 Almost invariably, insurance policies for those over 65 are cancellable, provide coverage for only a limited time, and have a ceiling on daily benefits. Typically, a private policy for those over 65 will pay only $10.00 per day in benefits -- less than 1/3 the actual cost of care and will limit coverage to 60 days. Thousands of shocked policyholders find their policy cancelled upon its first use.

Millions of workers under 65 are covered by group insurance. This valuable protection for the individual during his productive years terminates when he reaches 65 and retires. At the time when his medical needs will soar, his production is slipping away. He is no longer a member of the "group". Again, replacement protection is almost invariably

1 Cancellable
2 Limited in daily benefit
3 Benefits last only 30 or 60 days.

Another highly objectionable feature of private plans for the aging is their usual failure to make provision for drug costs which forms a large part of the medicine cost of the senior citizen (42%).

Under some policies, actual hospitalization is required before benefits are payable. In others, there must be a doctor's call or visit. Few of the policies make any provision for any costs in any event.

The three leading chronic ailments of the aged all typically require daily intake of expensive drugs. These illnesses are:

1 Arthritis and rheumatism
2 Heart disease
3 High blood pressure

Drug bills for these conditions may run as high as $10.00 per day. We may legitimatly conclude that a majority of those persons who

should have drugs therefore, do not receive the drugs, however generous any individual doctor may be in not charging to write the prescription.

A final practical point should be made at to private health insurance. While there are many fine companies in the health insurance field, lawyers and general insurance agents agree that this area of insurance is ladden with high pressure salesmanship, misleading advertising, and hidden policy exclusions, reservations, and limitations which make the purchase of such policies a hazardous venture.

PROGRAM

We believe it is abundantly proven that the present population over 65 has insoluble medical care problems. In the past 2 years, two major public proposals have been made to attempt a partial solution. One, the Kerr-Mills Bill, allows each state to pass its own medical care legislation. The Federal government will then pay from 50 to 80% of the benefits paid under the state program. The other proposal, the Kennedy "medicare" plan for financing such bills through social security, is still under study by Congress. Strong debate has raged on these two proposals. The propenants of the Kerr-Mills Bill claim that the states are best able to handle the administration and benefits. The Kennedy Social Security plan is louder as a program in which those benefits actually pay for the cost of the program.

We feel that several points should be made:

1 The Minnesota State Legislature, like many others, has neglected the Kerr-Mills Bill. Therefore, as to Minnesota, this Bill finds Minnesotans paying medical bills for the citizens of other states and receiving nothing in return.

2 There is no question but what the social security approach would insure uniformity of benefits, would cost less than $1.00 per month per worker, and would grant to each person absolute freedom of choice of doctor, hospital or nursing home.

One of the major criticisms leveled against the President's program is that it fails to afford coverage to those not under Social Security. Inasmuch as no one in Minnesota is now protected by any public medical assistance program, this argument seems particularly hollow to the people of our state and to those of

sister states whose legislatures have rejected the Kerr-Mills program.

Almost 75% of the couples reaching 65 are now covered by Social Security. By 1980, the figure will be closer to 95%. The handful not covered by that time would typically consist of those who have sufficient resources so that they did not have to work, or the unemployable, both classes of which require separate treatment.

Social Security financing for medical problems of the aged may be delayed for several years or, it is possible that alternative methods can be found. However, on present information, the President's program does seem the most sound and equitable formula devised. But major steps can be taken immediately to connect present confusion existing in voluntary health insurance programs and to extend coverage to aging citizens.

1 Standard policy provisions. Minnesota has pioneered in legislation establishing policy provisions which each insurance company must incorporate into policies sold in this state. Such provisions are designed to eliminate the "fine print" exceptions and are designed to require companies writing insurance to provide realistic coverage for the risk which they allege to insure.

Congress should take action to insure standard provisions for:

1 Daily rate for hospital and medical charges.

2 Inclusion of drug expenses.

3 Duration of coverage

4 Non-cancellability feature

5 Guaranteed premium.

Obviously, private insurance groups cannot accurately predict the premium cost of such insurance over an indefinite period. However, before any company could change its charge for coverage, such charge would have to be approved by an agency of the H E W, much like rates for utilities are reviewed by Federal agencies both to protect the public and to insure a fair return for the owners or stockholders.

2 Until a universal public health proposal is adapted, Congress should immediately grant assistance to local welfare agencies for medical and drug costs to persons over 65 who have catastrophic illness. Presently, local agencies must rely almost exclusively on already over-taxed local funds. One of the most humane and successful program of Federal-State-County cooperation has been the aid to dependent children, a program which assists families with depleted or no income to maintain their family under one roof. This program can be a model for maintaining the integrity of our older couples home and companionship.

3 We obviously support government efforts to control manufacture of useless drugs and close review of drug pricing policies. It is paradoxal that a government which will closely regulate plane fares and the price of corn, takes almost no steps to protect the public against drug hoaxes. At present, the Food & Drug Administration may temporarily block mass distribution of drugs which it deems harmful to the human body (e g Thalidomide). Even in such cases, it is helpless to prevent indiscriminate distribution band on a pretext of "research". (Over 2000 v.s. doctors received and distributed Thalidomide without warning of its dangerous propensities.) Even more damaging from the average public point of view is the millions of dollars spent on worthless panaceas.

Many lifesaving drugs, because of patent protection, can be producted by only one company under terms and at the price it may choose. While a reasonable return should be granted for invention, drugs are now too vital a part of our senior citizen's survival to allow indiscriminate patent protection.

Finally, competition among the drug companies frequently consists mainly of high pressure advertising, common remedies for arthiritis, high blood pressure and heart disease one saw under trade names, rather than by their actual common name. As a result, many drug prices skyrocket from advertising budgets rather l than from production costs.

The Drug Inquriy Committee of the U S Senate clearly demonstrated that drug patent abuse and trade name monoplies frequently found U S drug prices 9 to 25 times as high as identical products sold in Europe and South America.

We therefore propose as follows:

That the Food & Drug Administration be empowered:

a To require the owner of each drug patent to allow the use of such patent by any competitive company, subject to a maximum royalty of 10% for a period of not more than 5 years.

m

b To affix to every marketed drug the seal of approval of the Food & Drug Administration.

c To withhold absolutely from any human consumption any drug found to be unsafe, subject only to review by the courts.

d To require all drug companies to file a complete report on the research and development of each drug proposed for market.

e To require all advertising literature to clearly describe all side-effects noted in the use of the advertised drug which have medical significance.

Medical care for our older citizens, however, is just one aspect of our opportunity to face the challenge of increasing longevity. Housing, vocational opportunity, nursing home care, adequate medical staffing and financial security.

Older people <u>are</u> people. In some cases, like children, they require protection and special care. In the majority of cases, they require only the same opportunities for job and life fulfillment that the sudden and arbitrary 65th birthday took from them.

Simply the financial burden of living in our modern society requires the older citizen to maintain an income, if possible. But the challenges and requirements of our own economy strongly suggest that absolute retirement at 65 is a national and individual tragedy.

Our country is desperately in need of skilled craftsmen, nurses, teachers, and service vocations. Under proper medical supervision, almost all those "retired" at 65 could continue to serve usefully for many years. White House conference statistics show that the work record of citizens 65 and over exceeds that of workers 35 to 54. Yet, the percent of working men 65 and older has sharply dropped since 1900.

In the areas mentioned above, and in countless parttime service occupations, senior citizens can make valuable contributions. These positions will not compete with jobs held by the present wage earner; they will supplement and enrich our society. We propose:

a Elimination of social security wage limitations between ages 65 and 75.

b Vocational retraining benefits for those over 65.

For many older citizens, with their vastly restricted income, retirement will eventually require them to move from their established homes, either because of financial necessity or because their home user in actual years is too large or is unsuited to their present needs. Unhappily, few communities offer a practical solution to low cost older citizen directed housing. Too often the State Hospital or a prohibitive expensive nursing home becomes the lot of an aging couple where more open and independent possibilities are apparent.

As stated earlier, the average annual income of the elderly person is less than $1100. This is not sufficient to allow nursing home care (average charge in the district is about $225 per month) nor does it permit the maintenance of a small home. We suggest the following program:

1 Grants, similar to Hill-Bunbon, for low cost housing for the aged, emphasizing centers in such areas for limited service vocation, dietary assistance, and recreation,

2 Special homestead exemptions for persons over 65.

3 Loan funds for creation of old age centers, locales which would have residential and service units for persons who are physically unable to completely take charge of their daily affairs but who can, with assistance, of varying degree, maintain their own living unit and daily program. These centers not only would be self-financing but would give each person, with his separate ability, an opportunity to serve others.

Our population "explosion" in the age class, our age class must make use for the decreasing number of trained medical personnel in this country. While our medical research has extended life expectancy enoromously in the past 60 years, we have seen a steady decline in the per capita ratio of doctors and nurses. Because of limited financial resource, these persons who need such trained personnel must necessarily the must of such service. We propose a national loan program to medical and nursing schools, together with scholarships, to allow more men and women to enter into this increasingly critical field. Most medical schools, and almost all nursing schools, have no funds with which to provide this needed expansion. Under the National Defense Act, similar assistance is given to colle ges and university for scientific research. Both programs legitimately involve a problem of national

Finally, as we have pointed out, the health problem of the aging concentrates on blood and circulating diseases, arthiritis, and rheumatism; and many other chronic physical and emotional illneses. The Rockefeller Report indicated that no less than 3200 private and semi-public agencies were conducting research in this area. This is commendable and illustrates the peculiar American genius for private philanthropy. However, it is fearfully wasteful.

No sizable industry, seeking a technical solution, would tolerate such multiple, uncoordinated effort, particularly where existing reports and literature make communication on separate effort and results impossible.

Cancer, heart disease and other problems of the young and old can be solved or ameliorated. But this requires coordinated effort, effort which would obviously be welcome by many researchers and research centers.

We propose that our agencies doing research on the problems of health be organized with the National Institute of Health. The agencies, in turn, would elect from their own numbers a Board of Governors whose responsibility if would be to develop and disseminate information and member research projects, and it accounts, and evaluate areas in which any member or members can make a maximum contribution. This private agency, operating only with the assistanee of the N.I.H., would immeasurably accelerate medical researeh and, in turn, would strengthen public donfidence in our treat private philanthropic institutions.

X 5364

January 14, 1963

Memo for John S.
cc: Peter Bell

From Senator

Please check the Select Committee on the Aging & see what they want. John

John, I think we ought to get a report on the Kerr-Mills bill. I noticed sometime ago where there was criticism to the effect that the Department of HEW in its annual report had played down the Kerr-Mills bill. Of course, this newspaper article was attempting to point out that Kennedy didn't want a favorable report on Kerr-Mills and, therefore, the Department didn't publish one.

Now I want you, through Peter, or someone else that you may assign, to get a full report on what is happening under Kerr-Mills, not only what happened last year but the year before. Get a report of the use of the Kerr-Mills legislation for health care for the elderly since its inception. In other words, how much did we spend the first year - how much did the states spend - how many people were aided and assisted - what did it mean to the states and localities in terms of reducing their budgets or providing better medical care for the elderly.

I want a complete full report. And if this can't be done by you or Peter, then let's get the Library of Congress to do it. But I need it rather soon, so let's speed it up.

Make Medicare 1963

Work file

Jay Constantine

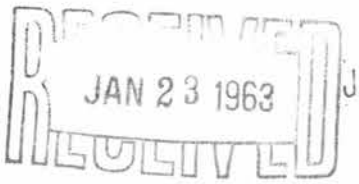
Since Act of 1962

New Jersey

Dss157 Benton.

DEPARTMENT OF
HEALTH, EDUCATION, AND WELFARE
WASHINGTON

OFFICE OF
THE SECRETARY



JAN 22 1963

Dear Senator Humphrey:

This is in further reply to your letter of November 6 concerning an inquiry from Mr. George B. Benton, Executive Secretary, United Hospital Fund of Minneapolis and Hennepin County, 512 Nicollet Building, Minneapolis 2, Minnesota.

Your inquiry was referred to the Social Security Administration. I am enclosing two copies of their report.

Sincerely yours,

Wilbur J. Cohen

Wilbur J. Cohen
Assistant Secretary

Hon. Hubert H. Humphrey
United States Senate
Washington 25, D.C.

Enclosures (2)

OPTIONAL FORM NO. 10
5010-104

UNITED STATES GOVERNMENT

Memorandum

TO : Mr. Wilbur J. Cohen
Assistant Secretary

DATE: JAN 22 1963

FROM : Robert M. Ball
Commissioner of Social Security

SUBJECT: Letter from Senator Humphrey Concerning an Inquiry from Mr. George B. Benton, Executive Secretary, United Hospital Fund of Minneapolis and Hennepin County, 512 Nicollet Building, Minneapolis 2, Minnesota, about two Editorials in the October 29 Issue of the AMA News.

We are attaching a copy of the AMA News editorial on which we have numbered the paragraphs. In the first editorial, "The Elderly's Status," the AMA News refers to statements which it indicates were made about the health needs of the aged people in Iowa, Illinois, and the Nation. (See paragraphs 2-5 of the editorial.) The editorial suggests that proponents of health insurance for the aged under social security have asserted that every single aged person in these areas would need financial help in case of serious illness. No responsible supporter of health insurance for the aged has, to our knowledge, used such an argument. Obviously there are some aged people who can meet all medical expenses they may ever incur, even very large expenses. Such persons, however, are not in the majority; nearly all the aged suffer insecurity from the fear that expensive illness will befall them and they will be unable to meet its cost. It is our goal to alleviate this insecurity of the great majority.

The AMA News states flatly (paragraph 6) "A recent study by the University of Michigan Research Center shows that the aged as a group are better off on the average than younger Americans." However, the University of Michigan Survey Research Center itself has apparently reached quite the opposite conclusion from the findings of its survey. In a press release of October 24 (a copy of which is attached) the University of Michigan described their findings as follows: "Not only do older units have substantially lower incomes than younger ones, but low incomes are commonly temporary among younger families and permanent among the aged." The release also stated that "It appears that there are close to 4.5 million spending units 65 and older who had a 1961 disposable income of less than $2,000 (including social security benefits). Forty percent of these units have practically no assets, and most of them have no medical insurance either." These 4.5 million spending units represent almost half the aged spending units in the survey.

The University of Michigan research group has also disputed the validity of comparing the total assets of those over age 65 with those of the rest of the population, including persons as young as age 18. Furthermore, the AMA News omits the significant fact that most of the total assets of the aged are represented by their equity in their homes. Of course, few people would consider an owned home, because it can be sold, as a resource available to pay for medical or any other expenses.

The AMA News states (paragraph 6) that "More significant is the fact that 96 percent of the over 65 families--and 90 percent of the younger families--had no medical debts." It should be recognized that although aged persons have substantially larger medical expenses than younger persons, the ability of people to incur any kind of debt depends upon the willingness of others to extend credit or lend money to them. When the aged cannot meet a medical bill, they must generally depend upon donated care in charity wards, help from their relatives or public assistance agencies or, perhaps, forego needed medical care.

The editorial (paragraph 7) notes that another study by the U. of Michigan Research Center shows "that large medical expenses tend to decline after age 54." This is based on the fact that there was a somewhat erratic incidence by age of "yes" answers to the following vague question in the 1961 survey, "Have you had other large expenditures during 1960 that you have not mentioned? Things like medical, hospital, and funeral expenses?" Since spending units with younger heads have more members, on the average, a larger proportion with large expenses for the unit as a whole would not be surprising. Nevertheless, the 1962 study shows 43 percent of the spending units over 65 reported having had what they called large medical expenses for doctors, nurses and hospitals in 1961, according to the attached release, as against 36 percent for the 55-64 age group and 39 percent for all those between 35 and 64. We have not seen the Kalamazoo study. In any case, the incidence of large expenses relates to cost the respondent could assume, not the cost of the services needed, or even received, because the cost of care obtained through welfare agencies or public hospitals would not be reflected in the responses.

The AMA remarks on the comparative incomes of aged and younger families appear intended to distort the facts. The same Census release (Series P-60, No. 37) from which they draw the figures on the median income of all families with head 65 and over and head under 65 includes median income figures for families cross-classified by size and by age of head (Table D). Obviously it is more meaningful to compare income data for families of the same size than to estimate income per family member by dividing a median income figure by the mean size of family (not necessarily at the median). (Such a procedure is resorted to only in the absence of better data.) More important, however, is the fact that the distribution by size of family is very different for the two age groups: Of all families with head 65 and over, 73 percent had only

two members, thus making this group the one of major importance among the aged; of the families with head under 65, on the other hand, those with 3 or more members comprised 74 percent. Since two-person families make up the bulk of so-called aged families it is logical to compare the median incomes of old and young for 2-person families, namely $2,530 and $5,314. To take account of the tax advantage enjoyed by older persons, it would be appropriate to assume that no Federal income tax is payable by aged 2-person families with incomes at the median or below. Assuming for the younger family the standard 10 percent deduction and 2 exemptions, the tax for younger 2-person families would be $717. Their median income would thus be reduced to $4,597, or 82 percent higher than the median of $2,530 for the aged. The so-called adjustment for families receiving old-age assistance is neither intelligible nor valid.

Almost one-fourth of all persons 65 and over live alone or with nonrelatives, and yet the AMA ignores the income data for these persons that appear in the same Census release (Table F--the Census calls them unrelated individuals). Again the median income is less than half as large for those 65 and over as for those younger, namely $1,053 and $2,571. When the median income figure for the younger person is reduced by the tax liability of $343, to $2,228, it is still more than twice the median income for persons 65 and over who live apart from relatives. This comparison takes no account of another large group of aged persons--about 15 percent of the total--who live in the home of relatives. The great majority of them have little or no income of their own: In 1960 more than half the men and four-fifths of the women in this situation had less than $1,000 cash income (Table G). Often the relatives with whom they live are themselves not well off. Sharing a home, though it may mean crowding, is often the only feasible way for younger persons to help support their aged parents.

The editorial (paragraph 9) says that the income of the aged is increasing more rapidly than that of all families, because from 1960 to 1961 incomes increased more for families with head 65 or over than for all families. Differences between any two years are not necessarily significant. From 1956 to 1961 the increase was slightly larger for all families than for the aged, also according to Census; over the past decade (1951 to 1961) the percentage change was the same.

The AMA editorial implies (paragraphs 10 and 11) that a health insurance program for the aged would place an unfair burden on younger persons. It fails entirely to take account of the fact that most of the people to whom the aged turn in a health crisis, according to a Health Information Foundation study, either have children of their own to care for or themselves are already at or close to the age when their own problems of retirement loom large. Relatively few young or even middle-aged workers have enough assets so that they would not be seriously depleted by the expenses of one serious illness of an aged parent. The small social security tax that would pay for proposed hospitalization insurance would immediately save many from extremely burdensome bills at the same time that it would build up protection for their own future.

The editorial, "A Shaky Fund," attempts to create the impression that, because disbursements from the old-age and survivors insurance trust fund have exceeded income to the fund in the past few years, the program has a shaky financial structure. Such an impression would be completely false.

It is true that in 1957, 1958, 1959, and 1961 the expenditures from the old-age and survivors insurance trust fund were more than the income to the trust fund, and it is expected that in 1962, also, expenditures will be more than income. This does not, as the editorial contends, indicate financial weakness. The assets of the trust fund are now about $19 billion. The reserves of the program have been much more than was needed in past years and will continue to be much more than is needed to meet benefit and administrative expenses whenever the costs may be in excess of the income to the system.

There is nothing alarming about the use of the assets of the social security trust funds as a contingency reserve in temporary situations in which the income of the system is less than the disbursements of the system. Under the social security tax rate schedule now in the law, which provides for tax increases in 1963, 1966, and 1968 to bring social security taxes to the ultimate rate needed to support the present program (4 5/8 percent each for employees and their employers and 6.9 percent for the self-employed), the old-age and survivors insurance trust fund is expected to grow to many times its present size.

Recent temporary excesses of outgo over income followed changes in the law which caused a relatively large increase in expenditures in the period immediately after their enactment. One such change was lowering from 65 to 62 the minimum age at which women could retire and start getting benefits. Since the benefits paid to women who start getting benefits as retired workers or wives before age 65 are permanently reduced to take account of the longer period of time over which benefits will be paid, the payments to those women will be smaller in future years than they would have been under the previous law. As a result, this change did not have a significant effect on long-run costs. It did, however, substantially increase the immediate outgo of the system. Another, and even more recent, change in the law that substantially increased the immediate outgo of the system without having a significant effect on long-run costs was the amendment that made retirement benefits available to men at age 62.

The editorial suggests that social security taxes have been increased because the cost estimates were unreliable. The fact is that the law provides a schedule of increasing taxes because it has generally been thought advisable not to put into effect all at once the full contribution rate required to support the program. Also, the original Social Security Act provided only for retirement benefits. Under that Act, contribution rates began at one percent each for employees and employers and were scheduled from the beginning to increase gradually to an ultimate rate of 3 percent each for employees and employers.

As a result of amendments to the original Act, benefits have been provided for the dependents and survivors of workers--their wives, widows, and orphans--and disability insurance protection for disabled workers and their wives and children has been added to the program. In other words, the program now protects against two additional risks of income loss--the disability and the death of the family earner. The difference between the original 3 percent ultimate rate and the present 4 5/8 percent ultimate rate is partly to pay for these additional types of protection; one-half of one percent is specifically allocated to meet the costs of disability insurance benefits. Also, benefit increases that were provided as prices and wage levels rose and liberalized eligibility requirements to provide benefits for more retired workers, widows, children, and other groups have added to the cost of the program.

Under the social security tax schedule now in the law, social security taxes, together with interest from investments, will provide sufficient funds to meet all the costs of the present program, in the immediate future as well as over the long run. In fact, if average earnings continue to rise in the future, as there is reason to expect they will, the increased income flowing from the higher level of earnings will be greater than the increase in benefit outgo resulting from the higher level of earnings and the program will be over-financed at the contribution rates now scheduled.

No aspect of the social security program has received more careful consideration by the Congress than the financing of the system. Whenever improvements have been made in the program, adequate provision has been made for meeting the additional costs. On the basis of the record there is every reason to believe that the Congress, in enacting health insurance

for the aged under the old-age, survivors, and disability insurance program, would make provision to meet the additional costs and that there would be no need for concern over the financial soundness of the new program.

The Administration's estimates of cost for the proposed health insurance program were prepared on a sound basis after intensive study of all available data. According to these estimates, the income of the health insurance program in 1964, if it were in effect that year, would be $1 1/2 billion and the outgo for benefits and administrative expenses would be $1 1/4 billion. Under the proposal, there would be a separate trust fund for the health insurance program, in addition to the present old-age and survivors insurance trust fund and the disability insurance trust fund. The proposal specifies the portion of the social security taxes that would be allocated to the health insurance trust fund and provides that the health insurance benefits and administrative expenses could be paid only from the health insurance fund.

Robert M. Ball

Attachments (2)

JFC - Medical WF

THE AMA NEWS
The Newspaper of American Medicine

published under auspices of the Board of Trustees

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Editorial Viewpoint

The Elderly's Status

The hawkers of government medicine, dolefully inspired by next week's elections, have presented the public with a gloomy picture of the elderly. Here are some of the details:

• In Iowa the entire aged population is in need of federal health care.

• In Illinois, where there is an aged population of 975,000, a total of 1 million aged people are in need of aid.

• In the nation, 17 million elderly people (all of them) have twice the health expense and less than half the income of younger people.

Fortunately, none of this is true. If our society has created as its end product a vast population of helpless outcasts, then surely the country is in serious trouble. If people over 65 are as sick and indigent as they are painted, our system of government must be a failure. Let's take a look.

A recent study by the U. of Michigan Research Center shows that the aged as a group are better off on the average than younger Americans. The median value of total assets held by families with the head over 65 was $8,349 in 1960, compared to $4,839 for other age groups. More significant is the fact that 96% of the over-65 families—and 90% of all younger families—had no medical debts.

The need of the elderly for federal care at the expense of younger taxpayers is a fiction. An earlier survey by the U. of Michigan Research Center shows that large medical expenses tend to decline after age 54. A survey of Kalamazoo, Mich., by Public Service Research, Inc., shows that in this typical industrial city people over 65 have much less difficulty in meeting health care expenses than do younger persons.

Continued on column 1 of next page

Nothing Like the Model

A Shaky Fund

The Old Age and Survivors Insurance Trust Fund lost $599 million in 1961. For the fourth time in the past five years the social security trust fund was in the red.

It is through this declining fund that the Administration is proposing to finance health care for the aged, and many candidates have made their support of the proposal their main claim to votes. The staggeringly high but quite unpredictable cost of such a program, its threat to the entire Social Security System, is ignored for obvious reasons.

Losses in the OASI Trust Fund have occurred despite increases in both the tax base and the tax rate. In 1957 the fund lost $126 million, in 1958 it lost $528 million, and in 1959 it lost $1 billion, 724 million. In 1960 it gained $184 million.

Continued on column 2 of next page

In their grab for votes and taxing power, the dreary friends of nationalized medicine mention none of these points. They prefer to speak only of the income of the aged. All right. The annual median income of over-65 families was $2,897 in 1960, compared to $5,905 for under-65 families. But when these figures are adjusted to account for the larger families and the larger income tax obligations of the younger group, the difference narrows to $248 per person a year. A further adjustment to account for the 524,000 families receiving old age assistance reduces the younger family's per capita income advantage to $148 annually.

And that was in 1960. The Census Bureau this month reported that the income of over-65 families increased to $3,026 in 1961. Last year the income of over-65 families showed a gain of 4.5%, compared to a 2.1% gain for all families. The increasing income of our elderly, the spreading coverage of health insurance and the progressing implementation of the Kerr-Mills Law indicate that our society's voluntary system is enjoying great success and will continue to be successful.

"The time has come," said economist Edna Lonigan in 1949, "to ask of every federal 'welfare' program whether it is caring for the true 'needy,' that is, for people who are poorer than those who are paying the taxes." This test of need remains valid and it should be applied by a free people before—not after—yielding to government control.

There are elderly people who need help. They should be helped and they are being helped. But the evidence is overwhelming that the majority of the aged are caring for themselves, that the financial situation of the elderly is getting better rather than worse, and that a federal tax to pay for the aged's health care would be an unfair burden on younger wage earners.

The melancholy picture of the elderly is a fraud. It is a crude caricature and should be seen for what it is—an insult to the aged and a disservice to the nation.

Nothing Serious

There are two well known finishes for automobiles —lacquer and liquor.

The tax base was increased by $600 after 1958 a the OASI tax rate rose 1¼%. The fund saw a mid increase only in 1960 when the social security tax rate went up from 5% to 6%. However, by 1961 at the 6% rate the fund had a loss of $599 million. The government had predicted that OASI Trust Fund assets would total $27 billion by 1960, $35 billion by 1970. As a result of deficits, however, the fund declined from $23 billion in 1957 to $18.9 billion this year.

The OASI Board of Trustees estimates that the fund will lose another billion dollars in 1962, in spite of the fact that the tax rate rose to 6¼%. Under existing law, the social security tax is scheduled to rise to 7¼% in 1963, to 8¼% in 1966, to 9¼% in 1968. In 1937 a worker under social security paid a maximum of $30. By 1968 he will pay $222. There is no assurance that this will be enough to keep the trust fund in the black.

None of the already scheduled increases are intended to provide for health care of the aged. This would require another hike in the tax base, the tax rate, or both. Such a program, which would cost as much as $3 billion in the first year, threatens to topple a shaky structure upon which millions of people have put their trust.

THE UNIVERSITY OF MICHIGAN NEWS SERVICE
ANN ARBOR (115) October 24, 1962

Contact. Gil Goodwin
Phone: 663-1511, Ext. 3436

EDITORS: A tabulation of income, assets and net worth follows text.

FOR IMMEDIATE RELEASE

ANN ARBOR - New and detailed data on the economic condition of the aged have been collected in the 1962 Survey of Consumer Finances, conducted by the Survey Research Center (SRC) of The University of Michigan.

In view of current interest in the subject, the Center has reported some comparisons between the financial situation of younger groups and that of spending units whose heads are 65 years of age or older in advance of the publication of the 1962 Survey.

Among the older units (65 and over), 71 per cent had a disposable income of less than $3,000 and 10 per cent had more than $5,000 in 1961. (In the 55-64 year group, figures were 34 and 38 per cent respectively).

Not only do older units have substantially lower incomes than younger ones, but low incomes are commonly temporary among younger families and permanent among the aged. On the other hand, the number of persons included in a spending unit (family or individual) decreases with age; therefore, th age differences in per capita income are smaller than in spending unit incomes.

- Average income reaches its peak among those in their forties and declines slowly among those in their fifties and rapidly among people over 65. Average assets are highest in the 55-64 year age group and decline slightly among those over 65. Financial reserves are gradually accumulated over many years, and spending unit net worth also increases with age because of the gradual repayment of mortgage debt on the part of home owners.

(more)

The distribution of assets among the spending units 65 years and over is much more unequal than among younger units. The average asset data are greatly influenced by the small proportion of aged with sizable asset holdings. While the average assets of those 65 and older are similar to those 55 to 64 years old, 34 per cent of the former have practically no liquid assets at all (less than $100 in bank deposits and bonds) as against 28 per cent of the latter. Net worth data, including home ownership and investments and deducting debt, show that 23 per cent of those 65 and over have net worth under $1,000 as against 14 per cent in the 55 to 64 years group.

Consumer debt is less common among the aged than among middle-aged or young people because the latter are much more frequent purchasers of automobiles and appliances.

Forty-three per cent of spending units over 65 reported having had what they called large medical expenses for doctors, nurses, and hospitals in 1961 against 36 per cent in the 55-64 age group and 39 per cent among all those between 35 and 64.

These data consider only aged people with some income, who form independent spending units. In addition, there are about 2 million aged individuals excluded from the tabulation because they have no income and form a part of the spending units of their children or other relatives. Many other older people are excluded because they live in institutions.

Altogether there are approximately 9½ million spending units in which the head is 65 years of age or older. A large proportion of the heads are widowed so that altogether heads and wives represent 14½ million people. Among these older spending units, those with relatively high income tend to have sizable assets, while those with low income tend to have small assets. It appears that there are close to 4.5 million spending units 65 and older who had a 1961 disposable income of less than $2,000 (including social security benefits). Forty per cent of these units have practically no assets, and most of them have no medical insurance either.

Distribution of Income and Assets by Age
(Percentage distribution of spending units)

	Age of Head of Spending Unit			
	35-44	45-54	55-64	65 & over
Disposable Income in 1961*				
Under $3,000	14	22	34	71
$3,000 - $4,999	25	21	28	19
$5,000 - $7,499	33	27	22	4
$7,500 and over	28	30	16	6
	100	100	100	100
Liquid Asset Holdings early in 1962**				
Under $100	36	31	28	34
$100 - $999	36	28	20	14
$1,000 - $4,999	22	26	36	27
$5,000 and over	6	15	16	25
	100	100	100	100
Net Worth early in 1962***				
Under $1,000	26	19	14	23
$1,000 - $4,999	21	15	17	14
$5,000 = $24,999	39	41	47	44
$25,000 and over	14	25	22	19
	100	100	100	100

* Spending unit annual income minus Federal income taxes.

** Deposits with banks, savings and loan associations, and credit unions, and U. S. Government savings bonds.

*** Liquid assets plus investments in stocks and bonds, farm, livestock and equipment, other real estate, business, plus equity in owner-occupied home, minus debt. The most frequent assets are liquid assets and home ownership.

# # # # # #

(SRC-Katona-Lininger)(R1-3.ISR.SRC.Age.B1-9.Lab1,2.F.SW.X1,2)

Sugar Distribution

WASHINGTON — The Agriculture Department announced that distribution of sugar by primary distributors during the week ended [illegible] 136,663 short tons, raw value, [illegible] week before, and 154,452 in the corresponding week of last year.

Total distribution for civilian and military use since Jan. 1 is 769,000 tons, compared with 648,000 in the like period of last year.

Deliveries by the three types of primary distributors in the week ended Feb. 2 were: Refiners 87,431 short tons; beet processors 46,329 and importers 2,903.

Kennedy Asks Medical Care, Health Bills Similar to Those Congress Rejected in '62

By a WALL STREET JOURNAL *Staff Reporter*

WASHINGTON — President Kennedy asked Congress for much the same medical care and public health proposals it refused him last year. But Mr. Kennedy's message also proposed enforcement authority to control interstate air pollution and a five-year extension and expansion of the Hill-Burton hospital construction program, which expires next year.

Mr. Kennedy asked again for Federal aid for graduate education in health, tightened food, drug and cosmetic laws, and low-interest loans to encourage group medical practice.

The President said he would include his proposal for medical care for the aged in a special message, expected next week.

He placed major emphasis on the Administration's health professions assistance bill, which would establish a 10-year system of grants to help build medical, dental, osteopathic and public health schools, and provide added student financial aid. This is the medical measure Administration strategists believe has the best chance of Congressional approval this year; it already has passed the conservative-leaning House Commerce Committee and isn't expected to encounter difficulties in the full House or more liberal Senate. First-year appropriations would be $34.3 million and expenditures would be $9 million.

In a departure from past policy the President urged that some form of Federal enforcement authority be established over interstate air pollution. Current Federal efforts are restricted to supporting research and aiding state programs.

But the Administration hasn't made clear how far it wants to move in this area, or whether a strict enforcement program is feasible. Many experts contend that too little is known about the causes and remedies of air pollution to justify Federal control efforts. One possibility is that the Administration would urge mandatory public hearings in cases of interstate pollution so public interest could be aroused.

The proposed Hill-Burton modification would raise the ceiling in appropriations for construction of nursing homes by states and communities to $50 million a year from $20 million, and add $5 million a year for planning grants to enable states to make comprehensive surveys of medical construction needs. The Administration also wants to switch the act's emphasis from construction of new general hospitals in rural areas to remodeling and renovating existing facilities in big cities. Annual outlays of $150 million are authorized for general hospital construction. In fiscal 1964 the modifications would require added appropriations of $35 million and expenditures of $5 million.

The President also said he intended to send Congress proposals later for remedying the critical shortage in trained nurses. The proposals would probably include some form of construction aid for schools and financial assistance to students.

The food and drug proposals were those left over from last year's Administration bills. They seek: Additional factory inspection authority, particularly over records and reports, over concerns in the food, over-the-counter drugs, cosmetics and therapeutic devices business; additional authority for the Food and Drug Administration to pass on the safety of new cosmetics before they are allowed on the market, and similar powers to approve premarketing safety and effectiveness of new therapeutic devices. Administration officials are far from optimistic that much progress can be made on these measures this year.

More Liberal Payments By Kerr-Mills Medical Plans Urged by AMA

Trustees Also Propose New Tax Aids for Aged, Building of Nursing Homes, Other Benefits

Staff Reporter of THE WALL STREET JOURNAL

CHICAGO — The American Medical Association, steadfast foe of the Kennedy Administration's medical plan for the aged, took the offensive by proposing new state and Federal benefits for elderly citizens.

The AMA's board of trustees, in a broad, eight-point program, recommended more liberal medical payments to the aged under Federal-state Kerr-Mills laws and changes in income tax treatment of medical expenses of those over 65.

The program would "help insure a better life for the nation's elderly citizens," the AMA said. Its trustees, who are the top governing body of the nation's largest medical organization, also called for construction of more nursing homes, greater efforts to prevent and cure mental ills, and a "recasting" of retirement policies by employers to allow those healthy employes to continue working.

While the AMA proposals make no basic change in the organization's past position, they appear to be significant concessions to those who have argued that something more must be done to help the elderly pay medical bills. As such, the proposals seem aimed at shoring up the AMA's defense against a comprehensive, Federally administered medical care program. The Kennedy Administration has advocated that everyone over 65 be covered by a Social Security-financed plan that would pay hospital bills.

Yesterday, the President said he would present his medical care for the aged plan in a special message to Congress; the message is expected next week. The Kennedy plan got nowhere in Congress last year.

The Kerr-Mills Law includes the Medical Assistance for the Aged program that is in effect in about two dozen states. The program provides Federal-state matching grants to assist aged persons who need medical care; the state laws generally set maximum income limits for recipients of benefits and require proof that aid is needed.

"The A.M.A. will recommend a change to provide that a person with higher income (than the maximum allowed by law) who suffers a major illness may qualify for benefits if the expense of the illness would reduce his income for the year below the maximum provided," the trustees said. They added that the AMA will continue to urge adoption of Kerr-Mills programs "where the need may exist and to expand existing programs where it appears justified."

Among changes proposed in the income tax law, the AMA group said, will be amendments to allow a taxpayer to deduct all payments for medical care for any person over 65 who is a dependent; a taxpayer currently may take such deductions only for a parent or spouse. Other amendments will be proposed to permit all costs of drugs to be deducted by people over 65, to allow medical expenses of the elderly to be carried forward

Arizona Halts Land Sales At [illegible] Sa[illegible]

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to future years or back to past years for tax purposes in the same manner as business losses, and to "change the method of computing medical expense deductions so that income tax liability of lower income persons among the aged would be reduced."

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Medical Care Plan Again Depends Mainly on House Ways-Means Unit

Committee Approval Seems More Likely This Time Due To Changes in Membership

By a WALL STREET JOURNAL *Staff Reporter*

WASHINGTON—If the House Ways and Means Committee ever approves President Kennedy's medical care plan, chances are it will sail through Congress.

That appraisal was true of the Administration's priority social welfare measure last year, when it died a slow death in the Ways and Means Committee. It remains true for a slightly revised health care plan submitted to Congress last week by Mr. Kennedy.

The only difference is that prospects for Ways and Means approval—probably early next year—are much greater than in 1962.

The basic provision of the new plan is identical to the 1961-62 version: Persons over 65 years of age would receive limited hospital care under the Social Security System, with financing provided by a quarter-percentage-point increase in Social Security taxes paid by both employer and employe and an increase to $5,200 from the present $4,800 in the maximum annual wage subject to the tax. The program would take effect Jan. 1, 1965.

The Congressional battle lines haven't changed from last year's. House Republican leaders remain adamantly opposed to Social Security financing of health care, but many rank-and-file GOP lawmakers are skittish about voting against it—probably enough of them to compensate for Southern Democratic defections on the House floor.

Change in Committee

What has changed is the composition of the Ways and Means Committee. Former Reps. Harrison (D., Va.) and Frazier (D., Tenn.), who probably would have opposed the plan last year had it been brought to a vote in the committee, have left Congress and have been replaced by liberal Reps. Bass (D., Tenn.) and Jennings (D., Va.). These changes increased committee members supporting medical care to 11, plus conservative Rep. Herlong (D., Fla.), who probably would vote to send the bill to the House floor even if he doesn't approve of it—a total of 12 out of 25 committee members, or one vote shy of a majority.

All 10 Republican committeemen are expected to hold firm against the bill. But the course to be taken by Chairman Mills (D., Ark.) and Reps. Thompson (D., Texas) and Watts (D., Ky.), all foes of the measure last year, is less certain. Nobody can read Rep. Mills' mind, but some of his colleagues doubt he would want to supply the decisive vote in a 13-to-12 tally to keep the bill from reaching the floor.

Thus it's possible Mr. Mills may try to cook up a compromise along the lines of a plan he toyed with last summer but never formally proposed. Such a compromise might turn over administration of the program to a private, nonprofit organization such as Blue Cross instead of to the Health, Education, and Welfare Department as the President proposes. If the chairman does devise a compromise, it is conceivable that Mr. Thompson and possibly Mr. Watts will follow him.

Supporters of medical care are crossing their fingers that Mr. Mills will hold hearings late this year to permit committee action one way or another early in 1964. Assuming the committee finishes work on the Kennedy tax cut and tax "reform" package by late May or early June, its agenda for the summer seems light enough to leave room for medical care hearings—if Mr. Mills wants to. Here again, nobody can be sure what the Arkansan will do.

Senate Obstacle Less Threatening

If the bill does clear the House, the Senate Finance Committee poses a somewhat less formidable obstacle than it did last year. The late Sen. Kerr (D., Okla.), who led the 1962 fight against medical care in the Senate, has been succeeded by Sen. Ribicoff (D., Conn.), last year's chief Administration spokesman for the bill as Secretary of Health, Education, and Welfare.

This change narrows the committee's line-up against the bill to 10 to 7. The opposition consists of all six Republican members plus Chairman Byrd (D., Va.) and Sens. Long (D., La.), Smathers (D., Fla.) and Talmadge (D., Ga.). However, supporters of medical care have some hope of winning Mr. Smathers' vote.

Actually, Senate Democratic leaders could, if need be, bypass the Finance Committee and bring the bill directly to the floor—a procedure close to impossible under the House's stricter rules. What's more, the measure probably would be adopted by the Senate under this procedure, now that the influential Sen. Kerr no longer commands the anti-medical care legions.

Nevertheless, Administration strategists would prefer to obtain Finance Committee approval in order to ease the way for passage by the Senate. Southern Democrats, resentful of how often their Dixie-dominated Judiciary Committee has been bypassed to bring civil rights bills directly to the floor, supplied the decisive votes last year to kill medical care on the Senate floor after the Finance Committee had been bypassed by the Democratic leaders. If the leadership had followed conventional procedures, the bill might have been supported by such influential Southerners as Sens. Russell (D., Ga.) and Hill (D., Ala.).

Compromise of 1962 Included

The proposal submitted to Congress by Mr. Kennedy last week contains one compromise accepted by the Administration last year in order to pick up the support of five liberal Republican Senators headed by Sen. Javits of New York. It would provide health care for about 3 million persons over age 65 who aren't covered by the Social Security System.

These extra benefits would be financed directly out of the Treasury at an estimated net cost of $360 million over the first five years—a net cost, because the estimate allows for reductions in other Government welfare outlays expected as a result of the medical care program. The Administration contends direct Treasury expenditures would drop in later years and finally disappear, because of the ever-rising proportion of Social Security beneficiaries among retired people.

The chief concession to the Javits group last year—a complicated plan giving retired persons the option of having the Government help them pay premiums for private health insurance plans—was dropped this year. However, the Administration probably would be glad to reinstate it, if necessary, to win final approval of a bill.

The 1963 bill does contain an option plan of sorts that is new. Just as it did last year, the Administration is proposing 90 days of hospital care coverage per illness, with the beneficiary paying from $20 to $90 at the rate of $10 a day for up to 9 days. But this year's bill contains two other choices: 45 days' coverage with no charges to the beneficiary, or 180 days' coverage with the patient paying the costs of the first 2½ days of hospitalization. Selection of the option would have to be made by the beneficiary before he reached age 65 or received any benefits, and couldn't be changed once made. Other benefits proposed—a maximum 180 days of skilled nursing home care, out-patient diagnostic services, and a maximum 240 home health care visits—are identical to last year's.

Costs Estimated

In the first year of operation, the Administration estimates, the overall cost of the entire package would be $1 billion, while $1.7 billion would be taken in from the quarter-point tax increase and put into a special medical care trust fund.

However, Social Security experts expect the wage base for taxes would have to be raised again by 1970—perhaps to $5,800—if the current pattern of rising hospital costs continues.

Moreover, passage of the bill and its tax increase would put the Social Security tax on employer and employe at 4⅞% by January 1968, even if no further Social Security liberalizations are enacted. Present law automatically boosts the rate to 4⅛% in January 1966 and to 4⅝% in January 1968.

Mr. Kennedy also proposed a new Senior Citizens Act, which would establish four grant programs to states and localities to improve services and employment opportunities for the aged. The cost over five years is estimated at $132 million.

A series of modifications, estimated to cost $18.5 million over five years, is proposed for old age assistance and public welfare programs. States would be required to provide the same minimum benefits under old age assistance medical programs as under the more recently adopted medical assistance for aged plans, which are designed to aid those over 65 years who don't need cash welfare grants but require help in meeting extra medical costs. The limitation of 42 days of hospital care costs under the old age assistance program for those suffering mental illness or tuberculosis would be removed.

Residence Requirements

Minimum residence requirements for old age assistance payments, which go to about 2,250,000 aged and total $2 billion annually in Federal-state-local funds, would have to be reduced by the states from a maximum of five years to one year by 1970. A new system would be authorized under which payment of welfare cash grants could be made to a responsible third party on behalf of those aged who have proved incapable of handling relief checks. Relief payments are normally made directly to the recipient. A new provision would require that states establish minimum rental housing standards for recipients of old age assistance. About one-fourth of all old age assistance payments are used for rent and the object of the new requirement would be to prevent welfare

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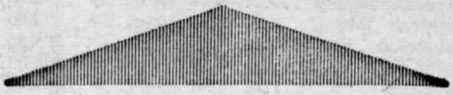

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new requirement would be to prevent welfare subsidization of substandard housing.

President Kennedy also urged adoption of other new housing policies and expanded appropriations to meet needs of the aged for low cost residences. He said he was directing the Housing and Home Finance Agency to give greater emphasis under existing programs to construction of group residences for those aged who need some assistance but not full-time nursing care. A modification was proposed in a low-interest loan program adopted in 1961 for moderate income families who aren't eligible for public housing to permit participation of single, elderly people.

The President also asked approval of a supplemental appropriation of $45 million to the fiscal 1963 budget and an appropriation of $125 million in the fiscal 1964 budget to increase funds available under the Housing and Home Finance Agency's long-term, low-interest residence loan program for the aged. He requested an initial $10 million to begin a similar plan for rural areas of less than 2,500 population.

Financial General Buys 51% Of Bank in Buena Vista, Va.

WASHINGTON—Financial General Corp., a bank holding company, said it had acquired 51% of the outstanding stock of Peoples Bank of Buena Vista, Va. Peoples Bank deposits are $2.3 million.

Financial General also has interests in 23 other banks with total assets of about $54 million. The other banks are in New York, New Hampshire, Virginia, Washington, D.C., Georgia, Tennessee, Illinois, and Maryland.

February 25, 1963

Memo for John S.
From Senator

Please note this item by MacGregor. It is something we ought to watch. That's a fairly good proposal.

Fyi
Richard W

Article prepared at the request of
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Economic Problems in the Distribution of Medical Care

Wilbur J. Cohen
Assistant Secretary of Health, Education, and Welfare

U.S. DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE
Washington, D.C.

ECONOMIC PROBLEMS IN THE DISTRIBUTION OF MEDICAL CARE

by

Wilbur J. Cohen*

Assistant Secretary of Health, Education, and Welfare

We are the richest Nation in the world today with the highest standard of living. The advances we have made in the prevention and treatment of illness would be as astounding to our great-grandfathers as the rockets we are aiming at the moon, the missiles we are sending into space. Over the past 30 years alone, the proportion of our gross national product spent on health and medical care has risen from 3.6 percent in 1928-29 to 5.7 percent in 1960-61—in dollars from $3.6 billion to $29.0 billion. The rate of increase in expenditures has been greater than the rate of population growth—an indication that increased and improved medical services are reaching more people each year. But, modern medicine costs money, and, although more people today are receiving medical care than ever in our history, adequate medical care is still not available to millions of our citizens—mainly because they cannot afford it.

We have a population of almost 190 million men, women, and children living in some 56 million households. More than one-sixth of them are in families with incomes so low that they do not owe any income tax; that is, less than $1,325 for a mother and child; less than $2,675 for a married couple with two children; less than $4,000 for a family of six. Half of our aged couples have an annual income of less than $2,500; half the aged persons living alone have less than $1,000 a year to live on. It will be conceded by almost everyone that these families have incomes that are considerably less than adequate. An estimated 17 million children—one out of every four children in our population—live in families with inadequate incomes. Among the other several million poor persons are people who never recovered from the

* Wilbur J. Cohen was sworn in as Assistant Secretary (for Legislation) of Health, Education, and Welfare on April 14, 1961. He came to this position from the University of Michigan, where he had been Professor of Public Welfare Administration since 1956. Prior to accepting the position with the University of Michigan, Mr. Cohen held various Government posts concerned with social security and welfare programs. His first appointment was Assistant to the Executive Director of President Roosevelt's Cabinet Committee on Economic Security (1934-35) which drafted the original Social Security Act.

Great Depression of the thirties and those affected by automation and other shifts in the pattern of our industrialization.

The Poor Are Ill More Often

Illness is not predictable. Nor can the poor choose inexpensive illnesses. The very fact that they are poor—have inadequate diets, substandard housing, unhygienic living conditions—may make them get sick more often than people with higher incomes. And, they stay sick longer. During the year a person living in a family with an income under $2,000 a year (about one in seven of our total population) will be sick enough to restrict his usual activities for the whole day an average of 28 days a year. A member of a household with an income of $7,000 or over will have his activities so restricted an average of only 13 days a year. But those with family incomes of less than $2,000—with more than twice the illness—will consult a physician only five times per year, while persons in families with incomes of more than $7,000 will consult a doctor six times a year.

An aged person in a family with less than $2,000 income experiences nearly 3 days restriction of his activities for every 2 by a person of the same age with an income of more than $7,000, but he will consult the doctor an average of seven times a year, while his contemporary with an income of more than $7,000 will consult the doctor an average of nine times a year. Sickness makes it difficult for a poor person to work steadily and hold a job, and so income goes down. Then, there is less money than ever to spare for medical care. And, the spiral takes the victim down deeper and deeper into poverty.

A poor person may be able to get along for a time without consulting a doctor—until his illness reaches an acute stage—but, when it does, if he does not die first, he may have to go to the hospital. In fact, according to figures gathered in the National Health Survey, people with low incomes are more likely to enter a hospital than people with high incomes, and, when they do go in, the low income patients stay in the hospital longer. These poor people who get sick and who go to the hospital are statistics. But, they live among us; and their misery, buried in the statistics, is very real.

Margaret H. was widowed 63 years ago after only 2 years of marriage. She went to work for a milliner and after 5 years of working 12 hours a day, 6 days a week under the sweatshop conditions of the period, had saved enough to buy an old house in which to operate a boarding house. She was over 80 when she decided to retire. With her social security checks of $80 a month and $2,000 cleared from the sale of her house, she moved into the home of an elderly cousin, confident that she could live out her remaining years in dignity, if not in luxury. Late in 1962, Mrs. H. fell and broke her hip. After a little more than 6 weeks in the hospital, her carefully cherished $2,000 was exhausted. A few weeks later, she was a "charity" patient. When she died in April, her cousin said, "It was not from a broken hip but from a broken heart."

John W., a successful businessman, retired 8 years ago at the age of 70. He owned a home and had $10,000 in other assets, in addition to social security benefits of $105 a month for himself and $52.50 for his wife. When his wife died of cancer, 3 years ago, Mr. W.'s $10,000 in assets were exhausted. Three operations for his wife and the costs of her terminal illness, plus his own hospitalization for a heart condition on three occasions, had exhausted them. The private health insurance policy he had prudently purchased before he retired was not renewed after the first year and he found it impossible to purchase the protection needed from another company. The required health history statement brought rejection of his application, or else an offer to insure him and his wife only with a waiver of benefit for their existing conditions. A year or so ago he sold his house. He lives in a small apartment in a quiet but shabby neighborhood populated by lonely old men and women. Many of them, he supposes, are living on much less than his $105 social security benefit. He tells of the old gentleman he met shortly after he moved in who offered him a piece of hard candy from a crumpled paper sack with the remark, "Have one, it helps kill the appetite." John W. still has a little money left from the sale of his house, but he fears that his next heart attack will exhaust it.

What Are the Facts About Private Health Insurance?

Private health insurance is available from three principle sources: commercial and nonprofit insurance companies; the nonprofit Blue Cross and Blue Shield plans; and from nonprofit independent plans. Over 800 life and casualty insurance companies write various types of medical care insurance today on a group or individual basis or both. They have sold policies covering hospitalization benefits to some 91 million persons, 57 million under group policies and 34 million under individual policies. A somewhat smaller number of persons is covered for surgical benefits and about half of the total for doctors' calls in the hospital or office and home. A total of 77 Blue Cross and 70 Blue Shield plans together have enrolled about 58 million persons for hospital benefits, 49 million for surgical benefits, 45 million for doctors' visits in the hospital for nonsurgical cases, and perhaps 8 million for doctors' visits in the office and home. There are about 800 independent plans that have enrolled about 7 million persons for hospitalization and about a million more for various types of medical services.

Taking all types of plans together and eliminating duplication due to individuals having multiple policies or coverage through more than one type of carrier, some 74 percent of the civilian population as of the end of 1961 had some form of hospital-ex-

pense insurance, 69 percent had some type of surgical-expense protection, and 51 percent had some coverage against the cost of medical services other than surgery.

These figures on the percentage of the population with one or another type of health insurance coverage must be understood for what they are and what they are not. The figures do not mean that the specified percentage of the population had adequate health insurance coverage. The insurance coverage that people have against the cost of the various services varies from poor to good. The person who has a policy providing $10 a day for 30 days against the cost of room and board and $100 against the cost of the ancillary hospital services figures in these statistics on the same basis as one who has complete coverage of all hospital care in a semiprivate room for up to 365 days in any one illness.

Population Coverage Uneven

The percentage of the population having some type of health insurance coverage varies widely from State to State—from about 92 percent in New York to 47 percent in Mississippi—and by income level. The National Health Survey found that as of July-December 1959, only 33 percent of persons in families with incomes under $2,000 had some type of hospital insurance as against 85 percent of persons in families with incomes of $7,000 or more.

Adequacy of Health Insurance

Too many people are without any insurance, and in general they are people with low incomes who need it most. Many who have some insurance have coverage which is so meager that it leaves them poorly protected in the event of serious illness. Most of existing insurance does little to encourage preventive or even early care. Voluntary health insurance has come a long way in the past 25 years, but it has a long way still to go. And it must be acknowledged that, in the main, it is and will continue to be a mechanism for meeting some of the medical expenses of those who have incomes which leave something to spare after the costs of food, shelter, and clothing are met.

There is no indication that it will ever be able to provide a way for those with inadequate incomes to get the medical care they need. These people, an estimated 33 million of our population today, do not have incomes adequate to meet even the essential needs of today's level of living. They are better off, to be sure, than the peasant of southeastern Asia, living on three bowls of rice a day in a grass shack, but they are not sharing the level of living we hold out to the world as the American standard of living.

Our Economy Must Catch Up With Technological Progress in the 20th Century

This is the heart of the matter. And the problem facing our Nation today is how to organize our economy and our society so that the Nation can make full use of its huge technical capacity and its wealth of potential human resources. Our technology has been progressing at a whirlwind pace, but our economy—our method of distributing our material abundance—is still organized along the same lines as it was a generation ago. Just as the individual, private enterprise, and the Government all play roles in our present pattern of economic security, all will have a part to play in helping to mold the pattern for the future. The task will not be easy, and it will not be accomplished overnight because the causes of poverty and of the dislocations in our economy must be eliminated before poverty itself can be permanently abolished.

Among these causes are technological unemployment—in the city and on the farm—a rapidly increasing population, lack of education, broken families, disability and disease, the slum psychology, and discrimination against minorities. And, among the minorities I list the aged, both white and nonwhite.

There is a long, long road ahead, but "the longest journey begins with but a single step." And, the first steps could begin right now. Some are being taken—the program for aid to depressed areas, manpower retraining, the Community Health Services and Facilities program. The Public Welfare Amendments of 1962 are directed toward finding and treating the causes of dependency. How nearly this goal is realized will depend upon whether full advantage is taken in the States and localities of the legislative changes and the additional Federal funds now available. Other changes are coming. President Kennedy has recommended a tax reduction to get the economy moving upward at a faster rate and also action in expanding opportunities for youth —in employment, training, and education—to help today's youth in low-income families to climb out of the subculture of poverty.

With income levels raised, with more people working and able to obtain and pay for medical protection provided under private group health insurance plans, many of the present inequities in the distribution of adequate medical care would be eliminated.

But, for the aged person with a low income today, there is no prospect of an improved future—only a certain knowledge that failing strength, sickness, and disability will be ever more constant companions during the years or months left to him and a fear that the last thing he may see before he closes his eyes

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forever will be the walls of a charity ward. Because of the special problems of the aged, the President has asked Congress to enact now a hospital insurance program for aged persons to be financed through the existing social security program.

Why a Special Program for the Aged?

People over 65 are ill much more often than younger people, and their illnesses last longer. They have medical costs twice as high as younger people, and they must meet these costs out of annual incomes that on the average are only half as much.

Although an aged person may not be poor at the time he first retires, his financial situation deteriorates as time goes on—even without illness. He uses up his assets, and his fixed income feels the effect of inflation. And more and more people today are living on into their 80's and 90's; 10,000 are past the century mark. Most of these people who live to an advanced age outlive their assets.

More People Are Living To Be Old

Paradoxically, this situation is an indication of our ability to provide a better life for our citizens. With the diseases, the malnutrition, the working and living conditions that existed in earlier centuries, many people now grown old would have died in their childhood or youth. According to the 1960 census, we had 16.6 million aged, 1 out of every 11 people in our population. We now have nearly 18 million aged. During the years between 1950 and 1960 alone, the number of people aged 85 or over increased by 60 percent. It is in these oldest age groups that the costs of illness become especially high.

Those Who Most Need Health Insurance Don't Have It

Among the aged, as among the rest of the population, it is those most in need of health insurance who are least likely to have it: The chronically ill, the ones not working, and those with low income. And, these people generally find the costs of insurance beyond their means or are considered too poor a risk for the commercial insurer. Some who have protection find the policy canceled when they most need it—when they develop expensive, long-drawn-out "conditions," or when they reach the older age brackets, although currently more noncancelable policies are being written.

Hospital Stays Can Be Lengthy, Unpredictable, and Costly

Although the average elderly patient leaves the hospital within 2 weeks, nearly 1 in 10 remains a month or longer. The longer his hospitalization lasts, the more likely is the aged person to need help in paying for his care. The burden of paying for hospital care is even greater when one takes account of those who do not leave the hospital alive. Terminal illnesses often are especially expensive and those at the older ages, who are most likely to die, are least likely to have any insurance. Often they leave a legacy of debt with a heavy burden on widows and children.

No one can foresee just when he will enter the hospital—although 9 out of 10 persons who reach age 65 are sure to go at least once in their remaining lifetime. But, all the evidence indicates that, when one does have to go, he will have unusually high medical bills of all kinds. Aged social security beneficiaries in general hospitals during 1957 had total medical bills for the year five times as high as those with no hospital illness—not counting the costs of persons who did not know what such costs were, often because some care was given without charge or paid for directly by a public or private agency.

At December 1962 prices an elderly couple with one or both members receiving hospital care could expect their combined medical bills for the year to total about $1,200. For the elderly person without a spouse, a hospital stay might mean average medical bills for the year of about $925. With half the aged couples having less than $2,500 income and about half the single aged persons less than $1,000 it is obvious that most of them would be hard put to pay such a bill and still have enough left for groceries and housing—unless they had the benefit of health insurance, could count on getting free care, or received help from relatives. Except for an owned home, few of the aged have assets in substantial amounts. Those who do are more likely to be the relatively small number who already have the advantage of higher income.

How Medical Expenses of the Aged Are Paid

How then do the aged manage when ill? Some seek help from relatives and, failing that, from public assistance. Some borrow money. A small number can manage on their own, especially if they have insurance. Some, as is true of all low income groups, probably never get the care they need. Relatives provided help with medical bills for every seventh social security beneficiary couple and every fourth nonmarried beneficiary who went to a hospital. Many beneficiaries who paid their own bill could do so only because relatives had either taken them into their own home or contributed in cash to their living expenses. Typically, the relatives to whom old people must turn for help already have

families and children to take care of or are themselves old enough to be facing their own problems of retirement.

Some aged persons with medical problems ask for public assistance—either to meet the emergency itself or for regular living needs after using their resources to pay for the medical care. In the first half of 1962, just about every third person approved for old-age assistance needed it directly or indirectly as a result of health difficulties. Among people getting the assistance to supplement social security benefits, the proportion obtaining assistance on account of medical needs was as high as two in five. Currently about half the aged going on the old-age assistance rolls are social security beneficiaries.

The kinds of medical services and the amount of care provided through public assistance vary greatly from State to State. Some State public assistance programs pay for relatively comprehensive services, others meet emergency medical needs only. In December 1962, vendor payments for medical care under the old-age assistance averaged $15 per recipient; the range was from a low of $.41 per recipient per month in one State to a high of $72 in another.

The 1960 amendments to the Social Security Act increased the Federal matching funds for vendor payments under old-age assistance. (Vendor payments are those made directly to hospitals, physicians, and other suppliers of medical services.) Under the Kerr-Mills Act, Federal matching grants were provided for a new program of medical assistance to aged persons not eligible for old-age assistance but whose income and resources are insufficient to meet the cost of needed medical care. As of April 1963, medical assistance for the aged programs were in effect in half the States, the District of Columbia, Puerto Rico, the Virgin Islands, and Guam. The services provided under these new programs also vary widely. In December 1962, about 53 percent of all expenditures under the Kerr-Mills program were being made in two States—States that transferred to medical assistance for the aged most of the nursing care cases on their old-age assistance rolls. Liberalization of the Federal contribution in the federally aided assistance programs has often meant more improvement in States already doing a better-than-average job than in those where standards and available funds were low.

Aged persons with no health insurance and in need of hospitalization are more likely to go to a public hospital than patients with health insurance. Public hospitals more commonly than private institutions must tailor their charges to ability to pay, including taking as public charges those who cannot pay at all.

Public programs are now responsible for 28 percent of total expenditures for medical care for persons aged 65 and over. This much of the burden of medical care of the aged population already falls on the community at large. One may well question, however, whether the cost of this burden is distributed among all our citizens in the most efficient and equitable fashion.

Trends in Health-Care Costs

Over the past decade, prices of all goods have gone up but not as much as has income of the population. Real income, as measured in purchasing power, has improved for most Americans. On the other hand, medical care prices, and especially the cost of hospital care, have risen more than other prices and by and large have outstripped gains in income. This has been a serious problem for all low income groups and particularly so for persons aged 65 and over.

A part of the increase in the cost of hospital and medical care has resulted from improvements in the earnings and conditions of work of hospital employees who have been among the relatively lowest paid groups and are among the last to move from a 12-hour to an 8-hour working day. Changes in medical technology, such as the increasing use of specialized equipment and expensive drugs and antibiotics, while increasing the power of medicine, have also made it more costly.

The organization of medical services is also in process of change. The hospital is assuming a new importance as the center for medical care in a community, at the same time that more effective use of home health services and skilled nursing home or other services is making it possible to transfer many long-term patients out of the hospital, to their benefit as well as that of the community. The further development of a wide range of community and social services can have a significant effect on medical-care problems.

In planning for the next decade, it seems reasonable to assume that the overall cost of medical care will increase at not less than the rate of increase in our total national output—and probably at a somewhat faster rate. Whatever the future costs may be, the question of how the benefits of modern medicine can best be assured to all who need them will be one of the most important challenges to our ingenuity.

Hospital Insurance for the Aged Under Social Security

The President of the United States said in his message on the elderly citizens of our Nation in February 1963:

Hospital insurance for our older citizens on social security offers a reasonable and practical solution to a critical problem. It is the logical extension of a principle established 28 years ago in the social security system and confirmed many times since by both Congress and the American voters. It is based on the fundamental premise that contributions during the working years, matched by employers' contributions, should enable people to prepay and build earned rights and benefits to safeguard them in their old age.

There has been opposition to this proposal on the part of certain organized groups. No responsible person or responsible organization has said that there is no need—that action is not necessary and necessary now. The difference of opinion is about how the problem shall be met—whether the more expensive costs of illness in old age should be paid through our contributory social security system or whether an ever-growing number of the aged must be taken care of as charity cases, requiring annual appropriations from the general revenues of the State and Federal Governments.

The medical bill will be paid one way or another. If it is not paid through the social security trust funds out of contributions from workers and their employers, it will be paid by every taxpayer in some other way. Briefly, the program proposed by the President would provide payment for basic hospital services, skilled nursing-home care after discharge from the hospital, outpatient hospital diagnostic services, and visiting-nurse and other health-worker services in the old person's home.

In the payment of his hospital bills, the aged person would have a choice of three plans. He could choose:

1. Up to 45 days of hospital care at no cost to him;
2. Up to 90 days of hospital care at a cost to him of $10 a day for the first 9 days, with a minimum payment of $20; or
3. Up to 180 days of hospital care, with him paying either the national average cost for 2½ days or the hospital's customary total charge for the care given—whichever is less—but no more than $92.50 under the rates estimated for the first 2 years of the program.

Benefit payments would cover the cost of all services in semiprivate accommodations, drugs, and supplies customarily furnished for the care of patients in a hospital or skilled nursing facility. No payment would be made for the services of personal physicians and private duty nurses or luxury items furnished at the request of the patient.

Social security hospital insurance would be provided to all people over 65 who are entitled to social security or railroad retirement benefits. In addition, all people now over 65 as well as those becoming 65 in the next few years who do not or will not qualify for social security benefits would be eligible for the benefits.

Hospital insurance through social security would be financed by an increase of ¼ of 1 percent in social security contributions for both employees and employers (0.4 of 1 percent for self-employed persons) and an increase in the taxable earnings base from $4,800 to $5,200. Part of the income from the increase in the earnings base will go for higher cash benefits for those earnings over $4,800 a year. The cost of the hospital insurance program to the average worker would be about $.25 a week.

If hospital insurance were provided under social security the workers' payments would be spread over their working lifetimes and would be matched by payments by their employers, so that only modest employee payments would be required.

Those already old, it is true, would receive this hospital insurance protection without having contributed to the cost. But this is one of the advantages of a social insurance program. Under social insurance, the benefit of any improvements that are made in the program are made available to those who are already retired as well as those who will retire in the future. This has been the case with all the social security benefit increases enacted since the program started.

The cost of providing hospital insurance protection to the small proportion of the present aged who have not had the opportunity to participate in the social security program would be met from general revenues. Since almost everyone who will reach 65 in future years will be eligible under the social security program, this would be a relatively temporary arrangement.

Because of the practically universal coverage of social security, the problems of adverse selection of high-cost risks that plague private health insurance and that require exclusion of the preexisting conditions and similar restrictions do not exist for social security; and it can use the advantages of group coverage to keep administrative expenses to a minimum. Collection of contributions and recordkeeping for hospital insurance would add little or no cost to going social security operations. All administrative costs are expected to be about 3 to 4 percent of benefits.

Social security protection has many other advantages over public assistance. Social security avoids the application of a means test, which most people find distasteful and humiliating. It would cover the cost of quality care in every State of the Union. It would cover the cost of care at the time when it was needed without delays for investigation of financial capacity. It would not destroy the incentive to save or for personal and employer arrangements for additional protection, which make the individual

ineligible for aid under a means-test program. It would, most important, prevent dependency among the aged rather than merely offering aid to the poverty stricken.

Finally, hospital insurance for the aged under social security would fit into the existing pattern of our other institutional arrangements. It would work side by side with private insurance, just as retirement benefits and private pension plans have worked together. It would relieve public assistance of a great part of its present burden and permit the States to offer truly meaningful aid to the few in specially disadvantaged circumstances. It would provide a basic benefit that could easily be supplemented on a private basis. It would encourage free choice by removing cost barriers that now stand in the way of free choice.

It is for all these reasons that the President has said of his proposal, "Health insurance for our senior citizens is the most important health proposal pending before the Congress. We urgently need this legislation—and we need it now."

Our social security program has been in operation for over a quarter of a century. When the program was enacted in 1935, there were dire predictions about what it would do to our form of government, to our economy, and to the moral fiber of our citizens. Social security has not led to socialism; it has not destroyed free enterprise; and it has not made our people into "regimented slaves" or "slackers." Today few of the opponents who made these predictions would want to risk the ups and downs of our economy without the cushion of the $1.2 billion paid out each month to 18 million retired and disabled workers and the widows and orphans of workers who have died.

Twenty-six years ago the United States Supreme Court ruled in a 7 to 2 decision that the Social Security Act was constitutional. Justice Cardozo wrote at that time:

> Needs that were narrow or parochial a century ago may be interwoven in our day with the well-being of the Nation. What is critical or urgent changes with the times. . . .

Certainly the soaring health costs of the aged constitute an urgent and critical problem affecting the well-being of the Nation. It is puzzling to find the President's logical, conservative, and fiscally sound proposal called "a step toward socialism." By accepted definition, "socialized medicine" is a system in which the Government owns and controls hospitals, and hires, pays, and controls doctors. The plan the President has proposed would do none of these things. It is simply a means of financing the costs of hospitalization, nursing-home care, and certain home health services for the aged through the social security system. Each person would have the same freedom of choice of physician and hospital that exists today. Indeed, he would have more. One does not have very much of a choice of services if he does not have the means to pay for them.

Additional Health Care Facilities and Personnel Would Be Needed

The ability to afford adequate health care protection is, of course, meaningless without adequate health care facilities. While the enactment of the proposed Hospital Insurance Act would in itself stimulate the construction of more facilities and the provision of additional services, the communities would need additional help so that these facilities and services would be available where everyone could use them.

A good start was made in the enactment of the Community Health Services and Facilities Act which was mentioned earlier. Under this legislation, additional Federal funds are helping States and communities to develop new and improved community health services, to build more nursing homes, and to provide better care in homes of patients as well as in nursing homes. In addition, the President has recommended legislation to authorize planning grants to public and other nonprofit organizations to assist them in developing comprehensive, areawide plans for the use and construction of all types of health facilities. These studies will enable such organizations to study ways of attaining maximum economical use of existing facilities, how hospital facilities can be built, and how services within hospitals should be organized and administered to provide the best possible care with the personnel available.

The provision of adequate health care to all our citizens requires an adequate supply of well-trained personnel. This means that the number of doctors and dentists must keep pace with our growing population. To achieve this goal, we will need new schools and teaching hospitals to train our future physicians and dentists.

President Kennedy has made four recommendations which, if adopted, will bring the goal closer:

1. Grants to help our academic institutions plan new facilities for medical and dental schools and to explore ways of improving the whole educational process.
2. A 10-year program of matching grants to assist in the construction, expansion, and restoration of medical and dental schools to increase their capacity.

3. A program of student financial assistance for talented but needy medical and dental students.
4. Cost-of-education grants to schools for each Federal scholarship to meet costs not covered by tuition and fees.

Conclusion

The equitable distribution of adequate health care to all our citizens requires a wide range of private and public medical care resources. With private expenditures accounting for about three-fourths of all expenditures for health services, private individuals and nongovernmental groups will continue to bear a major responsibility for promoting needed improvements in methods of organizing and financing health services. State and local governments can also do much within their jurisdictions to express public concern and initiate public action on medical care problems. However, Federal leadership, technical aid, and financial support are needed to strengthen the Nation's medical services.

[1964?]

WHITE HOUSE FOLDER

Johnson File - Medicare

Memo to Senator

From John Stewart

Re: Status of Medicare.

I have talked with Wilbur Cohen and Ribicoff's office on the status of the attempts being made to formulate a workable medicare amendment. The following points seem worthwhile bringing up at the legislative breakfast tomorrow:

1. The Finance Committee meets Tuesday at 10:00 a.m. to formulate plans for the remainder of the session. Wilbur Cohen suggests pushing Smathers at the breakfast to agree to work for brief hearings on the omnibus social security amendments--without medicare--beginning the end of this week. The general opinion seems to be that hearings on medicare would last too long to permit floor action on any of the social security amendments this session. Perhaps the President might be able to persuade Senator Byrd to keep the hearings short and to the point. But Smathers seems to be the key person on this.

2. If hearings were completed by next Tuesday, August 11, the medicare amendment could be introduced on the floor by Thursday, August 13, with the debate scheduled for Saturday or Monday.

3. HEW is attempting to decide what will be in the medicare option--just hospital care or a combination of hospital care, skilled nursing home care, home ~~xixi~~ visits. If the combination is adopted, there will have to be a lower number of days of hospital care. Attached is one proposal from the staff of the Select Committee on Aging.

4. Some clear statement of Presidential desires on the timing and strategy of the medicare amendment would be very helpful.

Present discussion of a "medicare" amendment has centered around the offering of a flat 45-day hospital insurance benefit as an option to an increase in monthly cash benefits. The program described on the following page is, however, a sounder proposal medically, economically, and politically than the "45-day" option. This new proposal -- essentially derived from the McNamara bill (S. 65) -- is preferable because:

1. Cost is slightly lower than the "45-day" plan.

2. It offers a comprehensive range of benefits -- hospital, skilled nursing home, home health services, and out-patient diagnostic -- rather than just hospital care. The types of benefits included are precisely those which have been discussed during the past several years and which the elderly have been led to anticipate.

3. Senator Javits has indicated that he intends to offer as amendments one or both of his health insurance bills. Both bills offer a broad range of coverage. It would be difficult for the Democrats to demonstrate that a "45-day" hospital benefit, by itself, is in any way superior to the Javits' measures. On the other hand, the Democrats can make a much stronger case for the proposal described on the attachment.

4. If it were deemed advisable at some future time to expand a health insurance program for the elderly, it would be much simpler to extend an existing benefit than to establish a new benefit.

5. The skilled nursing home and home health service benefits are provided under more liberal definitions than those in the King-Anderson bill -- meeting objections which were raised to the effect that the King-Anderson benefits would be available on an extremely limited basis only.

6. Assuming that it is desirable to vest overall control of the program with an agency of the Federal Government rather than with a private organization such as Blue Cross, it would be easier to justify such control where different types of benefits were provided than if hospital care were the only item. Blue Cross does not have meaningful experience with non-hospital benefits and it could be argued that conflicts of interest might arise if Blue Cross were given responsibility for the non-hospital benefits.

7. King-Anderson and related measures are essentially designed as short-term care programs. The 30-day hospital benefit under the proposal described on the following page is consistent with this objective because: (1) it would cover 90 percent of all short-term hospital stays and (2) a long-term hospital is defined as one where the average length of stay exceeds 30 days.

1. Maximum of 45 units of coverage during benefit period:

hospital day	- 1 unit
skilled nursing home day	- ½ unit
home health visit	- ¼ unit

2. Limits on specific benefits during a benefit period:

hospital care	- 30 days
skilled nursing home	- 60 days
home health visits	- 120 visits

NOTE: Under the provisions of "1" and "2" an individual could receive 30 hospital days and 30 skilled nursing home days (45 units); 15 hospital days and 60 skilled nursing home days (45 units) or similar combinations of benefits not to exceed 45 units.

3. Outpatient diagnostic services would be covered on the same basis proposed in King-Anderson and the McNamara bill and no unit charge made for such services.

4. Skilled nursing home care and home health visits would be paid for only following hospitalization. Benefits would be provided in facilities and on the basis outlined in the McNamara bill (S. 65).

5. A "benefit period" would be as defined in the King-Anderson bill.

[1964?]

SUMMARY OF MAJOR HOSPITAL INSURANCE PROPOSALS

Administration Bill, 88th Congress (H.R. 3920, S. 880)

Protection is provided, through contributory social insurance financing, for people 65 and over who are entitled to monthly OASI or railroad retirement benefits. Same protection is provided, through general revenue financing, for people who are not eligible for such monthly benefits but who reach age 65 before 1967, or who reach 65 after 1966 and have 3 quarters of coverage for each year elapsing after 1965 and before age 65. (Provision for uninsured persons would not apply to retired or active Federal employees, persons who are convicted of subversive activities or are members of subversive organizations, and aliens with less than 10 years of continuous residence in U.S.)

Payment would be made for (1) inpatient hospital services for up to 90 days, with deductible of $10 a day (minimum of $20) for first 9 days, unless beneficiary chooses either hospital coverage for up to 45 days with no deductible or up to 180 days with deductible equal to average cost of 2 1/2 days of hospital care; (2) skilled nursing home services in facilities affiliated with hospitals (after transfer from hospital) for up to 180 days; (3) outpatient hospital diagnostic services, as required, subject to $20 deductible for services furnished within 30-day period; (4) home health services for up to 240 visits during calendar year. Beneficiary would be eligible, as prescribed by physician, for up to maximum hospital days provided under option selected and 180 days nursing home care in each benefit period. A new benefit period could not begin until 90 days elapsed in which beneficiary was neither in a hospital or nursing facility; the 90 days outside an institution need not be consecutive but must fall within period of not more than 180 consecutive days. Secretary would be required to study ways of increasing availability of skilled nursing facility care and may authorize participation of facilities not affiliated with hospitals if such facilities are operated under conditions assuring good quality care -- provided such action does not create (or increase) an actuarial imbalance in trust fund.

A provider of health services may participate if it meets, in addition to statutory conditions, conditions specified by Secretary of HEW to assure health and safety of beneficiaries, but conditions could not be more strict than those required for accreditation by Joint Commission on Accreditation of Hospitals. Accreditation by Joint Commission would be accepted as meeting all requirements for participation save the requirement that the providers of services have a utilization review plan. Providers could designate a private organization of their own choice to receive and pay bills in lieu of dealing directly with Federal Government. The Secretary could delegate additional administrative functions to designated organizations. The Secretary would be required to assist providers, carriers, other public and private organizations in developing and making available to the aged supplementary private insurance protection.

Social Security contribution rates would be increased 1/4 of 1 percent each for employers and employees and 4/10 of 1 percent for self-employed. The earnings base would be increased to $5,200. A separate hospital insurance trust fund would be established.

King-Anderson Bill, 87th Congress (H.R. 4222, S. 909)

Same as Administration bill except for following substantive differences:

(1) did not provide protection for uninsured aged;
(2) did not provide option for beneficiary to elect alternative to 90-day inpatient hospital benefit;
(3) did not limit Secretary's authority to prescribe additional conditions for hospital participation relating to health and safety to requirements for accreditation of Joint Commission on Accreditation of Hospitals;
(4) did not require that an intern and resident-in-training teaching program be approved by AMA Council on Medical Education and Hospitals;
(5) did not limit nursing facility payment to facilities affiliated with hospitals;

[1964?]

Comparison of Major Hospital Insurance Proposals

Administration bill, 88th Congress Anderson (S.880) King (H.R.3920)	King-Anderson bill, 87th Congress (S.909) (H.R.4222)	Anderson-Javits bill, 87th Congress (S.3565)	Javits Bill, 88th Congress (S.849)
Eligibility			
All persons 65 and over entitled to monthly OASI or railroad retirement benefits. Persons not eligible for monthly OASI or railroad retirement benefits who reach 65 before 1967, or reach 65 after 1966 and have 3 quarters of OASI coverage for each year elapsing after 1964 and before age 65--excluding, however, retired or active Federal employees, persons convicted of subversive activities or members of subversive organizations, and aliens with less than 10 years of continuous residence in U.S.	All persons 65 and over entitled to monthly OASI or railroad retirement benefits.	Same as Administration bill.	Same as Administration bill except, with respect to persons not eligible for monthly OASI or railroad retirement benefits, coverage provided for those who reach 65 before 1968 or reach 65 after 1967 and have 3 quarters of OASI coverage for each year elapsing after 1965 and before age 65.
Benefits			
Hospitalization: Inpatient hospital services for up to 90 days per benefit period with deductible of $10 a day (minimum of $20) for first 9 days, unless beneficiary elects either up to 45 days with no deductible or 180 days with deductible equal to average cost of 2 1/2 days of hospital care.	Hospitalization: Inpatient hospital services for up to 90 days per benefit period with deductible of $10 a day (minimum of $20) for first 9 days.	Hospitalization: Inpatient hospital services for up to 90 days per benefit period with deductible of $10 a day (minimum of $20) for first 9 days.	Hospitalization: Same as Anderson-Javits bill.

Administration bill	King-Anderson bill	Anderson-Javits bill	Javits bill
		Private insurance option: Beneficiary who has private insurance plan in effect which provides coverage for 45 days with no deductible (as well as at least the same coverage for the other benefits provided under the Government plan) could elect to receive 45-day hospital benefit through private plan.	Private insurance option: Same as Anderson-Javits bill.
Nursing Home: Services furnished (after transfer from hospital) in facilities affiliated with hospitals for up to 180 days per benefit period.	Nursing Home: Services furnished (after transfer from hospital) for up to 180 days per benefit period.	Nursing Home: Same as Administration bill.	Nursing Home: Same as Administration bill.
	Maximum on combination of hospital and nursing home services: 150 units of services with 1 unit equaling 1 day of hospital service or 2 days of nursing home service.	Maximum on combination of hospital and nursing home services same as King-Anderson bill.	Maximum on combination of hospital and nursing home services same as King-Anderson bill.
Benefit period: New period could not begin until 90 days have elapsed in which beneficiary was neither in a hospital or nursing facility; the 90 days need not be consecutive but must fall within a period of not more than 180 consecutive days.	Benefit period: New period could not begin until 90 consecutive days have elapsed in which beneficiary was neither in a hospital or nursing facility.	Benefit period: Same as Administration bill.	Benefit period: Same as Administration bill.

Administration bill	King-Anderson bill	Anderson-Javits bill	Javits bill
	Benefits (cont'd)		
Home Health: Intermittent nursing care, therapy, part-time home health aid services, services of interns and residents under approved teaching program of hospital with which home health agency is affiliated furnished in patient's residence under plan established by physician, for up to 240 visits per calendar year.	Home Health: Same as Administration bill, except coverage for services of interns and residents not provided.	Home Health: Same as Administration bill.	Home Health: Covers any item or service necessary for beneficiary's care and treatment furnished in beneficiary's residence which is prescribed by physician. Excludes medical and surgical services of physicians, interns and residents.
Outpatient Hospital Diagnostic: As required, but subject to $20 deductible for services furnished within 30-day period.	Outpatient Hospital Diagnostic: As required, but subject to $20 deductible for each diagnostic study.	Outpatient Hospital Diagnostic: Same as Administration bill.	Outpatient Hospital Diagnostic: Same as Administration bill.
Studies: Secretary required to study ways of increasing availability of skilled nursing facility care; may authorize participation of nursing facilities not affiliated with hospitals if facilities are operated under conditions assuring good quality care and provided such action by the Secretary does not create (or increase) actuarial imbalance in trust fund. Secretary required to study (and develop recommendations relating to) adequacy of health care facilities, methods of encouraging development of economical forms of care and effects of deductibles.	Studies: Secretary required to study (and develop recommendations relating to) adequacy of health care facilities, methods of encouraging development of economical forms of care and effects of deductibles.	Studies: Same as Administration bill.	Studies: Same as Administration bill.

Administration bill	King-Anderson bill	Anderson-Javits bill	Javits bill
Participation of Private Organizations			
Providers could designate private organization to receive and pay bills in lieu of dealing directly with Government. Secretary could delegate additional administrative functions to designated organizations.	Providers may authorize private organizations to act on their behalf in dealing with Secretary with respect to provider participation and payments for provider services.	Same as Administration bill.	Same as Administration bill.
Role of Private Insurance			
Secretary required to consult with and assist providers, insurance carriers, State agencies and other organizations to develop and make supplementary insurance protection available for aged.	No specific provisions relating to participation or encouragement of private insurance.	Beneficiary who has approved private plan in effect could exercise option to have the Government pay the costs of the statutory benefits (or, as an alternative to the 90-day inpatient hospital benefit, up to 45 days inpatient hospital care with no deductible) through a qualified private carrier of beneficiary's choice. Private plan would have to provide at least the same benefits as the Government plan. Government would assume all administrative functions--negotiate agreements with providers, conduct audits, establish reimbursement rates, etc.--and reimburse private carrier for cost of statutory benefits provided beneficiary.	Same as Anderson-Javits bill.

Administration bill	King-Anderson bill	Anderson-Javits bill	Javits bill
Administration			
Under established OASDI system (railroad system for railroad annuitants and pensioners), with States and national accrediting bodies used in determining eligibility of providers to participate and private organizations performing functions related to providers of services. Provision for Advisory Council to advise Secretary on policy matters in connection with administration.	Same as Administration bill.	Same as Administration bill.	Same as Administration bill.
Financing			
Increase of 1/4 of 1 percent in social security tax for employers and employees (4/10 percent for self-employed) and increase in amount of earnings taxable from $4,800 to $5,200.	Increase of 1/4 of 1 percent in social security tax for employers and employees (3/8 percent for self-employed) and increase in amount of earnings taxable from $4,800 to $5,000.	Same as Administration bill.	Same as Administration bill.

[1964?]

Comments on Saltonstall Bill (S. 2705)

The bill is drafted in such a way as to establish only the general outline of a health insurance program. Moreover, many of the provisions in the bill are highly ambiguous; the content of the two State programs, for example, is not at all clear. In addition, so much is left to regulations and to the discretion of the Secretary, the States and the insurance commissioners of the States that it would require an exercise of imagination and ingenuity to visualize how the plan would operate in practice. The following describes some of the problems that would arise as a result of this ambiguity and outlines the numerous inherent limitations in the proposal itself as a solution to the problem of financing health care costs for the aged.

Income Test

Under the bill, health insurance protection would be made available only to people aged 65 and over whose adjusted gross income, as defined for income tax purposes, does not exceed a given amount in the year previous to enrollment in the State plan. (For purposes of computing income under this bill, OASI benefits, railroad retirement benefits and veterans' pensions would be added to the adjusted gross income.) The income limits are $3,000 for an individual and $6,000 for a couple.

This proposed income test is not a reasonably effective or equitable means test. It is neither a test of indigency nor a test of ability to meet medical bills. While the income limits may appear high, they would exclude, for example, an individual who has an income of $3,200 a year even though such a person might not be able to stand the cost of an extended hospital stay or surgical and medical services attendant upon an acute illness.

An equally fundamental problem stems from the "all or nothing" character of a test which uses a single specified amount of income as a criterion of eligibility--when the matter of a dollar in income could mean the difference between eligibility to health insurance protection under the State plan for an entire year and no protection at all. It would not be unreasonable to expect, under such a test, that people would be encouraged to trim their income wherever possible, so as to be sure of becoming eligible. Such a strong incentive to manipulate annual income, particularly in the case of individuals working full-time, would be undesirable. Actually, the trend in other programs, for example, veterans' pension and OASI legislation, has been to avoid the inequities that arise under tests of this kind.

The bill makes some attempt to get around this problem by providing that once an individual is enrolled he may continue to enroll in succeeding years without regard to his income providing he meets certain unspecified criteria which the State, in its discretion, may establish. It is not at all clear what kind of criteria these could be, but whatever they may be they would certainly reinforce the incentive to trim income in at least one year in order to enroll.

Moreover, any cash income test--even if not tied to income tax--would favor persons receiving noncash income as contrasted to those receiving cash income. Noncash income is an important source of the income of the aged, with home ownership the most common source of significant income of this kind. About two-thirds of the aged people are homeowners. The value of this rent-free housing--ranging from $500 to $1,500 in most cases--would not be counted as income, whereas the nonhome owner while no better off but with savings equivalent to the value of a home invested in assets providing interest or dividends might find the increase in cash income disqualified him.

Other Implications of Income Test

The nature of the income test provided in the Saltonstall bill is such that protection under the program would not be available to an individual until after he had served a waiting period of at least a year during which his income was below the required amount. An individual who stopped working permanently when he became ill and was hospitalized would not receive any benefits during his hospital stay. If he had no private hospital insurance protection he could be impoverished by his hospital expenses.

One effect of this "waiting period" would be to substantially increase the number of cases of persons attempting to delay medical treatment until eligible for protection. Delayed treatment would sometimes result in a longer period of hospitalization than would otherwise be necessary and sometimes in reduced chances for recovery.

The provision for including for purposes of the income test monthly OASI benefits, railroad retirement benefits, and veterans' benefits is inequitable if it is not recognized that the former are contributory and should be treated in the same manner as benefits under Federal, State and local retirement systems and private pension plans. Furthermore, nontaxable income such as interest on State or local government bonds, is not counted at all.

Regardless of income, a person is eligible and apparently subsidized thereafter if he once had a year in which his income is $2,900, but a person with $3,100 each year is out and not subsidized at any time.

Choice Among Alternative Programs

The provision which permits eligible individuals to choose between alternative benefit packages would result in a number of serious problems. The bill leaves the problem of how and when the election would be made--including how often shifts would be permitted--for the Secretary to struggle with after enactment. In the absence of the protection afforded by a provision in the law the Secretary would be under powerful and conflicting pressures to revise his regulations on what shifts were possible.

It is questionable whether a sound choice could be made by beneficiaries among the options provided under the bill. The choice between the short-term diagnostic benefit package and the catastrophic benefit package amounts to a choice between (a) coverage of brief duration without a deductible and coinsurance feature and (b) somewhat more extensive coverage with a deductible and coinsurance feature. (Actually the descriptive titles given to the options are misnomers and, thus, seriously misleading, since the difference between them is fundamentally the existence of a deductible-coinsurance element which, if accepted permits broader coverage at a given price.) In effect, therefore, this proposal would require aged people to hazard a guess--gamble, as it were--on the form their medical expenses will take. It is doubtful that the choice, in the vast majority of cases, could be made on any meaningful basis.

Also, many serious problems would arise under the provision of the bill that permits beneficiaries to change from plan to plan after their initial choice has been made. One of those problems is that it would be possible to "work" the system through a choice of moves from one plan to another--from a plan covering doctor bills, for example, to one with long-term nursing-home coverage--as health needs change. The bill leaves open the question of how frequently shifting between plans is to be permitted. Of course, any effective limitations on shifting would be subject to a great deal of criticism as the choices people made and were stuck with turned out to be not the best ones for them.

Cost of Plans

The cost of the plan is not at all clear because the benefits to be provided--and therefore their cost--is unclear. The benefits are "subject to regulations of the Secretary" of Health, Education, and Welfare and the States may add benefits unspecified in the bill. A minimum premium cost might be $120 a person since this is the enrollment charge for a person earning $3,000 a year and a maximum cost might be about $250 a year (the $150 maximum from the Federal Government and about $100 from the States). The cost range would also depend on what States would participate. In the foreseeable future probably not over about two-fifths of the aged would be in States that would participate because they would get more favorable matching grants than are now available to them. The cost is likely to be in the low part of the range, about $700 million, of which $400 million would be Federal but the cost could reach $4 billion, of which $2 1/2 billion might be State.

Adverse Selection Among Plans

Although the intent of the bill apparently is to provide equal protection under any of the three options an individual chose, it is extremely doubtful that such equivalence could be obtained. Persons in reasonably good health, for example, who elected one of the two options under the State plans would tend to select the short-term option; those anticipating the

need for long-term institutionalization or who are resident in nursing homes apparently for the rest of their lifetimes would select the long-term benefits. To the extent that their expected use of various benefits prove to be correct, the value of the benefits to an individual under the two plans would be very different.

Similarly under the private insurance policy option the private insurance carriers would be able to take the "cream" of the market--simply by employing commonly accepted underwriting practices such as refusal to enroll persons in poor health who may be expected to be poor risks--and may leave the State programs with substantially all of the most expensive risks, thus creating a further imbalance between all of the three options. In addition to the initial refusal to accept poor risks adverse selection could also occur as individuals switch to the State programs when their private health insurance policies become too costly for them because of increased premiums with older age or when they exhaust the benefits payable under such policies. If equity among the plans were to be maintained, the likelihood of continuing adverse selection would require constant re-evaluation and modification of the scope and content of each of the two State programs.

It is true that the definition of a "qualified private health insurance policy" provided in the bill establishes certain criteria for the private health insurance in whose costs the State program will share. These criteria however would not effectively eliminate or even significantly reduce the likelihood of adverse selection against the State programs. Essentially this is because there is no requirement that private carriers accept all applicants and because there is no effective prohibition against increasing premiums for classes of individuals--in effect of course a class can be defined by enrollment year which is related to age. Moreover the requirement that a policy to be qualified must be guaranteed noncancellable for life is not an effective safeguard against adverse selection since carriers would also be permitted to cancel such policies if they do so for a whole class of individuals--again a simple matter of cancelling a policy for a class of people at advanced ages and offering a new policy only for people at lower ages.

Relationship to MAA and Other Assistance Programs

The bill provides that the Federal Government would match funds for the proposed State program only in those States which have in effect an MAA program. The bill is silent, however, about the relationship of the proposed new State program to the existing MAA program. Moreover, this uncertainty concerning the relationship of the proposed new program to MAA extends as well to the other existing Federal-State assistance programs (OAA, APTD) already devoting a substantial portion of their expenditures to purchasing or providing medical care for the aged. At some point, of course the proliferation of Federal-State assistance programs all designed to meet essentially the same problem becomes administratively chaotic and self-defeating. It is relevant to inquire, therefore, whether the enactment of a fourth assistance program is the most rational and effective way to cope with the health costs financing problem of the aged.

Like all Federal-State assistance programs, the proposed program would go into effect only where the State is willing to establish it. It is, of course, assumed by the sponsors of the bill that most States would be willing to take on the administrative tasks required under the bill and to bear the required 50 percent of the costs of administration. However, the incentive may be much greater for some States than for others. Wealthy States such as New York or California might find it desirable to establish this program since the Federal Government's share would be 60 percent in contrast to MAA in New York and California where the Federal medical percentage is now 50 percent. On the other hand, a State like Arkansas (where the Federal medical percentage is 80 percent) would clearly have much less incentive to establish the new program, especially since this program would involve substantially greater administrative costs than are now incurred in administering MAA and half of these costs would still have to be borne by the State.

The proposed program is characterized by proponents of the bill as a "voluntary" program, although, of course, the taxes that would be required to finance the program would be assessed, like all taxes, on a compulsory basis. The decision to apply for the benefits provided would be voluntary, but no more so than is the case under MAA or the social security program. What the proposed program adds in the way of voluntary choice is the option to pay an enrollment fee; i.e., the choice facing the individual is whether to pay the $10 enrollment fee (or whatever it might be) in order to get a benefit package worth up to $250. Such a choice, however, would not be meaningful for a man whose income is below $500 and who could not in any event afford to pay the $10 enrollment fee. It would be far better in such a case to provide protection under MAA without requiring any enrollment fee than to offer a tantalizing but meaningless choice.

State Problems Under the Proposal

1. The effectiveness of the plan in each State would depend upon the State having or being able to raise sufficient funds to set up and meet the commitments of a State plan. The Federal matching formula, however, would not make it possible for those States with less resources to participate since they would in fact receive no more in Federal funds than they are presently receiving under MAA.

2. Under the bill, the States would have the responsibility for establishing and enforcing standards for facilities providing medical care under the State plan. Because most of the States have shown little inclination for responsible action in this area in the past, it seems unlikely that in general there would be satisfactory standards established under the new State plan. Moreover, even if standards were developed by the States, there is sufficient evidence to assume that many States would be loathe to enforce them or to engage in the periodic inspections and supervisory activities necessary to assure continuing conformity to the standards. Without reasonably good standards for participating facilities and responsible enforcement of these standards inadequate, or even poor, care may be encouraged.

3. The presumed advantages of greater flexibility and adaptability for local conditions claimed for decentralized State administration would be so restricted by the requirement that all States must undertake the same type of benefit coverage as to be virtually non-existent. Many States without previous experience in providing protection for a variety of medical services would probably refuse to participate. Others would undoubtedly incur costly failures as a result of their inexperience. The inclusion of coverage areas with which there has been no experience on a large scale introduces substantial risk even for States that have previously undertaken to provide some type of medical care protection for the aged.

4. One measure of the value of benefits provided is the percent of the premium that would be needed for the administration of the program. A Federal-State program would be substantially more expensive to administer than say, a social insurance program offering comparable benefits and using the centralized organization of appropriate Federal agencies. A large number of individually administered State plans in which a large number of commercial insurance companies participated would inevitably result in a mushrooming of administrative costs. Thus, the administrative costs of the State program would eventually be so high as to generate pressures to curtail the benefits provided.

5. Those persons who would elect participation in the voluntary State program would generally be those who would expect to make the most frequent use of the health benefits provided. On the other hand, many of the individuals who would choose not to participate (and many of these people would be persons of very low income who would probably feel that they could not afford the enrollment fee) would, nevertheless, be faced at some point with medical expenses which they could not meet out of their own resources. As a consequence, these individuals would be able to draw upon public assistance programs and have their expenses paid without having made contributions in the form of enrollment fees toward the payment of these costs. Whether falling back on public assistance would be an advantage or disadvantage would, of course, depend upon the content of the public assistance medical care benefit which, so far as the bill is concerned, could be more or less than or the same as the content of the proposed new program.

Ambiguities in the Bill

1. The content of the benefits that must be provided under the State options is not clearly specified, particularly with respect to the long-term illness benefit program. For example, under this option a State must provide "skilled nursing home care," "prescribed drugs," "outpatient hospital services," and "physicians' services" yet the bill nowhere stipulates the minimum extent to which these services must be provided nor is it clear from the bill whether the State can in fact impose any limitations on these various benefits. For example, under the long-term option the State is apparently required to provide

payment for 80 percent of the costs of the entire nursing home stay of a permanent nursing home resident and contains no provision that would bar payment of major medical benefits for custodial care. The only restriction on payment is that a doctor determine that the service is medically necessary. Custodial care may be considered to be medically necessary if an individual is physically impaired to a point where he cannot manage the chores of daily living. It might appear that administrative measures could be employed to prevent such payment. However, it is unlikely that such measures could be devised that would effectively prevent payment for custodial care since there is no indication in the bill that custodial care was intended to be excluded. For example, the nursing services covered are not required to be of a skilled nature.

2. There are a number of other ambiguities in the bill. For example, what happens in the event an individual elects the private insurance policy option and subsequently fails to pay his share of the premium cost of that policy? Apparently this individual would be left without any protection at all until the next enrollment year even though his income was negligible.

Summary of Saltonstall Bill (S. 2705)

General

This bill would authorize Federal matching grants to those States which have an MAA program in effect and which establish an additional program of health benefits for persons aged 65 and over whose income does not exceed a specified limit. Coverage under the State plan would be voluntary and an eligible individual electing to participate would be required to pay an enrollment fee based on his income. The State plan would have to provide for a choice among three "actuarially equivalent" benefit plans--a diagnostic, short-term plan; a long-term major illness plan; a private insurance policy plan involving payments to help defray the premium costs of a qualified private insurance policy. The State plan would be financed by individual enrollment fees, and Federal and State funds, and would be administered by the State.

Description of Provisions

A. Eligibility. All persons aged 65 and over who are not recipients of OAA or other Federal public assistance programs, except for persons eligible under MAA, and who meet the annual income test--$3,000 or less for single people, $6,000 or less for married couples.

B. Enrollment Fees. Each participating individual would be required to pay an enrollment fee based on income. The minimum fee would be $10 annually and would apply to individuals receiving $1,000 or less in income. The maximum fee would be $120.

C. Benefits. Eligible individuals would have a choice among the following three plans:

(1) A preventive diagnostic, short-term plan which would provide as a minimum: (a) 21 days of hospital care; (b) 63 days of nursing home care--with covered hospital days reduced by 1 day for each 3 days of nursing home care used--; (c) surgical services; (d) out-of-hospital physicians' services for 12 days; (e) first $100 of costs of outpatient diagnostic, laboratory and x-ray services: (State may cover other services at its own option)

(2) A long-term major illness plan providing payment for not less than 80 percent or more than 90 percent of the following costs, after the first $50 of medical expenses: (a) 120 days of hospital care; (b) surgical services; (c) skilled nursing home care; (d) prescribed drugs; (e) diagnostic lab and x-ray services up to $200; (f) outpatient hospital services.

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(3) A private insurance policy plan--individual may receive financial assistance in meeting the cost of a qualified private insurance policy. (To be a "qualified policy" it would have to provide benefits having an actuarial value at least equal to the benefits provided under the other two options.) The amount paid to the individual could not exceed an amount equal to the actuarial value of the other options less the enrollment fee payable under the other options.

D. Administration. A single State agency would be designated to administer the State plan. A State could utilize private organizations in the administration of one or more of the benefit programs under the State plan.

E. Financing. Federal participation in State program costs would consist of grants of 50 percent of State administrative costs and from 60 to 80 percent of other costs--exclusive of enrollment fee receipts--depending upon a State's per capita income, up to a maximum Federal contribution of $150 per enrollee.

WHITE HOUSE FOLDER

MEMO TO SENATOR

From John S.

Re: Administration plans for Medicare legislation.

It would be most helpful ~~mf~~ if you conld elicit some feeling from the President as to his desires on Medicare legislation in the Senate, timing, persons involved, etc. We are standing by waiting for some indication as to next steps.

Attached is the memorandum outlining the Senators who might wish to be brought into the effort under the joint leadership of Anderson-Humphrey. The first step might be a meeting of Senators Humphrey, Anderson, McNamara and Johnston with the President (perhaps Senator Hill should also be sounded out to attend this meeting.) Then we could start the staff operation similar to the one conducted during civil rights. We really must go into this fight fully prepared, geared up, and organized. This can be done if we get some initial word from the White House.

I am also attaching a memorandum from HEW on the legislative outlook for medicare in the Senate

If we are to win, it seems essential that the HEW staff be kept under tight control by the Senator-in-charge, probably yourself. The kind of relationship we established with the Justice Department in civil rights would be the model for the medicare battle.

[1964]

The President's Program of Hospital Insurance for the Aged

by Wilbur J. Cohen
Assistant Secretary of Health, Education, and Welfare

It is generally recognized that the problem that older people face in financing the cost of hospital and related care has become serious and widespread and presents a grave threat to economic security of the aged in this country. In response to the need to make old age more secure against this threat to economic independence, President Kennedy has proposed that the basic hospital insurance needs of the aged be financed through social security.

Let us review very briefly the thinking behind this proposal.

First, the social security approach offers the most practical mechanism by which people would be able to provide for hospital costs they will face in old age. It is while they are working that people are best able to contribute toward the cost of hospital care needed in old age. Under a contributory social security hospital insurance program, benefits would be provided as an earned right and the proposed program would avoid the personal indignities associated with means-test programs, which classify people who are aided as being too poor to pay their own way. Also, since social security benefits become available while the aged still have resources, the program helps them to preserve their independence throughout their lives. Conversely, under public assistance programs savings must be all but exhausted before help is made available. Once an aged person has exhausted his resources to the point where he can qualify for assistance, it is practically impossible for him to replenish them and again become self-reliant.

Another important social security feature that is part of the structure of the proposed hospital insurance program is that it would provide basic protection; the beneficiary would be expected to build on his basic protection and by his own means obtain supplementary protection against the health costs that would not be covered under the proposal. One of the key differences between providing hospital insurance through social security and providing financial aid through means-test programs is that, under social security hospital insurance, private resources can be used to supplement the protection provided, whereas, under a means-test program, one can get help only by using up or limiting whatever private resources he might have.

While the proposed hospital insurance program for the elderly would by no means provide protection against all of a beneficiary's health costs, it can be expected that once the basic hospital insurance needs are met under social security, many beneficiaries could, for the first time, afford to make their coverage more nearly complete by purchasing supplemental protection (against the costs of physicians' services, drugs, etc.) from nonprofit and commercial insurance carriers. Like the present social security program, the proposed hospital insurance program would depend upon public assistance to fill in the small and diminishing gap that would not be filled by the

combination of protection afforded through social security and the private sector. It is the purpose of this paper to review the proposal from the standpoint of the protection it would afford and from the standpoint of the proposal's relationship to the quality of health care the aged would receive--to review and appraise the proposal in terms of its technical adequacy.

PROHIBITION AGAINST ANY FEDERAL INTERFERENCE

The Administration proposal 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 proposal also 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 Administration's plan, 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 though 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 15 1/2 million would be covered as persons eligible under the old-age and survivors insurance or railroad retirement programs and about 2 1/2 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--9 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 Administration plan would provide payments for inpatient hospital services, follow-up 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 proposed insurance program 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 nine out of every ten people who reach age 65 will be hospitalized at least once before they die; two out of three will be hospitalized two 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 Administration plan, 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 national average cost for 2 1/2 days of hospital care or the hospital's customary total charge for the care provided, whichever is less. (The national average cost of 2 1/2 days of hospital care for the first two years of the program (1965-66) would be established as $92.50.)

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 patients. 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 proposed program 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 proposal 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 Administration's plan 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 Administration plan, 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 Administration plan 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 proposal, payment could be made for drugs furnished to hospital and skilled nursing facility patients for their use while inpatients. The plan would provide payment for drugs which are approved

by the hospital's pharmacy committee (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 administration.

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.

Hospital-Specialist Arrangements

Arrangements between the hospitals and the specialists who work with them regularly vary widely. Sometimes the specialist is on salary from the hospital. In other cases, the hospital and the specialist have agreed on a percentage division of gross or net receipts for the services, the arrangements with respect to authority for hiring and paying the nonmedical personnel, and the division of responsibility for equipment, supplies and other items.

The Administration proposal provides for reimbursing hospitals for X-ray and laboratory services to inpatient beneficiaries and for diagnostic tests furnished to outpatient beneficiaries, whether these services are furnished directly by the hospital or under arrangements made by the hospital. (With respect to outpatient diagnostic services provided under an arrangement, the services would be covered only if they are furnished in the hospital or a facility operated by or under the supervision of the hospital, with the hospital assuming professional responsibility for the services.) This provision is intended to pay the hospital for the same radiology and pathology services that are regularly furnished to all other patients (under whatever local arrangement may be) in the particular hospital.

The administration of anesthesia is carried out in part by anesthesiologists, in part by other physicians, and in part by nurse anesthetists who are hospital employees and who act under the supervision of the operating surgeons. Anesthesiology as a medical specialty is a recent development, and arrangements for providing the service vary widely. However, many accredited hospitals and some others assume responsibility for the availability of anesthesia service at all times, discharging this responsibility through an anesthesia department headed by one or more anesthesiologists who are on salary or, more frequently, under contractual arrangements with the hospitals. The Administration proposal would provide payment for the services of nurse anesthetists and also of those anesthesiologists who have assumed the responsibility for hospital service and who have agreed that the hospitals should collect the bills for their services.

Physiatry services, unlike radiology, pathology and anesthesia services, are available in only a limited number of hospitals--generally, those that have undertaken to provide an organized program of rehabilitation. Where such a program exists the physiatrist is ordinarily either on salary or under contract with the hospital and heads a department of physical medicine in which most of the services are rendered by lay technicians. Thus, in the typical situation where payments for the services of the physiatrist are made to the hospital, the Administration proposal would cover the complete service, both professional and nonprofessional, rendered by such a department. Generally, the coverage of physicians' services would occur in the four specialties in which the cost of the services is

generally treated as part of the cost of the hospital's services but the coverage would only be provided where receipt or payment by the hospital (either in its own right or as agent) discharges all liability for payment for such services. Thus physicians and hospitals would ultimately determine whether the service would be covered.

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 Administration plan 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 cut-off 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.

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.

The limitations 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. Under the proposal, as many as 240 home health visits could be paid for in a calendar year.

	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 2-4 bed room 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

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 costs 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 2 1/2 days of hospital care or the hospital's customary total charge for the services provided, whichever is less.

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 Administration plan 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 by-laws 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 by-laws 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 Administration proposal, 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 proposal, 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 on 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 proposal, 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 one week following the twenty-first 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 meets 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 proposal 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 proposal, 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, over-all 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 proposal 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 Administration proposal 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 Administration's proposal 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 principle 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 protection 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 proposal, 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.

FINANCING

To pay for the proposed hospital insurance benefits for persons under the social security system, the social security contribution rate would be increased by 1/4 of one percent each for employees and employers and 4/10 of one percent for the self-employed; the amount of earnings subject to contributions would be increased from $4,800 to $5,200 a year. The additional income to the program would be allocated for hospital insurance, except for that part of the income from the increased earnings base which would be allocated to pay for higher old-age, survivors, and disability insurance monthly benefits for persons earning over $4,800 a year. The amount of a social security benefit is based on the worker's average earnings covered under the program. With an increase in the covered earnings to $5,200, a worker's maximum monthly cash benefit would ultimately rise to $134 instead of $127 and the maximum family benefit to $268 instead of $254 as under present law.

The following examples illustrate the effect of the proposed changes in the contributions: A worker earning $2,400 a year would pay an additional $6 a year and a worker earning $4,800 an additional $12 a year. A worker earning $5,200 or more would pay an additional $27.50 a year, of which $17.68 would go for hospital insurance.

A corresponding increase would be made in the contribution rates under the Railroad Retirement Act to pay for the hospital insurance benefits for persons covered under that Act. The cost of the benefits for persons not insured under the social security or railroad retirement systems would be borne by general revenue of the Treasury.

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.

The income to the hospital insurance trust fund is estimated actuarially to meet the costs into the indefinite future. Estimated contribution income to the new trust fund for 1965 would total $1.4 billion and estimated expenses $1.0 billion. 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

The increases in social security contribution rates and in the amount of annual earnings subject to contributions would take effect on January 1, 1965. Benefits would be payable for covered hospital and related health services furnished after that date, except for skilled nursing facility services, for which the effective date would be July 1, 1965.

CONCLUSION

Very properly there has been considerable interest in the effect that a social security hospital insurance program would have on the quality of medical care. A number of our Nation's leading physicians and educators believe that, to the extent that it would have any effect on medical care, the proposed program would lead to medical care of higher quality.

In a statement issued by the Physicians Committee for Health Care for the Aged Through Social Security, these doctors made the following points:

> First, a health insurance program for the aged financed and administered through social security would greatly assist the aged to get better health care. The fear that a large hospital expense may be in the offing undoubtedly deters many older people from seeking needed care. Also, the patient's finances would be less a consideration in the physician's decision to advise hospitalization, post-hospital convalescence in a skilled nursing facility, home health services, or an expensive diagnostic series. By removing some of the economic deterrents to obtaining appropriate care, the measure would promote earlier utilization of health services.
>
> Second, the measure would be an incentive to improvement in the quality of care provided by nursing homes. About 40 percent of nursing home beds have been classified by States as unacceptable on the basis of fire and health hazards. Many other nursing homes provide inadequate nursing care. With participation in the proposed health insurance program open only to skilled nursing facilities with a hospital affiliation, those participating would serve as much-needed models for the improvement of other nursing homes.
>
> Third, the principle of free choice of institution would be made more meaningful, and continuous supervision of patient care by private physicians would be facilitated. The county hospital for indigents, with choice limited to county physicians, would no longer be the fate of many elderly people.
>
> Finally, by paying for the full, reasonable cost of the covered hospital services the elderly receive, the proposed program would put hospitals on a much more solid financial footing and make improvements possible that the hospitals now cannot afford.

This proposed program, of course, will not meet all the health insurance needs of our older people. It is, however, designed to meet the most pressing and most expensive health needs of our aged. It would still leave a substantial area for private responsibility and initiative.

We believe that hospital insurance for the aged will have an effect on private health insurance--a beneficial effect.

Insurance against the basic risk of hospitalization in old age under the social security system would enable private insurance to take advantage of these opportunities:

1. Supplemental and more comprehensive protection could be provided through private health insurance for older people who can afford it.

2. Private insurance would be able to sell more and better insurance programs for younger people--and the more younger people with voluntary health insurance coverage the more likely they would be in a position to continue voluntary protection when they become aged.

Pay-as-you-earn hospital insurance during a person's working years--whether public or private--is a sound way around the stubborn factor of high costs of health care in the high-risk, low-income years.

The Administration's proposed program would make it possible for individuals and their employers to pay in small sums during the working years--when they can best afford it--to provide insurance protection against the high costs of basic health services--at a time when aged individuals most need this protection and can least afford to obtain it solely through their own resources.

This program, in short, is a conservative and business-like approach to the problem with which it deals. It is a fiscally sound approach. It stresses individual responsibility and the contributory nature of insurance protection. It relates costs and benefits in the same package. And it does this in a way which stresses the complementary relationship of private and social insurance.

Hospital insurance under social security--reinforced by private savings and private health insurance and supplemented where necessary by medical care through public assistance--would together form a strong line of defense against the high cost of illness in old age.

Jill - ~~social security~~ medical & workfile

Draft statement for amendment to Social Security Act amendments bill

[1964?]

Mr. President, I have introduced an amendment to H.R. 11865, the so-called Social Security Amendments of 1964, which should cast a ray of hope on those Americans subject to the Old Age Assistance and Medical Aid for the Aged programs.

This amendment is very simple but very important for those it affects. It would permit the States to lower the age of eligibility for OAA and MAA from 65 to 62. Currently the Social Security Act fixes the age at 65.

Let me make it ~~perfectly~~ directly clear that this amendment does not affect Old Age and Survivors' Insurance benefits or Unemployment Insurance. It does affect the fate of those senior citizens who are beyond the full benefits of OASI and ~~beyond~~ unemployment insurance. The program is non-contributory; it is Federally-sponsored and State-administered with respect to both parts: Old Age Assistance, more commonly and crudely known as "relief," or public assistance and Medical Aid for the Aged, which was authorized under the Kerr-Mills Act.

These programs are familiar ones and they are programs which I am sure we all wish did not have to exist. But as long as they do exist, they should not ignore the needs of thousands of Americans between the ages of 62 and 65 who are constantly saddled with fixed incomes and higher costs of living.

Each State would continue to administer these programs in accordance with State law. They would be permitted, but not required, to lower the age at which persons may apply for Old Age Assistance or Medical Aid for the Aged. This means the minimum age under State law could be 65, 64, 63, or 62, but not lower.

This amendment is in keeping with the spirit of other proposed amendments to the Social Security Act, and it certainly lends a helping hand to those who are too old to find work, too poor to pay the bills, and too proud to beg.

88th CONGRESS
2d SESSION

H. R. 11865

IN THE SENATE OF THE UNITED STATES

Referred to the Committee on ..... and ordered to be printed.

AMENDMENT

Intended to be proposed by Mr. HUMPHREY to the bill (H. R. 11865)

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: At the end of the bill, add the following:

AMENDMENTS TO TITLES I AND XVI OF THE SOCIAL SECURITY ACT

Sec. 17. (a) (1) Subsection (a) of section 6 of the Social Security Act is amended by striking out "sixty-five years of age or older" and inserting in lieu thereof "aged individuals (as defined in subsection (d))".

(2) Subsection (b) of such section is amended by striking out "sixty-five years of age or older" and inserting in lieu thereof "who are aged individuals (as defined in subsection (d)) and".

(3) Such section is further amended by adding at the end thereof the following new subsection:

"(d) For purposes of subsections (a) and (b), the term 'aged individual', when applied with respect to individuals in any State, means an individual who has attained age 65, or if lesser, the age (which shall not be less than 62) fixed under or pursuant to the State plan of such State."

Amdt. No.

------ CONGRESS
------ SESSION } **H. R.**

AMENDMENT

Intended to be proposed by Mr.
to the bill (H. R.)

(L.C.-1961) U.S. GOVERNMENT PRINTING OFFICE 73158-h

(b) (1) Section 1601 of such Act is amended by striking out "65 years of age or over" each place it appears therein and inserting in lieu thereof "aged individuals (as defined in section 1605 (c))".

(2) Paragraph (14) of subsection (a) of section 1602 of such Act is amended by striking out "has attained age 65" and inserting in lieu thereof "is an aged individual (as defined in section 1605 (c))".

(3) (A) Subsection (a) of section 1605 of such Act is amended by striking out "65 years of age or older" and inserting in lieu thereof "aged individuals (as defined in subsection (c))".

(B) Subsection (b) of such section is amended by striking out "sixty-five years of age or older" and inserting in lieu thereof "aged individuals (as defined in subsection (c))".

(C) Such section is further amended by adding at the end thereof the following new subsection:

"(c) For purposes of this title, the term 'aged individual', when applied with respect to individuals in any State, means an individual who has attained age 65, or if lesser, the age (which shall not be less than 62) fixed under or pursuant to the State plan of such State."

(c) The amendments made by this section shall be applicable to calendar quarters (commencing January 1, April 1, July 1, September 1, or October 1 of each year) beginning the first calendar quarter which commences after the calendar quarter in which this Act is enacted.

UNITED STATES SENATE
OFFICE OF THE LEGISLATIVE COUNSEL

88th
2d

11865

HUMPHREY

11865

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Amdt. No.

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Jay B. Constantine
Research Director

United States Senate
Special Committee on Aging

6-233
~~182~~ Senate Office Building
Capitol 4-3121, Ext. 5364

Medicare.

United States Senate

MEMORANDUM

Ck w. the Larry Obrien
on this —

Bill Reedy
Li 4-5132 (Home)

[1964?]

SENATORS	SUBJECT	STAFF
Anderson, Pell, Ribicoff	Justification & technical defense of the Package	Cohen/Wolkstein
McNamara, Johnston Nelson	Need of the Elderly	Arner/Brewster
Randolph, Clark, Muskie, Williams, Neuberger	Inadequacy of Alternatives (Kerr-Mills; Blues; Commercial)	Livingston, Constantine, Fine
Douglas, McCarthy, Gore, Pastore	The Economics of Social Security and of the proposal	Ball/Myers
Young, Morse, Metcalf, Church	Attack on A.M.A.'s position	Cruikshank/Bamberger
McGovern, Burdick	Importance in Rural Areas	Sundquist
Long(Mo.) McIntyre	This the Conservative Way	

Other Senators to take overall approach, each emphasizing a different factor: Hart, Hartke, McGee, Yarborough, Bayh, Brewster

Check - Russ Long

[1964?]

Arguments Against Use of Blue Cross as Government's Agent in Proposed Hospital Insurance Program

1. Use of Blue Cross as the principal administrative agent in a national program is difficult to justify in view of the racial discrimination condoned by some of the Plans. For example, the Savannah, Georgia, Blue Cross Plan issues two Senior Citizens contracts--both at the same rates. One contract available to white subscribers provides coverage in four accredited hospitals. The other contract for negroes affords coverage in two unaccredited institutions.

2. There is validity to the idea of Blue Cross functioning as the agent of most of the hospitals participating in the program. Blue Cross is a creature of the hospitals. The Blue Cross symbol is franchised by the American Hospital Association and standards of approval for Plans are established and enforced by the American Hospital Association. Blue Cross boards of directors are dominated by persons directly or indirectly connected with the providers of health services (a subject of serious concern in a number of States).

   On the other hand, in view of hospital dominance of Blue Cross, there would appear to be a very definite conflict of interest in assigning that organization the job as the Government's agent in dealing with hospitals. It would certainly not be an objective agent whose primary interest and allegiance would be to the program.

3. Each Blue Cross plan has its own method of reimbursing hospitals for care provided to Blue Cross subscribers. These range from payment on the basis of charges to variations of reimbursement for actual or estimated costs. There are differences among plans as to which costs should be reimbursed -- for example, inclusion of research and nursing education expense as reimbursable cost items is a frequent subject of dispute. The point here is that each plan is committed to a particular pattern of reimbursement. The extent to which that commitment affects the ability of the plan to negotiate a different type of reimbursement contract in behalf of the Government program on an objective and impartial basis is an important question.

4. In the past, a number of Blue Cross plan directors have expressed strong opposition to a "medicare" program. Their "good faith" dedication to the success of the program would be subject to serious question. Despite all of the strong and sweeping statements of the President of the Blue Cross Association, Blue Cross is still a loose confederation of locally-oriented autonomous plans. Policies vary, reflecting local biases and methods of operation. These facts work against the uniformity and equality of treatment of beneficiaries which a Governmental program should insure.

None of the above criticisms could be leveled against the Social Security Administration if it administered the program. It is readily conceivable that the Public Health Service -- with its expertise -- could, in cooperation with Social Security, perform the functions envisaged for Blue Cross.

[1964?]

draft medicare

And there are other evidences that the problems of our older citizens are generally recognized.

They are even recognized, this year for the first time, by the American Medical Association.

You know, until the morning of November 4, 1964, the AMA had been telling the Congress for years that all the people over 65 were well-to-do. The mortgage was paid off, the sons were all corporation executives and the daughters were all married to doctors.

If the old folks got sick, all they would have to do was to pawn the Cadillac.

But on the morning of November 4, and a cold, bleak morning it must have been in the AMA headquarters, someone decided that this wasn't exactly the right approach. And so the line changed. What we get now is the AMA version of positive thinking. They call it "eldercare".

All of a sudden, the AMA isn't opposed to hospital and nursing home care for the elderly. No indeed. The AMA says it wants a lot more — payment for doctors' bills, and surgical expenses, and even drugs. And all of this for practically nothing in the way of taxes.

Well, I suppose we ought to be glad that the AMA finally admits that some of our older citizens have problems in paying the high costs of illness. That ought to dispose of one argument.

But unfortunately, the AMA hasn't really been converted. It got up when the organ started playing on November 3, but it hasn't been able to come down to the front and confess.

more

The AMA now proposes a bill that would authorize the states to give a wide range of benefits to older people in the lower income brackets.

I want you to pay attention to that word "authorize". What it means is that the states could do it if they felt like it -- and if they had the money. There are many states which -- with the best will in the world -- simply couldn't afford it. The experience under the Kerr-Mills program is clear and irrefutable proof.

So the states, then, would decide how much money they would spend on the program -- if they had any money to spend. And the states would also decide what size income is "lower". Now you know where this sort of thing can go. A state that sets a minimum wage of $1.25 a day for "experienced women workers" -- and that's the law in one state -- is likely to decide that anyone who makes $500 a year ought to be able to pay his hospital bills.

Let's go back to our experience under the Kerr-Mills law. In theory, this law provides hospital care for the impoverished old people. But the states have to put up the money; so you find that in, say, Kentucky, the maximum Kerr-Mills benefit is 10 days in the hospital. After that, you're out.

The AMA's so-called new proposal is simply Kerr-Mills warmed over. It doesn't guarantee a single day of care to a single citizen. And while it pretends not to apply a "means test," in the sense of a review of assets, it does tell the states to apply an income test ~~which in some respects is worse.~~

No, my friends, the AMA has not been converted; it is only sinning in a different direction. It is trying to shift the fight to a new front, in order to distract and confuse the American people.

I say this with genuine sorrow. As you know, I was raised in a pharmacy. I have a deep admiration for doctors and their profession. I feel a sense of personal affront when the trade association of doctors behaves in a way that casts discredit upon the most honorable of all callings, using tactics that would be considered unworthy by a cross-section of ward-heelers.

more

We have a medical problem — a health problem -- in this country, one that affects not only the citizens who have passed their 65th birthday, but all of us. It is not just a money problem, even though that is the most pressing part of it, for the elderly in particular. In the broader sense, our problem is to make available to all Americans the full benefits of modern medical science, in the form of readily-available, high-quality medical care.

Toward this end the AMA should be an ally, not an opponent. The issue is not the enrichment or the impoverishment of doctors. We don't see it that way, and neither should the AMA.

I hope the time will come when the AMA will sit down with us and seriously work out an approach to the real need — leaving all the slogans and gimmicks behind.

Maybe that day will come after this last, desperation gimmick called "eldercare" winds up in the trash basket with all the rest.

HH

[1964]

COMMITTEE ON FINANCE
UNITED STATES SENATE
Harry Flood Byrd, *Chairman*

BRIEF SUMMARY OF MAJOR PROVISIONS OF AND DETAILED COMPARISON SHOWING CHANGES MADE IN THE SOCIAL SECURITY ACT BY H.R. 11865 AS REPORTED BY THE COMMITTEE ON FINANCE

(Compiled by Education and Public Welfare Division, Legislative Reference Service, Library of Congress, at the Direction of the Chairman and Printed for the Use of the Committee on Finance)

U.S. GOVERNMENT PRINTING OFFICE
WASHINGTON : 1964

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SUMMARY OF MAJOR PROVISIONS OF THE BILL

Old-age, survivors, and disability insurance

I. Five percent across-the-board increase in insurance benefit payments

The bill would increase the insurance benefit payments under present law by 5 percent for all persons now on the benefit rolls and for all future beneficiaries.

Number of beneficiaries and effective date.—The increase would be effective for the 20 million beneficiaries on the rolls in their benefit payments which are due for the second calendar month following the date of enactment.

For the first full year, 1965, it is estimated that $925 million in additional benefit amounts would be paid as a result of this increase.

Workers, dependents, and survivors benefits.—Monthly payments for workers who have retired at age 65 would range from $42 to $133.40 for primary beneficiaries as compared with $40 to $127 under present law. Maximum primary benefits would range up to $143.40 for people who retire in the future as the increase in the earnings base, also contained in the bill, makes possible the counting of up to $5,400 (now $4,800) of annual earnings toward benefits along with the 5-percent increase in payments. Survivors and dependents benefits would also be proportionately increased.

Family maximum.—Under present law, the ceiling on the total amount of family benefits payable on a worker's earnings record ranges from $60 to $254 a month, depending on the worker's average monthly earnings. The bill raises the minimum amount of monthly benefits for a family to $63 and the maximum would be $281.20 at the $400 average monthly earnings level, which is the highest possible under the present $4,800 earnings base. In the future, maximum family benefit amounts up to $300 would be payable as the $5,400 earnings base which the bill provides becomes effective and average monthly earnings rise above $400.

(See p. 11)

II. Payment of benefits to certain aged persons

The bill would provide limited benefits for certain aged individuals (now in their seventies or older) who have some social security coverage but not enough to meet the minimum required by existing law.

A special provision would liberalize the eligibility requirements so that some aged people who do not meet the minimum work requirements in present law of six quarters could qualify for benefits on the basis of as few as three quarters of coverage. Upon attaining age 72 or older, a worker or widow who qualifies under these provisions would get a monthly benefit of $35; a wife who qualifies would get a benefit of $17.50.

Persons affected, benefits, and effective date.—These provisions would become effective for the second month after the month of enactment. It is estimated that 400,000 individuals will be added to the social security benefit rolls by this provision, with such benefits totaling about $160 million in 1965.

Men and women workers.—A new concept of "transitional insured" status under the bill would provide that the oldest workers will receive benefits with as little as three quarters of coverage. For those workers who are not quite so old, the quarters of coverage requirement would increase until the requirement merges with the present minimum requirement of six quarters.

The following table illustrates the operation of the "transitional insured" status provision for workers:

Transitional insured status requirements for worker's benefits

Men		Women	
Age (in 1965)	Quarters of coverage required	Age (in 1965)	Quarters of coverage required
76 or over	3	73 or over	3.
75	4	72	4.
74	5	71	5.
73 or younger	6 or more	70 or younger	6 or more.

To be eligible for benefits an individual must both (1) meet the above age and coverage requirements, and (2) have attained age 72.

A wife's benefit would be payable at age 72 to the wife of a worker who qualified for benefits under the transitional provisions if she attains age 72 before 1968.

Widows.—Any widow who is age 72 or over in 1965, if her husband died or reached age 65 in 1954 or earlier, can get a widow's benefit if her husband had three quarters of coverage. Present law requires six quarters. If the husband died or reached 65 in 1955, the requirement is four quarters. If he died or reached 65 in 1956, the requirement would be five quarters. If he died or reached 65 in 1957 or later, the minimum requirement would be six quarters, the same as present law.

For widows reaching age 72 in 1966 and 1967, there is a grading-in of coverage requirement of four or five quarters of coverage, respectively. Widows reaching age 72 in 1968 or after would be subject to the requirements of existing law of six or more quarters of coverage.

The table below sets forth the requirements as to widows:

Transitional insured status requirements for widow's benefits

Year of husband's death (or attainment of age 65, if earlier)	Present quarters required	Proposed quarters required for widow attaining age 72 in—		
		1965 or before	1966	1967
1954 or before	6	3	4	5.
1955	6	4	4	5.
1956	6	5	5	5.
1957 or after	6 or more	6 or more	6 or more	6 or more.

(See pp. 12–13.)

III. Payment of child's insurance benefits to children attending school or college after attainment of age 18 and up to age 22

The bill would provide for the payment of child's insurance benefits until the child reaches age 22, provided the child is attending public or accredited schools, including a vocational school, or a college, as a full-time student after he reaches age 18. Children of deceased, retired, or disabled workers would be included. No mother's or wife's benefits would be payable on the basis of a child who has attained age 18 but is in school.

This provision will be effective for the month following the month of enactment. It is estimated that 275,000 children would benefit in the total amount of $175 million under this provision in 1965.

(See pp. 8–9.)

IV. Benefits for widows at age 60

The bill would provide the option to widows of receiving benefits beginning at age 60 with the benefits payable to those who claim them before age 62 actuarially reduced to take account of the longer period over which they will be paid. Under present law full widow's benefits and actuarially reduced worker's, wife's and husband's benefits are payable at age 62.

This provision would be effective for months after the month of enactment. In the first full year, 1965, it is estimated that 180,000 widows will take advantage of this provision and receive $150 million in benefits.

(See p. 8.)

V. Coverage extensions and improvements

Employees of States and localities

(1) *Division of retirement systems:* Alaska and Kentucky would be added to the list of 17 States which may cover State and local government employees under the divided retirement system provision. This provision allows existing members to elect coverage, but future members are covered compulsorily.

(2) *Extension of time for election of coverage:* Another opportunity would be provided, through 1965, for the election of coverage by people who originally did not choose coverage under the divided retirement system provision.

(3) *Certain hospital employees:* Coverage would be extended to certain hospital employees in California whose positions were removed from a State or local government retirement system. (See pp. 5–7.)

Computation of self-employment income from agriculture.—The maximum amount of gross farm income which farmers have the option of using in computing covered farm self-employment income would be increased.

Under the provision, persons with agricultural self-employment would have the following option in reporting their earnings: (*a*) if annual gross income from agricultural self-employment is not over $2,400, either actual net earnings or 66⅔ percent of gross income may be reported; (*b*) if gross income from agricultural self-employment is over $2,400 and actual net earnings are less than $1,600, either actual net earnings or $1,600 may be reported; and (*c*) if gross earnings are more than $2,400 and net earnings are more than $1,600, the actual net earnings must be reported. Under existing law the $2,400 and $1,600 figures are $1,800 and $1,200, respectively.

This amendment would be effective with respect to taxable years ending after December 31, 1964.

(See p. 5.)

VI. Automatic recomputation of benefits

The retirement benefits of people on the rolls would be recomputed automatically each year to take account of any covered earnings that the worker might have had in the previous year that would increase his benefit amount. Under existing law there are various requirements, including filing of an application and earnings of over $1,200 in a year after entitlement.

(See p. 10.)

VII. Filing proof of support

The bill eliminates the time limit for filing proof of support with applications for dependent husbands, widowers, and parents benefits and for lump-sum death benefits if good cause can be shown for failure to file within the initial 2-year period.

(See p. 9.)

VIII. Financing provisions

Increase in the earnings base.—The earnings base which establishes the amount of annual earnings for benefit and tax purposes would be increased so that earnings up to $5,400 would be taxed and credited beginning with 1965. The annual base is $4,800 under present law.

Revision of the tax schedules.—Under the bill, the schedule of social security contribution rates would be modified as follows:

[In percent]

Year	Contribution rates			
	Employer and employee, each		Self-employed	
	Present law	H.R. 11865	Present law	H.R. 11865
1965	3.625	3.8	5.4	5.7
1966–67	4.125	4.0	6.2	6.0
1968–70	4.625	4.5	6.9	6.8
1971	4.625	4.8	6.9	7.2

Reallocation of contribution income between the trust funds.—Under the bill, an additional 0.15 percent of taxable wages and 0.1125 percent of taxable self-employment income would be allocated to the disability insurance trust fund bringing the total allocation to 0.65 and 0.4875 percent, respectively, beginning in 1965. A corresponding amount would be deducted from the allocation to the old-age and survivors insurance trust fund.
(See p. 14–15.)

IX. Relationship with railroad retirement system

The bill amends the Railroad Retirement Act so that the social security benefits increases in the bill will be reflected in the so-called social security minimum guarantees provision of the Railroad Retirement Act. The bill also provides for the payments of the railroad retirement child's benefit beyond age 18 but not after age 22 for full-time students in schools or colleges.
(See p. 15.)

X. Effect of benefit increase on veterans pensions

The increase in old-age, survivors, and disability insurance benefits provided by the bill will not be taken into account in determining the annual income of a veteran or his widow drawing a non-service-connected disability pension. (See p. 15.)

Public assistance

I. The bill would increase the maximum amount which will be matched by the Federal Government by $5 a month per individual in the State public assistance programs for the aged, the blind, and the disabled, and the combined aged, blind, and disabled program. The bill increases the matching maximum from $70 to $75 a month for the needy blind and disabled and an equivalent amount for old-age assistance where a special provision of $15 of medical matching in existing law brings the maximum to $90 a month. (See p. 16–19.)

II. The bill removes the prohibition in the public assistance medical programs for the aged against payments to persons in mental or tuberculosis institutions. (See p. 20.)

OLD-AGE, SURVIVORS, AND DISABILITY INSURANCE

I. COVERAGE

Item	Present law	H.R. 11865
A. Self-employed farm operators	*Covers* farm operators on the same basis as other self-employed persons except that farm operators whose annual gross earnings are $1,800 or less can report either their actual net earnings or 66⅔ percent of their gross earnings. Farmers whose annual gross earnings are over $1,800 report their actual net earnings if over $1,200, but if actual net earnings are less than $1,200, they may report $1,200. Rentals from real estate are not creditable as self-employment earnings, but if landlord undertakes with tenant or share farmer participation materially in the production of, or in the management of, the crops or livestock on his land, the income is covered.	Modifies exception so that farm operators whose annual gross earnings are $2,400 or less can report either their actual net earnings (if $400 or more) or 66⅔ percent of their gross earnings. Farmers whose gross earnings are over $2,400 report actual net earnings if over $1,600, but if actual net is less than $1,600, they may report either actual net earnings or $1,600. Effective as to taxable years beginning after Dec. 31, 1964. No change.
B. State and local government employees	*Covers* employees of State and local governments *provided* the individual State enters into an agreement with the Federal Government to provide such coverage, with the following special provisions: a. *States have the option* of covering or excluding employees in any class of elective position, part-time position, fee-basis position, or position performing emergency services. b. *Excludes* the services of the following persons, specifying that they cannot be included in a State agreement and cannot, therefore, be covered: (1) employees on work relief projects; (2) patients and inmates of institutions who are employed by such institutions; (3) services of the types which would be excluded by the general coverage provisions of the law if they were performed for a private employer, *except* that agricultural and student services in this category may be covered at the option of the State. c. Employees who are in positions covered under an existing State or local retirement system may be covered under State agreements only if a referendum is held by a secret written ballot, after not less than 90 days' notice, and if the majority of eligible employees under the retirement system vote in favor of coverage. However, except in 19 named States, employees in policemen and firemen positions under a State and local retirement system cannot be covered in the agreement. The Governor of a State or his delegate must certify that certain Social Security Act requirements under the referendum procedure have been properly carried out. In most States, all members of a retirement system (with minor exceptions) must be covered if any members are covered.	No change. No change. No change.

OLD-AGE, SURVIVORS, AND DISABILITY INSURANCE—Continued

I. COVERAGE—Continued

Item	Present law	H.R. 11865
B. State and local government employees—Continued	Employees of any institution of higher learning (including a junior college or a teachers' college and employees of a municipal or county hospital) under a retirement system can, if the State so desires, be covered as a separate coverage group, and 1 or more political subdivisions may be considered as a separate coverage group even though its employees are under a statewide retirement system. In addition, employees whose positions are covered by a retirement system but who are not themselves eligible for membership in the system could be covered without a referendum. Employees who are members or who have an option to join more than 1 State or local retirement system cannot be covered unless all such retirement systems are covered. Individuals in positions under retirement systems on Sept. 1, 1954, are precluded from obtaining coverage under the nonretirement system coverage provisions.	
	The 1960 amendments permit California to cover, before 1962, persons employed by a hospital in 1957, 1958, or 1959 in positions removed, after Sept. 1, 1954 and before 1960, from retirement system coverage for whom social security taxes were erroneously paid. Hospital employment before 1960 on which taxes were paid and all subsequent hospital employment of such persons could be covered.	Would modify provision so that service of persons first employed in such positions after 1959 would also be covered. Upon modification of agreement by the end of 6 months following the month of enactment, service performed on or after Jan. 1, 1962, would be covered. Services performed before Jan. 1, 1962, would be covered, if contribution in the proper amount was paid prior to date of enactment.
	Exceptions to general law concerning coverage in named States: (1) *Split-system provisions.*—Authorizes California, Connecticut, Florida, Georgia, Hawaii, Massachusetts, Minnesota, Nevada, New Mexico, New York, North Dakota, Pennsylvania, Rhode Island, Tennessee, Texas, Vermont, Washington, and Wisconsin, and all interstate instrumentalities, at their option, to extend coverage to the members of a State retirement system by dividing such a system into 2 divisions, 1 to be composed of those persons who desire coverage and the other of those persons who do not wish coverage, provided that new members of the retirement system coverage group are covered compulsorily. Also authorize similar treatment of political subdivision retirement systems of these States.	Adds Kentucky and Alaska to the list. Effective upon enactment.
	Those employees covered by a divided retirement system who did not elect coverage in the original agreement, may, nevertheless elect coverage until 1963, or, if later, until 2 years after the date on which coverage was approved for the group that originally elected coverage. Also provides that the coverage of persons electing under this amendment would begin on the same date as coverage became effective for the group originally covered. Also provides that where an individual who has chosen not to be covered under the divided retirement system provision becomes a member of a different retirement system group which has elected coverage because of the annexation of the employing political subdivision by another political subdivision, or through some other action taken by a political subdivision, such individual will continue to be excluded from coverage.	Extends the time in which such employees can elect to be covered until the end of 1965 (or, if later, the expiration of 2 years after the date on which coverage was approved for the group that originally elected coverage). Effective upon enactment.
	(2) *Policemen and firemen.*—Allows the States of 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 and all interstate instrumentalities to make coverage available to policemen and firemen in those States, subject to the same conditions that apply to coverage of other employees who are under State and local retirement systems, except that where the policemen and firemen are in a retirement system with other classes of employees the policemen and firemen may, at the option of the State, hold a separate referendum and be covered as a separate group.	No change.

II. BENEFIT CATEGORIES

A. Worker—old age	Full benefit payable at age 65 to fully insured retired worker. Payable at age 62 to fully insured retired worker, but on an actuarially reduced basis. Benefit is reduced by 5/9 of 1 percent for each month worker is entitled to receive a benefit before age 65—the total reduction is 20 percent if worker begins drawing benefits at age 62. The reduced amount is permanent, continuing after worker reaches age 65.	No change.
Reduction where individual is entitled to a wife's benefit and an old-age benefit.	In the case where a woman is entitled to a reduced old-age insurance benefit and at the same time or subsequently becomes entitled to a wife's benefit, the wife's benefit would be reduced by the dollar reduction which was applicable to the old-age benefit, plus the regular reduction amount on the excess of the unreduced wife's benefit over the unreduced old-age benefit. A similar provision is applicable to men entitled reduced old-age and dependent husband's benefit.	No change.
B. Wife or dependent husband	A full benefit for a wife or dependent husband is 50 percent of spouse's primary benefit. Full benefit paid at age 65. Payable at age 62 to a wife or dependent husband, but on an actuarially reduced basis. Benefit is reduced by 25/36 of 1 percent for each month prior to age 65. An individual who takes benefit at 62 receives 75 percent of full benefit.	No change

II. BENEFIT CATEGORIES—Continued

Item	Present law	H.R. 11865
C. Widow, widower, or parent	Full benefit payable at age 62 to widow, dependent widower, or surviving dependent mother or father of the insured worker. Full benefit is 82.5 percent of deceased worker's primary benefit. (75 percent each in case of two parents.)	Widows would be allowed to elect an actuarially reduced benefit upon attaining age 60. Benefits would be reduced by 5/9 of 1 percent for each month she is entitled to receive a benefit prior to age 62. Thus the reduction for a widow who elects a benefit when she attains age 60 would be 13⅓ percent for the 24-month period—reducing her benefit from 82½ percent of her husband's benefit to 71½ percent of his benefit. In the case of a widow who is entitled to an old-age benefit in her own right, the old-age benefit will be reduced to take into account widow's benefits paid to her before age 62. Effective for benefits beginning with month after month of enactment on the basis of applications filed in or after month of enactment. No change as to widowers and parents.
D. Children	A child's benefit is paid to child of the insured worker who has died, reached retirement age, or become disabled if the child is unmarried and either— (a) is under age 18, or (b) is under a disability which began before age 18. The benefit paid to a child of a retired or disabled worker is ½ of the workers primary benefit. The benefit to the child of a deceased worker is ¾ of the worker's primary benefit, except a sole surviving child is entitled to the minimum benefit of $40 a month.	Adds a 3rd qualifying alternative: (c) is age 18 or over and under age 22 if he is a full-time student. Permits a child whose benefits have terminated because he has attained age 18 to become reentitled upon filing a new application if he is a full-time student and has not attained 22. Provision would prevent a wife, widow, or former wife divorced from getting benefits if the only child in her care has attained 18 and is getting benefits solely because he is a student. *Student and institution defined:* A full-time student is defined as an individual who is in full-time attendance as a student at an educational institution; whether or not the student was in full-time attendance would be determined by the Secretary in the light of the standards and practices of the school involved. Specifically excluded is a person who is paid by his employer while attending school at the request of his employer. Provides for benefits for any period of 4 calendar months or less in which a person does not attend school if the person shows to the satisfaction of the Secretary that he intends to continue in full-time school attendance immediately after the end of the period. An educational institution is defined so as to permit the payment of benefits to students taking vocational or academic courses and includes all public schools, colleges, and universities and all accredited private schools, colleges, or universities. An accredited school would be one approved by a State recognized or nationally recognized accrediting association. The Secretary also would be authorized to prescribe regulations defining the standards for schools for which no accrediting body exists or which are newly established and which have not been in existence for a long enough period to qualify for approval or accreditation by an accrediting agency.
E. "Transitional insured" benefit for certain aged workers, wives and widows.	----------	Effective for months after month in which bill enacted on basis of applications filed in or after month of enactment. For children currently on rolls, effective for months following month of enactment. (See fully insured status, pp. 12–13.)
F. Proof of support by dependent husbands, widowers, and parents.	Dependent husbands, widowers, and parents must file proof of their support by the worker within 2 years after application for benefits or death of the worker, except that an additional 2-year period is allowed upon a showing that good cause existed for failure to file within the initial 2-year period.	Proof of support may be filed at any time upon a showing that good cause existed for failure to file within the intial 2-year period.

III. BENEFIT AMOUNTS

A. Creditable earnings	Maximum amount of earnings which may be credited for benefit purposes is $4,800 a year.	Raises maximum amount to $5,400 a year, effective for employee wages after 1964 and for self-employment income for taxable years ending after 1964.
B. Average monthly wage	In general, an individual's "average monthly wage" which determines his old-age insurance benefit amount (before reduction for retirement before age 65) is computed by dividing the total of his creditable earnings after the applicable starting date and up to the applicable closing date, by the number of months involved. Excluded from this computation are all months and all earnings in any year any part of which was included in a period of disability under the disability "freeze" (except that the months and earnings in the year in which the period of disability begins may be included if the resulting benefit would be higher). The average monthly wage in retirement cases is computed on the basis of a constant number of years, regardless of when, before age 22, the person started to work or when he files application for benefits. The number of years for a person who had at least 6 quarters of coverage after 1950 would be equal to 5 less than the number of years (excluding years in periods of disability) elapsing after 1950 or after the year in which the individual attained age 21, whichever is later, and up to the year in which the person was first eligible for old-age insurance benefits and had attained retirement age (65 for men; 62 for women). In death and disability cases the number of years would be determined by the date of death or disability. In those cases where a larger benefit would result (because the individual's best earnings were in years before 1951) the number of years would be those elapsing after 1936, rather than after 1950.	No change except: Worker may have average monthly wage computed entirely on years after 1950 regardless of whether he has 6 quarters of coverage after 1950, and may use closing date of the year of attainment of age 65 (62 for women) regardless of whether he is eligible (fully insured) in that year.

OLD-AGE, SURVIVORS, AND DISABILITY INSURANCE—Continued

III. BENEFIT AMOUNTS—Continued

Item	Present law	H.R. 11865
B. Average monthly wage—Continued	The earnings used in the computation are earnings in the highest years. Earnings in years prior to attainment of age 22 or after attainment of retirement age can be used if they are higher than earnings in intervening years. The span of years can never be less than 2. Generally, the span of years to be used for the benefit computation in retirement cases can not be less than 5—the number of years that would have to be used under the prior law by people who attained retirement age in 1960.	
C. Recomputations	After a person has become entitled to benefits, he may, under certain circumstances, have his "average monthly wage" recomputed if it will increase his monthly benefit: (1) Recalculation to correct errors in original computation. (2) 1954 work recomputation: Where an individual who has 6 quarters of coverage after 1950 returns to work after becoming entitled to benefits and earns more than $1,200 in a year he may have his average monthly wage recomputed including such earnings. Survivors are also entitled to any increase in benefits which would result from such recomputation. (3) Dropout recomputation: Beneficiary who became entitled to benefits prior to the amendment which allowed a dropout of 5 years of lowest earnings may have a recomputation using the dropout if he has 6 quarters of coverage after June 1953. Survivors are entitled to any increases which would result from such a recomputation. (4) Current year recomputation: An individual becoming entitled to benefits after August 1954 may have a recomputation which will include earnings in the year he retires if such earnings were not included in the original calculation. Survivors are entitled to any increases which would result from such a recomputation.	Provides for automatic annual recomputation; beginning with 1964, earnings in and after the year of 1st entitlement will be taken into account regardless of whether the worker has 6 quarters of coverage after 1950, or earns over $1,200, or files an application to have his benefits recomputed. Individuals eligible for a recomputation under present law would be deemed to have applied for such recomputation on Jan. 1, 1965 (so that it would be made automatically).
	(5) Recomputation of benefits at age 65 (the "round up"): If a reduced benefit has been withheld (most common reason would be earnings which caused benefit withholding under the retirement test) during the period of reduced benefit a person is entitled to a recomputation at age 65 which will readjust post-65 benefits to take into account the months in which the reduced benefit was withheld.	Provision also made applicable at age 62 to reduced benefits for widows who were aged 60–61 at time of claim.
	(6) Other recomputations: Provides several recomputations of limited application.	
D. Benefit formula	The law provides a consolidated benefit table which is used in determining benefit amounts for both future beneficiaries and those now on the benefit rolls. Though not specifically stated in the law the formula for the primary insurance amount is in effect, 58.85 percent of the 1st $110 of the average monthly wage, plus 21.40 percent of the next $290 of such wage (except that is some cases, for average monthly wages under $85, a slightly higher amount is payable so as to fit in with the minimum benefit).	The existing benefit table is amended so as to increase all primary insurance amounts by 5 percent. The existing benefit table is extended to reflect the new annual earnings base of $5,400 a year. For the resulting new average monthly wages (which run from $400 to $450 a month) primary insurance amounts are derived by applying the benefit formula underlying the old table and adding $6.40, which $6.40 is the same amount of increase for persons with average monthly wage of $400, the maximum under the existing table. The formula underlying the new table is approximately 61.79 percent of the first $110 of the average monthly wage, plus 22.47 percent of the next $290, plus 21.4 percent of the next $50.
E. Maximum primary insurance amount	$127 a month ($400 average monthly wage)	Increases to $133.40 ($400 average monthly wage) and eventually to $143.40 ($450 average monthly wage).
F. Minimum primary insurance amount	$40 a month	Increases minimum benefit to $42 per month.
G. Maximum family benefits	Family maximum monthly benefits are set by the table and range from $60 to $254. Though not specifically stated in the law, the maximum family benefit shown in the benefit table is 1½ times the primary insurance amount or approximately 80 percent of the average monthly wage, whichever is larger, up to an absolute maximum of $254—twice the maximum primary insurance amount of $127.	Family maximum will range from $63 to $300. Although not specifically stated in the bill, the formula used to determine the maximum family benefit shown in column V of the new benefit table is the larger of (*a*) 1½ times the primary insurance amount or (*b*) approximately 80 percent of the average monthly wage up to $300, plus 40 percent of the remainder of the average monthly wage. The $300 point at which the 40-percent part of the formula begins to operate is ⅔ of the maximum average monthly wage of $450. At the maximum average monthly wage of $450, the maximum family benefit would be ⅔ of the average monthly wage. (Because this new formula for determining the maximum family benefits would result in lower family benefits at a few earnings levels than under present law—namely, for average wages between $301 and $333—the present maximum benefits are retained at these earnings levels.) Effective for monthly benefits after the 1st month following month of enactment, for lump-sum death payments where death occurs after the 1st month.
H. Lump-sum death payment	3 times the primary insurance amount with a statutory maximum of $255.	No change.

III. BENEFIT AMOUNTS—Continued

I. Illustrative monthly benefits payable under present law and H.R. 11865:

Average monthly wage	Old-age benefits [1]				Survivors benefits				
	Worker		Man and wife [2]		Widow aged 62, widower, or parent		Widow aged 60 [3]	Widow and 2 children	
	Present law	Bill	Present law	Bill	Present law	Bill	Bill	Present law	Bill [4]
$67 or less	$40.00	$42.00	$60.00	$63.00	$40.00	$42.00	$36.40	$60.00	$63.00
$100	59.00	62.00	88.50	93.00	48.70	51.20	44.40	88.50	93.00
$150	73.00	76.70	109.50	115.10	60.30	63.30	54.90	120.00	120.00
$200	84.00	88.20	126.00	132.30	69.30	72.80	63.10	161.70	161.70
$250	95.00	99.80	142.50	149.70	78.40	82.40	71.50	202.50	202.50
$300	105.00	110.30	157.50	165.50	86.70	91.00	78.90	236.40	240.00
$350	116.00	121.80	174.00	182.70	95.70	100.50	87.10	254.10	260.40
$400	127.00	133.40	190.50	200.10	104.80	110.10	95.50	254.10	281.40
$450	[5]	143.40	[5]	215.10	[5]	118.40	102.70	[5]	300.00

[1] Worker aged 65 or over at time of retirement, and wife aged 65 or over at the time when she comes on the rolls.
[2] Survivor benefit amounts for a widow and 1 child or for 2 parents would be the same as for a man and wife.
[3] Not applicable under present law.
[4] For families on the benefit roll in the month after the month of enactment who are affected by the maximum-benefit provisions, the amounts payable under the bill would, in some cases, be somewhat higher than those shown here (namely, for the cases where the average monthly wages are $150 through $350).
[5] Not applicable since maximum average monthly wage possible is $400.

IV. FULLY INSURED STATUS

Item	Present law	H.R. 11865
	To be fully insured an individual must have either: (1) 40 quarters of coverage; or (2) 1 quarter of coverage (acquired at any time after 1936) for every year elapsing after 1950 (or after the year in which he attained age 21, if that was later) and up to the year of disability, death, or attainment of age 65 for men (62 for women), but with a minimum of 6 quarters of coverage; or (3) 6 quarters of coverage if individual died before 1951.	No change in regular provision but adds a new concept of— *Transitional insured status worker:* Adds a provision for a special insured status for individuals who have attained 72 so that the 6-quarter minimum is reduced to 3 quarters. The following chart shows the "transitional" requirement for workers as compared with the regular requirement of existing law:

Year of attainment of retirement age 62 (for women) or age 65 (for men)	Required quarters	
	Existing law	Proposed
1954 and earlier	6	3
1955	6	4
1956	6	5
1957	6	6

A worker who meets the above requirements (including attainment of 72) will be paid a benefit of $35 a month, and his wife a benefit of $17.50 at age 72 if she has attained age 72 before 1968.

Widows: Similarly the 6-quarter minimum would be reduced to insure certain workers who died (or attained age 65) before 1957 and whose widows have attained 72 or over by 1967. The quarters of coverage required will not be less than 3 and will vary with the year of the husband's death and the age of the widow. Widows who attain age 72 in 1965 or before would be eligible for benefits if their husband had 1 quarter of coverage for each year elapsing after 1950 and before the year of his death (or attainment of age 65, if earlier), with a minimum requirement of 3 quarters of coverage. Widows who attain age 72 in 1966 would be eligible for such benefits on the same basis except that the husband must have a minimum of 4 quarters of coverage, and similarly for widow attainments of age 72 in 1967, the minimum quarter-of-coverage requirement would be 5.

The following chart shows the "transitional" requirement for widows as compared with the regular requirements of existing law.

Year of husband's death (or attainment of age 65, if earlier)	Present requirements	Proposed special requirement for widow attaining age 72—			
		1965 or before	1966	1967	1968 or after
1954 or before	6	3	4	5	6
1955	6	4	4	5	6
1956	6	5	5	5	6
1957	6	6	6	6	6

Upon attaining age 72, an eligible widow will be paid a monthly benefit of $35.

Effective for monthly benefits for and after the second month following the month of enactment.

OLD-AGE, SURVIVORS, AND DISABILITY INSURANCE—Continued

V. RETIREMENT TEST

Item	Present law	H.R. 11865
A. Scope	Applies to covered as well as noncovered work	No change.
B. Test of earnings	Provides that benefits will be withheld from a beneficiary under age 72 (and from any dependent drawing on his record) at the rate of $1 in benefits for each $2 of annual earnings between $1,200 and $1,700 and $1 in benefits for each $1 of annual earnings above $1,700. Benefits not withheld for any month during which the individual neither rendered services for wages in excess of $100 nor rendered substantial services in a trade or business.	
C. Age exemption	Benefits are not suspended because of work or earnings if beneficiary is age 72 or over.	

VI. FINANCING

Item	Present law	H.R. 11865
A. Allocation between trust funds	The Federal old-age and survivors insurance trust fund receives all tax contributions other than those allocated for the disability benefit program, from which benefits and administrative expenses are paid for the old-age and survivors insurance program. The Federal disability insurance trust fund receives an amount equal to ½ of 1 percent of taxable wages plus ⅜ of 1 percent of self-employment income, from which benefit and administrative expenses are paid for the disability insurance program. These funds are administered by a Board of Trustees consisting of the Secretary of the Treasury, as managing trustee, the Secretary of Labor and the Secretary of Health, Education, and Welfare, all ex officio (with the Commissioner of Social Security as Secretary).	Provides that 0.15 percent of taxable wages and 0.1125 percent of taxable self-employment income that is allocated to the old-age and survivors insurance trust fund would be allocated to the disability insurance trust fund. Brings the total allocation to the disability insurance trust fund, for years beginning after 1964, to 0.65 percent of taxable wages and 0.4875 percent of taxable self-employment income.
B. Maximum taxable amount	$4,800 a year	Increases amount to $5,400 a year. Effective as to wages paid after December 1964 and self-employment income for taxable years ending after 1964.
C. Tax rate for self-employed	Taxable years beginning in— 1965 ... 5.4 1966–67 ... 6.2 1968–70 ... 6.9 1971 and thereafter ... 6.9	Provides changes in tax rates for employees, employers, and the self-employed which will add additional revenue to the system equivalent to 0.30 percent of payroll. In 1966–1970, however, tax rates are decreased over schedule in existing law. The ultimate rate schedule will be moved back from 1968 to 1971 and is higher than under existing law. Taxable years beginning in— 1965 ... 5.7 1966–67 ... 6.0 1968–70 ... 6.8 1971 and thereafter ... 7.2
D. Tax rate for employees and employers.	Calendar years: 1965 ... 3.625 1966–67 ... 4.125 1968–70 ... 4.625 1971 and thereafter ... 4.625	Calendar years: 1965 ... 3.8 1966–67 ... 4.0 1968–70 ... 4.5 1971 and thereafter ... 4.8
E. Railroad retirement tax	The Railroad Retirement Tax Act provides that the railroad tax will automatically adjust in the same amount, and at the same time, to any future change in the OASDI tax rate.	No change.

VII. MISCELLANEOUS

A. RELATED RAILROAD RETIREMENT BENEFITS

Item	Present law	H.R. 11865
1. Benefit increase	The social security minimum guarantee provision of the Railroad Retirement Act provides that a railroad retirement annuity shall in no case be less than 110 percent of the amount an individual would receive under social security if his railroad employment after 1936 had been subject to the Social Security Act. The guarantee applies also to spouses and survivors.	The 5-percent social security benefit increase contained in the bill would increase the railroad retirement benefits of those on the railroad retirement rolls whose benefits are now determined by the minimum guarantee provision, or would be so determined because of the social security benefit increase contained in the bill.
2. Child's benefits	In order to be eligible for a child's benefit under the Railroad Retirement Act, the child must be— (*a*) Under age 18, or (*b*) Under a disability which began before age 18.	The bill would make changes in the Railroad Retirement Act similar to those it would make in the Social Security Act, providing for payment of benefits to a child who is over age 18 but less than age 22 who is a full-time student.

B. RELATED VETERANS' BENEFITS

Item	Present law	H.R. 11865
1. Eligibility	The eligibility for and the amount of veterans' non-service-connected disability pensions are determined, after meeting other requirements, by the amount of an individual's annual income, including social security income.	The social security benefit increases provided by the bill would be excluded as income in establishing entitlement to, or amount of, veterans' non-service-connected disability pensions. The purpose of this amendment is to prevent certain VA pensioners from incurring a reduction in, or a complete loss of entitlement to, their pensions because of the social security benefit increases they would receive under the bill.

I. INCREASE IN FEDERAL MATCHING FORMULA

Item	Present law	H.R. 11865
A. Payments for old-age assistance, aid to the blind, and aid to the permanently and totally disabled, or the combined aged, blind, and disabled program.	Federal matching share is $29.00 of the first $35 (2/35 of the first $35) with variable matching on the amount above $35 up to a maximum of $70 per recipient per month. Variable matching for States whose per capita income is at or above the national average is 50 percent, while for States below the national average it varies up to 65 percent. The "Federal percentages" as promulgated for the period July 1, 1963, through June 30, 1965, are as follows:	Effective Oct. 1, 1964, Federal matching share is increased on permanent basis to $29 out of first $35 (2/35 of the first $35) up to a maximum of $75 per recipient per month.

State:	*Federal percentage*
Alabama	65.00
Alaska	50.00
Arizona	58.75
Arkansas	65.00
California	50.00
Colorado	50.00
Connecticut	50.00
Delaware	50.00
District of Columbia	50.00
Florida	60.69
Georgia	65.00
Hawaii	50.00
Idaho	65.00
Illinois	50.00
Indiana	52.06
Iowa	57.63
Kansas	56.63
Kentucky	65.00
Louisiana	65.00
Maine	65.00
Maryland	50.00
Massachusetts	50.00
Michigan	50.00
Minnesota	56.42
Mississippi	65.00
Missouri	50.45
Montana	59.69
Nebraska	55.10
Nevada	50.00
New Hampshire	56.38
New Jersey	50.00
New Mexico	65.00
New York	50.00
North Carolina	65.00
North Dakota	65.00
Ohio	50.00
Oklahoma	65.00
Oregon	50.00
Pennsylvania	50.00
Rhode Island	50.00
South Carolina	65.00
South Dakota	65.00
Tennessee	65.00
Texas	61.45
Utah	62.28
Vermont	64.75
Virginia	65.00
Washington	50.00
West Virginia	65.00
Wisconsin	52.50
Wyoming	50.00

(27 F.R. 9185)

Vendor medical payments.—For old-age assistance and for the combined aged, blind, and disabled program there is additional Federal matching as to medical vendor payments (i.e., payments directly to the providers of medical services) with respect to State expenditures for medical or remedial care, the larger of the following alternatives:

"Federal medical percentage" of vendor payment expenditures that are above $70 per month, up to $15 per recipient per month.

or

15 percent of vendor payment expenditures, up to $15 per recipient per month.

The "Federal medical percentage" is dependent on the relationship between State per capita income and the National per capita income. The percentage ranges from 50 percent for States at or above the national average to 80 percent for States with the lowest income. (See percentages, next page).

For States with average monthly payments over $70, the Federal Government participates at the rate of the "Federal medical percentage" in the expenditures over $70 except that such participation is limited to the amount of the average vendor medical payment up to $15 per recipient per month.

For States with average monthly payments of $70 per month or less, the Federal share in average vendor medical payments up to $15 per recipient per month is an additional 15 percentage points over and above the "Federal percentage" used to compute the Federal share of money payments.

Provision is also made that a State with an average payment over $70 per month can never receive less in additional Federal funds in respect to such medical service costs than if it had an average payment of $70 per month.

Permits Federal matching of State expenditures under all four public assistance programs for medical or remedial care furnished within 3 months before the month in which a person applies for assistance.

For those States which adopt the optional combined aged, blind, and disabled program the additional $15 matching for medical vendor payments will be applicable to the blind and disabled recipient under the combined program.

Formula also changed to reflect new matching maximum on assistance payments of $75.

Formula is restated so that amounts in which the Federal Government participates at the "Federal medical percentage" are counted before those in which participation is at this "Federal percentage".

I. INCREASE IN FEDERAL MATCHING FORMULA—Continued

Item	Present law	H.R. 11865
B. Payments for aid to dependent children.	For money and medical vendor payments the Federal share is $14 out of the first $17 (14/17 of the first $17) per recipient per month with variable matching on the amount above $17 up to a maximum of $30 per recipient per month. Variable matching for the States is at the same percentages as old-age assistance money payment matching.	No change.
C. Payments for medical assistance for the aged.	The Federal share of expenditures for medical vendor payments is based on a variable matching formula which runs from 50 percent for States at and above the national per capita average up to 80 percent for the lowest per capita income States. Federal matching of State expenditures for medical or remedial care furnished within 3 months before the month in which a person applies for assistance is permitted. The Federal share (the Federal-medical percentage) for each State is as follows:	No change.
	Federal-medical percentages applicable for July 1, 1963 through June 30, 1965.	No change.
	State: — *Percentage* Alabama — 78.29 Alaska — 50.00 Arizona — 58.75 Arkansas — 80.00 California — 50.00 Colorado — 50.00 Connecticut — 50.00 Delaware — 50.00 District of Columbia — 50.00 Florida — 60.69 Georgia — 73.69 Hawaii — 50.00 Idaho — 67.43 Illinois — 50.00 Indiana — 52.06 Iowa — 57.63 Kansas — 56.63 Kentucky — 75.27 Louisiana — 73.46 Maine — 65.65 Maryland — 50.00 Massachusetts — 50.00 Michigan — 50.00 Minnesota — 56.42 Mississippi — 80.00 Missouri — 50.45 Montana — 59.69 Nebraska — 55.10 Nevada — 50.00 New Hampshire — 56.38 New Jersey — 50.00	
	New Mexico — 66.55 New York — 50.00 North Carolina — 74.99 North Dakota — 73.03 Ohio — 50.00 Oklahoma — 65.65 Oregon — 50.00 Pennsylvania — 50.00 Rhode Island — 50.90 South Carolina — 80.00 South Dakota — 68.87 Tennessee — 75.53 Texas — 61.45 Utah — 62.28 Vermont — 64.75 Virginia — 65.05 Washington — 50.00 West Virginia — 71.76 Wisconsin — 52.50 Wyoming — 50.00 Guam — 50.00 Puerto Rico — 50.00 Virgin Islands — 50.00 (27 F.R. 9230.)	
D. Special formula for Puerto Rico, Virgin Islands, and Guam.		
1. Matching formula	Federal matching on a 50–50 basis on both money and vendor medical payments up to a maximum of $37.50 a month times the number of recipients on the old-age, blind, and disabled program with a maximum of $18 a month times the number of recipients on the program of aid to families with dependent children. Additional matching for vendor medical expenditures is available for up to $7.50 per month per recipient on old-age assistance or on the combined aged, blind, and disabled program rather than the additional $15 per month per recipient which applies to the States and the District of Columbia.	No change.
2. Dollar limitation	Total Federal payments for all 4 public assistance programs may not exceed— Puerto Rico — $9,800,000 Virgin Islands — 330,000 Guam — 450,000 In each case a portion of these amounts is only available if used to provide additional medical vendor payments on behalf of assistance recipients: Puerto Rico — $625,000 Virgin Islands — 18,750 Guam — 25,000 Federal payments for programs of medical assistance for the aged are excepted from dollar limitation provision.	No change.

PUBLIC ASSISTANCE—Continued

II. MENTAL AND TUBERCULOSIS EXCLUSION

Item	Present law	H.R. 11865
Exclusion of payments to, or on behalf of, aged persons in mental or tuberculosis institutions.	For cash payments on old-age assistance or for the combined aged, blind, and disabled program Federal matching will not be made as to patients in mental or tuberculosis institutions or in other medical institutions where the patient has a diagnosis of psychosis or tuberculosis. Same exclusion from Federal matching for vendor payments under medical assistance for the aged, old-age assistance, and combined program for persons in mental or tuberculosis institutions, but matching allowed for vendor payments for first 42 days for persons with a diagnosis of psychosis or tuberculosis in other medical institutions.	Eliminates all tuberculosis and mental exclusions as to persons age 65 and over.

○

[1964?]

Present discussion of a "medicare" amendment has centered around the offering of a flat 45-day hospital insurance benefit as an option to an increase in monthly cash benefits. The program described on the following page is, however, a sounder proposal medically, economically, and politically than the "45-day" option. This new proposal -- essentially derived from the McNamara bill (S. 65) -- is preferable because:

1. Cost is slightly lower than the "45-day" plan.

2. It offers a comprehensive range of benefits -- hospital, skilled nursing home, home health services, and out-patient diagnostic -- rather than just hospital care. The types of benefits included are precisely those which have been discussed during the past several years and which the elderly have been led to anticipate.

3. Senator Javits has indicated that he intends to offer as amendments one or both of his health insurance bills. Both bills offer a broad range of coverage. It would be difficult for the Democrats to demonstrate that a "45-day" hospital benefit, by itself, is in any way superior to the Javits' measures. On the other hand, the Democrats can make a much stronger case for the proposal described on the attachment.

4. If it were deemed advisable at some future time to expand a health insurance program for the elderly, it would be much simpler to extend an existing benefit than to establish a new benefit.

5. The skilled nursing home and home health service benefits are provided under more liberal definitions than those in the King-Anderson bill -- meeting objections which were raised to the effect that the King-Anderson benefits would be available on an extremely limited basis only.

6. Assuming that it is desirable to vest overall control of the program with an agency of the Federal Government rather than with a private organization such as Blue Cross, it would be easier to justify such control where different types of benefits were provided than if hospital care were the only item. Blue Cross does not have meaningful experience with non-hospital benefits and it could be argued that conflicts of interest might arise if Blue Cross were given responsibility for the non-hospital benefits.

7. King-Anderson and related measures are essentially designed as short-term care programs. The 30-day hospital benefit under the proposal described on the following page is consistent with this objective because: (1) it would cover 90 percent of all short-term hospital stays and (2) a long-term hospital is defined as one where the average length of stay exceeds 30 days.

1. Maximum of 45 units of coverage during benefit period:

hospital day	- 1 unit
skilled nursing home day	- ½ unit
home health visit	- ¼ unit

2. Limits on specific benefits during a benefit period:

hospital care	- 30 days
skilled nursing home	- 60 days
home health visits	- 120 visits

NOTE: Under the provisions of "1" and "2" an individual could receive 30 hospital days and 30 skilled nursing home days (45 units); 15 hospital days and 60 skilled nursing home days (45 units) or similar combinations of benefits not to exceed 45 units.

3. Outpatient diagnostic services would be covered on the same basis proposed in King-Anderson and the McNamara bill and no unit charge made for such services.

4. Skilled nursing home care and home health visits would be paid for only following hospitalization. Benefits would be provided in facilities and on the basis outlined in the McNamara bill (S. 65).

5. A "benefit period" would be as defined in the King-Anderson bill.

AMERICAN FEDERATION OF LABOR AND CONGRESS OF INDUSTRIAL ORGANIZATIONS

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815 SIXTEENTH STREET, N.W.
WASHINGTON 6, D.C. NATIONAL 8-3870

January 23, 1964

RECEIVED
JAN 24 1964

Dear Friend:

There is enclosed for your information a copy of the statement presented by President George Meany on January 20th to the House Ways and Means Committee, in support of Health Care for the Aged Through Social Security.

Sincerely yours,

Nelson H. Cruikshank
Director
Department of Social Security

Enclosure
NHC:fg
oeiu #2 afl-cio

John - Do we want this to go in The Record?
Wm

STATEMENT OF GEORGE MEANY, PRESIDENT
AMERICAN FEDERATION OF LABOR AND CONGRESS OF INDUSTRIAL ORGANIZATIONS
BEFORE THE HOUSE WAYS AND MEANS COMMITTEE
ON
HOSPITAL INSURANCE FOR THE AGED THROUGH SOCIAL SECURITY

January 20, 1964

Mr. Chairman, my name is George Meany. I am president of the American Federation of Labor and Congress of Industrial Organizations, and I am appearing here on behalf of that organization.

This statement was originally scheduled for November 26 and it was postponed when this Committee interrupted the hearings after the tragic assassination of President Kennedy. This is a measure which was close to the heart of our late President. It seems to me fitting indeed that it is the first piece of major legislation to be considered by this Committee in the second session of the 88th Congress. I trust, I hope, I pray it will be adopted by this Congress.

I am going to try to present our case in terms of people, with a minimum of statistics. All the statistics are already in the record. This is a human issue; that is the way President Johnson views it as he told the Congress in his State of the Union Message, and that is exactly the way we look at this matter too.

More than six years have passed since Congressman Forand rose in the House of Representatives to introduce the bill which was the prototype of the one you are presently considering. From the very beginning, this idea -- health insurance, and primarily hospital insurance, for the aged as part of the social security and railroad retirement systems -- had the warm support of the labor movement. We said then, and we say now, that this is the kind of program we must have to round out our social security concept -- to plug up its biggest loophole.

In the beginning, there were many who honestly disagreed with us. Some of them did not realize the scope of the problem. Others believed -- or at least hoped -- that it could be met by other means. But by now, the facts are clear.

First of all, the scope of the problem is no longer in dispute. The largest single share of the credit for clarifying this point -- for making the nation aware of how widespread the need really is -- belongs to the hearings of this Committee in 1959 and 1961, reinforced by the proceedings of last November and this week. I acknowledge that fact even though we have been disappointed, up to now, in your evaluation of the material placed before you.

In addition, there were Senate Finance Committee hearings in 1960, and the White House Conference on Aging in 1961. These, like your hearings, offered the fullest opportunity for the presentation and discussion of every shade of opinion, and every piece of relevant data.

So it is now agreed that the aged get sick oftener, and for longer periods of time; that they require much more institutional care; and that they have much less money to meet the costs of illness. There is no real dispute about that.

The only things that have happened in this respect, in the last six years, are that the number of aged has increased; that the cost of hospital care has risen far faster than their incomes; and that their life expectancy has been lengthened. In other words, they are worse off now than they were six years ago when it comes to the threat of a catastrophic illness.

Second, there is now a broad range of experience with alternative remedies, both public and private. Let us see what that experience has been.

There are only two basic proposals that have been offered as alternatives to the social security approach. One is private insurance, commercial or nonprofit. The second is public assistance, or as it was generally known 30 years ago, public relief. I will discuss them in that order.

Your Committee is well aware that private insurance companies have reacted violently to the social security proposal. They began by claiming that the federal government was cutting into their business.

Then, after it was pointed out that they had let this particular section of their business go by default, they began promoting -- with great fanfare and high-priced advertising -- a whole range of health insurance policies for the aged. This latter process is still going on.

Speaking for myself, and I am sure for the great majority of Americans, I would be delighted if these private plans could meet the need. We do not want a federal plan for its own sake. We do not have any ideological stake in extending the operations of the government. On this issue, as on others, we press for government action only when other means have proved to be inadequate.

Such is the case here. I am willing to assume that the insurance companies have made a sincere effort; but the actuarial facts doomed them to failure. The nature of the problem, as I described it earlier, makes it impossible for any

commercial insurance carrier or nonprofit health plan to devise a policy that will adequately protect the aged, at a cost they can afford to pay.

The proof of this lies in the policies now on the market. Let us look behind the inviting headlines on their advertisements and see what they really offer.

About half of all the aged who hold commercial health insurance are covered by one of two policies -- Continental Casualty 65-Plus or Mutual of Omaha Senior Security. These policies did cost $78 and $102 a year, respectively, for each insured person. Continental has now announced that effective next week the rates for its policy will be hiked by 23 percent. It will now cost $98 per year. While even these amounts would be burdensome to many of the aged, they are admittedly within the reach of many others.

But what do they get for the money? They get hospital room and board payments of $10 a day -- for a maximum of 31 days in one case, and 60 days in the other. Yet the average daily charge for semi-private hospital accommodations is $20 nationwide, and exceeds $35 a day in some cities.

This means that a Continental Casualty policyholder who was unlucky enough to be hospitalized for 45 days -- not an unusual length of time for an older person -- would have to pay 66 percent of the room and board out of his own pocket, assuming the average rate of $20 a day. That would amount to $590. And if he happened to live in Cleveland, Los Angeles or San Francisco, which are among the higher-cost cities, his personal share would be more than 80 percent.

Is this insurance? It may be better than nothing -- but not by much.

If you look at the other lower-cost policies on the market, you find just about the same terms. So let us turn to the insurance plans that offer the aged a more realistic degree of protection. The best place to start is with Blue Cross.

About two years ago, Blue Cross announced that it would soon offer a new, nationwide plan of hospital insurance for the aged. Since Blue Cross, in the mind of the average American, is practically synonymous with hospital insurance, this sounded very promising. And even though the details were vague, it was widely hailed by the press.

But as I am sure you know, Mr. Chairman, no such national plan ever materialized. Nothing more was ever heard about it. Instead, about a year later, there was another big public announcement. This one began with half-page advertisements

in the major national magazines -- Life, Look, Time, Newsweek, the Post -- and similar displays in newspapers. These ads proclaimed that a "senior citizens' program" would soon be available in each Blue Cross area.

It is true that eventually, 73 of the 77 local Blue Cross plans did offer some sort of nongroup contract to the aged. However, only 30 of these 73 plans offered the traditional Blue Cross service benefits for semi-private accommodations. Even in these cases, such provisions as the length of the benefit period are generally below ordinary Blue Cross standards.

Moreover, these plans -- available, as I said, in less than half of the Blue Cross areas -- are not cheap. The annual premiums exceed $200 a year per couple, and are rising. And this figure, let me stress, is for hospitalization alone. It does not include any medical benefits. In a relative sense, the 30 fairly adequate Blue Cross plans are a "best buy" among the private insurance policies, but in this field, their best is not good enough.

The proof is in the enrollment figures of Blue Cross itself. Before these new plans were devised, Blue Cross coverage of persons 65 or older was increasing on the average of 35,000 a month. In the 13 months since the plans were offered, the increase has been only 16,000 a month. This is less than the number of persons who reach 65 each month. And it can be taken for granted that a considerable part of the increase represents people already covered by Blue Cross, who reached their 65th birthday and continued their existing coverage.

The same facts as to cost and acceptance are ture, to an even greater degree, of the State 65 plans, which combine hospital and medical coverage. These plans cost, per couple, $456 a year in New York and Texas, and $420 a year in Massachusetts. Connecticut -- where the first such plan was started -- had an initial rate of $408 a year. But its losses have been so substantial that it is seeking an 18 percent rate increase, which would bring the premiums to $480 a couple, or $240 for a single person. The reason was simple -- it was paying out, according to its chairman, $1.05 in claims for every $1.00 collected in premiums. Now that its request for a rate increase has been denied by the State Insurance Commissioner, the fate of the Connecticut plan is a matter for speculation.

But even in the unusual circumstances where the insurance companies bear some of the losses, very few of the aged can afford to purchase reasonable protection. According to a report to the Society of Actuaries, and I quote:

"State 65 plans have experienced abnormally high lapse rates in the early months of their operation. Intensive sales campaigns based on emotional appeal undoubtedly encouraged many to commitments beyond their financial resources."

Even allowing for the effects of salesmanship, less than 8 percent of the aged in Connecticut, Massachusetts and New York have enrolled in State 65 plans.

What it comes down to is that the aged who are in the greatest need of protection do not have it. Here, reluctantly, I must offer a few more figures:

58 percent of the retired aged have no health insurance.

67 percent of the aged in families with incomes of less than $2,000 a year have no health insurance.

68 percent of those 75 years of age and over have no health insurance.

70 percent of the aged who are idle because of chronic conditions have no health insurance.

There is no reason to expect these figures to change to any great degree under present circumstances. These are the poorest sales prospects for private insurance -- the worst health risks with the least money.

Since I am sure that the insurance company actuaries are able, hard-headed men, it is hard to understand why the industry keeps insisting it can do a job which its own figures must prove to be impossible. I have reluctantly concluded that there is a political motive involved.

A few moments ago, I quoted an Actuary's reference to "intensive sales campaigns." Since the Members of this Committee follow developments in the field with at least as much care as we do, there is no need to belabor the point. I referred earlier to the Blue Cross advertising; it has since been far exceeded by the various commercial companies. In view of the insignificant effect all this has had on the problem itself, it would seem that the chief beneficiaries have been advertising men and publishers. They are not the ones who need the help.

What makes us suspect a political motive is the timing of these advertising campaigns. They have been heaviest, as a rule, just before elections, or at times when the social insurance proposal was under active discussion in Congress. In 1962, for example, we were actually informed in advance, by a source inside the insurance industry, that a national campaign was being planned for the period just before the Congressional elections. That is exactly what happened.

Are these campaigns really designed to sell insurance to the aged? Or are they designed as propaganda to influence the political attitude of Congress and the American people?

Let me repeat, we are not opposed to private health insurance, sold by either the commercial carriers or Blue Cross. On the contrary, we believe it has a great future, a great role to play, in protecting the aged. But we do say, and the record proves it, that private insurance cannot do the whole job.

I am not implying that some of the aged should be protected by a federal program and that others should be left to the private companies. That would be completely unsound. Inevitably, the private companies would siphon off the people in the best health, leaving the bad risks to the government. And that is not the only objection.

Take the proposal advanced by Congressman Bow, which would give the aged a tax credit for private insurance premiums. This is simply a device through which the government would use its power and its administrative machinery to collect funds, and then turn these funds over to a private agency which has demonstrated its inability to deliver for the money the kind of protection the elderly need.

No, the line between government and private insurance for the aged cannot be drawn on the basis of people; it must be drawn on the basis of function.

For that reason we were greatly pleased by the report of the National Committee on Health Care of the Aged, some of whose members, I believe, are appearing before this Committee. The unanimous agreement on this very point by a bi-partisan group of 12 distinguished experts has, we are sure, helped a great deal to clarify the issue. While we may not agree with every detail of the Committee's report, we urge you to give it the most serious consideration. I might note, in passing, that the AFL-CIO Convention last November commended the National Committee for its work, and also asked that its report be included in the proposals your Committee is studying.

The National Committee's report may be too optimistic in estimating what private insurance can do. But it is clear and categorical on what private insurance can <u>not</u> do. On this, we are in full accord.

There must be, as a minimum, a universal system of hospital insurance, covering all those who reach 65. And this system can only be made feasible, in

terms of both costs and benefits, if it is financed by contributions collected from people during their working years.

Building on that minimum, the aged can individually, according to their means, buy private insurance covering medical and surgical expenses; or even, if they choose, supplementary hospital benefits.

This, as we have been saying for years, is precisely the way that public and private protection are linked together in retirement programs and, more recently, in supplementary unemployment benefits. The social security pension system was the best thing that ever happened to the private insurance industry, though they fought it bitterly. Hospital care for the aged, as an extension of social security, may prove even more rewarding. We have repeatedly experienced this ironical turn of events since 1933 -- that those who most stubbornly oppose social progress wind up by making money from it.

So much for private insurance. Now let us examine the second approach that some suggest as an alternative to the King bill -- public assistance, or relief.

In 1960, the distinguished Chairman of this Committee and the late Senator from Oklahoma joined in creating, and causing to be enacted, the Kerr-Mills bill. This contemplated a vastly expanded program of health care for the aged who are unable to pay the costs themselves. There were many, besides the sponsors, who sincerely felt that this would solve the entire problem. Their hopes have been disappointed.

Shortcomings have developed which the supporters of the bill surely did not anticipate. I will not recite the statistics, for they are already in the record. They demonstrate that only a fraction of the needy aged receive assistance; and that benefits depend less upon a person's need than upon the State where he happens to live when the need arises.

Much of this is due, of course, to the failure or inability of the States to provide their share of the funds, to establish proper benefit standards and to set up adequate administrative machinery. But these handicaps are likely to be permanent, and since they reflect the policies of the various State governments, they cannot be overcome by Congress except through further legislation.

Even more important, it seems to us, is that the public assistance approach, when looked upon as the <u>only</u> program for helping the aged to meet the costs of

illness, puts a premium on indigence. It does nothing to meet the genuine dilemma of the retiree, whose income is enough to sustain him under ordinary conditions, but who can neither afford to pay for a severe illness, nor afford to pay for a private insurance policy that will give him a realistic degree of protection.

Many of you know from personal experience, as I do, that the great majority of these pensioners are proud of their independence -- proud that they have earned it. Yet when a severe and costly illness strikes, that pride and independence can be destroyed overnight -- not to mention the modest store of personal goods, the little luxuries, accumulated by a lifetime of honest work.

But let me make it clear -- and I want to emphasize this -- that we are not opposed to the Kerr-Mills Act. We do oppose it as a <u>substitute</u> for the King bill. We welcome it as a <u>supplement</u> to the King bill.

And contrary to the charge that has been levelled in some quarters, the labor movement has not tried to impede the passage of enabling legislation in the States. The truth is exactly the opposite. Since Kerr-Mills is all we have, we have done our best to make it work. Every State Central Body has been instructed to that effect since 1960. And the record shows that in general, the States where organized labor is strongest are the States which have done the most under the Kerr-Mills program. Among the first States to implement Kerr-Mills, for example, were Michigan, Massachusetts and New York.

We believe Kerr-Mills could be transformed into a very effective piece of social legislation by one simple action -- passage of the King bill. With the major share of the burden -- hospitalization -- met by social insurance, the States could afford to operate meaningful Kerr-Mills programs for those with residual needs.

In short, our attitude toward Kerr-Mills is very much like our attitude toward private health insurance. Both are welcome; both are needed; both will function effectively in conjunction with the kind of basic protection the King bill would provide.

I would like to say just a few words about financing -- the increase in social security taxes that would finance this program. Opposition to the King bill based on this point takes two different lines.

The first is that the American people in general, and workers in particular, will "revolt" against higher social security taxes. This is one of the enduring myths of our time.

We in the labor movement have been pressing for improvements in the social security system since it first came into being. We have been pressing for this particular improvement for six years. And in every statement, every speech, every leaflet, we have always been careful to say what the cost will be to workers, both the average and the maximum amounts.

The American Medical Association, the insurance industry and certain candidates for public office have all complained about this terrible tax burden we were trying to saddle on wage-earners. Even some of our liberal friends have expressed concern about it. Almost everyone seems to be worried but the workers themselves.

True, we hear from union members about this legislation. I assure you that Congressmen are not the only ones who get mail from their constituents. Our members complain about the deductibles. They complain that there is no surgical coverage. They say there ought to be more emphasis on preventive care. All they say about money is that we're not asking for a high enough tax to pay for these other things.

I have never had a letter from a union member protesting against social security taxes. There are very few issues -- possibly no other issues -- about which I could make such a statement.

It seems that workers have somehow mastered an economic point that has escaped a good many others, including some with higher educational status. They know that old-age security -- whether pensions or health care -- has to be paid for. And they are convinced that the best way to do it is in a working lifetime of small installments.

Where social security is involved, they have reversed the slogan of the travel agencies. They want to pay now and fly later.

We had an illustration of this about 10 years ago when, as many of you will remember, it was proposed to cancel a scheduled increase of one-half percent in the social security tax rate. Such an outcry arose that the proposal was quickly shelved. Workers remembered what had happened when the 1939 rates were frozen, and they had no desire for another 11 years of "bargain" taxes and cut-rate benefits.

No, there will not be a worker revolt against higher social security taxes. What workers want from social security is more benefits -- and they are perfectly willing to pay for them.

The other argument based on taxes is that an increase in social security rates is inconsistent with the need for general tax reduction, especially with respect to low incomes.

In the first place, the two tax changes will cancel each other out for only a relatively small minority of taxpayers. Under the tax bill which this Committee wrote and which has passed the House, a married couple with two dependents, earning $4,000 a year and using the standard deduction, would get an income tax cut of $100. The social security tax would rise only $10. A couple with three dependents and an income of $6,000 would show a net tax savings of about $115 using the standard deduction, and about $58 even under the average itemized deduction. The figure for the $6,000 family also includes, of course, their increased payments for pension benefits that will be caused by the higher earnings base effective January 1.

But aside from this, social security taxes are not like other taxes. They are linked directly to specific benefits. And they actually have the effect of increasing, rather than reducing, the purchasing-power of those who pay them.

A householder who knows his pension rights are assured does not need to put aside additional money for the same purpose. He can feel more free to buy the new washing machine, the new television set, the new car or even the new house. Hospital insurance will have the same effect.

So it seems to me that there is no merit whatever in the charge that social security taxes are deflationary. By guaranteeing, at least to some degree, the security of those who pay them, they release far greater sums into the consumer market.

Now, Mr. Chairman, let me turn again to the people directly involved in this legislation.

I do not mean just the old people; although we know that the major reason behind one-third of the new cases that go on the relief rolls each year is medical expenses.

I am not talking about the aged alone, although we know that more people were forced onto relief by medical expenses in 1962 than were ever struck, in any one year, by paralytic polio.

We all get polio shots. We are all in favor of preventive medicine. We have our children inoculated against smallpox, and diptheria, and whooping cough, and

scarlet fever, and measles -- even, sometimes, against poison ivy. But we shy away from the legislative inoculation that could prevent the dreadful plague of dependency that results from catastrophic medical costs in old age. But this is not only the problem of the aged. It is the problem of the young, too, and the middle-aged.

What happens when an elderly, retired person, of modest means, becomes seriously ill?

The first call goes out to his children. That is natural enough; the family is still at the heart of our society.

And the children, in most cases, are willing to do whatever they can to help out. But generally they are not children any more -- not in a chronological sense. They are men and women of 35, or 40, or 50. They have their own lives, their own obligations -- their own children.

Yes, they will go to great lengths to keep a father or mother, or a father-in-law or mother-in-law, from going on relief -- from becoming a public charge. But is it fair to demand so much?

Much is said about education, and the importance of making it available to all young people, to the limit of their abilities. I wonder how many young people lost their chance to go to college because their grandfather died a lingering death. We do not have statistics on that; we do not know how many carefully gathered college funds, saved in dimes and quarters and half-dollars over the years, went to pay a hospital bill instead. All we know is that there have been a great many.

These sacrifices, it may be argued, are a part of family life. They ought to be taken in good spirit, or at least with resignation. That would be true -- and in practice, it is indeed true today -- if there were no alternative.

But there is an alternative. We can prevent these personal tragedies that strike the old, the middle-aged and the young alike. The alternative is now before you -- a comprehensive program of hospital insurance for the aged, as part of the social security system, paid for, in pennies a week, by those who will reap its benefits.

Mr. Chairman, I urge you and your Committee to give this just and simple remedy, explored and refined over six years of examination, your prompt and favorable action.

2.1-3-6
Javits

AFL-CIO Department of Social Security
January 31, 1964

JAVITS "HEALTH CARE INSURANCE ACT OF 1964"

Summary, and Comparison with King-Anderson Bill

On January 16, 1964, Senator Jacob K. Javits, on behalf of himself and Senators Clifford P. Case, John Sherman Cooper, Kenneth B. Keating, Thomas H. Kuchel, and Margaret Chase Smith, introduced a bill to provide health insurance to the aged. The bill (S. 2431) is based on the recommendations of the National Committee on Health Care of the Aged.

The National Committee is a bi-partisan group, chaired by former Secretary of HEW, Arthur S. Flemming, and including representatives of the medical profession, industry, commercial and nonprofit health insurance, and hospitals. The Committee concluded in a unanimous report issued in November, 1963, that action to provide health insurance for the aged is required in both the public and the private sector of the nation.

S. 2431 incorporates this recommendation by providing for basic health insurance benefits for the aged to be financed through Social Security, and making certain provisions to encourage private health insurance carriers to offer supplementary coverage.

BASIC BENEFITS THROUGH SOCIAL SECURITY

Title I of the Javits bill is identical with the King-Anderson bill (H.R. 3920, S. 880) except for minor differences in benefits and in certain administrative arrangements.

1. People protected (Provision identical with King-Anderson bill)

   All persons 65 and over, (except employees of the United States, persons covered by the Federal Employees Health Benefits program, and people receiving care in publicly-financed mental or tuberculosis institutions) are eligible. This includes:

   Aged persons eligible under OASI (14.4 million in 1964)
   Aged persons eligible under Railroad Retirement (.8 million in 1964)
   Aged persons not eligible under OASI or RRA (2.5 million in 1964)

2. Benefits

   The program would provide payment, in the case of each illness of an aged beneficiary for:

   A. 45 days of hospital care, without cost to the patient. (This is identical with one of the three benefit options available under the King-Anderson bill.)

   B. Skilled nursing home services on direct admission to hospital-affiliated facilities, or after transfer from a hospital to affiliated or non-affiliated facilities for up to 180 days. (King-Anderson provides same benefit period, but limits benefits to services rendered in hospital-affiliated homes after transfer from hospital.)

C. Home health services provided by hospital-affiliated home health agencies, including nursing care and therapy for up to 240 days a year (King-Anderson provides for 240 visits, and does not require that the home health agency be hospital-affiliated.)

(An additional difference in the benefit provisions between the Javits bill and the King-Anderson bill is that the former does not include outpatient hospital diagnostic services among its basic, Social Security-financed benefits, while the latter does.)

3. Financing (identical with King-Anderson bill)

A. Coverage for persons eligible under Social Security or Railroad Retirement would be financed by an increase in the Social Security (and Railroad Retirement) tax of ¼% each on employer and employee.

B. Coverage for persons who are aged and not covered by another federal program would be financed from general revenues.

C. A new trust fund would be provided separate from the Federal Old-Age and Survivors Insurance Trust Fund and the Federal Disability Insurance Trust Fund. The amount allocated to the payment of health benefits would be deposited with, and health insurance benefit payments would be made from this new Federal Health Insurance Trust Fund.

4. Administration

Provisions for the administration of the program of basic benefits in S. 2431 are identical with the major provisions in the King-Anderson bill, including those relating to eligibility of hospitals and nursing homes and the use of state agencies. There are differences in the language relating to the use of voluntary organizations; the Javits bill directs the Secretary of HEW to use voluntary organizations "to the maximum extent practicable", while the King-Anderson bill encourages him to do so.

SUPPLEMENTARY BENEFITS THROUGH PRIVATE INSURANCE

The basic difference between the Javits bill and the King-Anderson bill is that while the latter provides that the Secretary shall encourage and assist insurance companies and prepayment plans to develop health insurance protection to supplement the basic benefits financed through Social Security, the Javits bill would make specific changes in existing federal law toward that same end.

1. Supplementary coverage to be sold through pooling arrangement among private insurers.

The bill authorizes the establishment of a National Association of Carriers to Provide Health Insurance for Individuals Aged 65 or Over, to be made up of insurance companies and prepayment plans.

A. The Association would operate on a nonprofit basis.

B. The Association would offer for sale one "standard" health insurance policy; both benefits and premiums under this policy could vary to reflect regional differences in costs.

C. Members of the Association could offer "alternative" policies, fulfilling the same purposes as, and representing a dollar value no less than, the standard policy, upon the approval of the Association and the Secretary of HEW.

2. Minimum supplementary benefits

The "standard policy" sold by the National Association would have to include at least these benefits:

A. Payment of part or all of most physicians' charges, including surgery.

B. Payment toward charges for diagnostic, laboratory and X-ray services.

3. Carriers exempt from certain laws.

The Association and each member carrier would be -- with respect to its operations relating to the sale and administration of the "standard" and "alternative" policies for the aged -- exempt from:

A. Regulations by State or local government

B. Federal or State income tax and all State taxes on policies or premiums

C. Anti-trust and other regulations of the Sherman Act, the Clayton Act, and the Federal Trade Commission Act.

4. Cost

The sponsors of the bill estimate that a "substantial" package of benefits can be made available under these provisions for about $2 per week. These costs would of course be met exclusively from private, non-governmental sources -- presumably primarily from the aged individuals themselves.

FINANCING MEDICAL CARE FOR THE AGED THROUGH SOCIAL SECURITY

by
Wilbur J. Cohen
Assistant Secretary of Health, Education, and Welfare
A Speech Presented to the Junior Branch of
The Actuaries Club of New York, March 18, 1964

I am very glad to have this opportunity to discuss with you the important subject of financing medical care for the aged through the Social Security system. This subject, as so described, is rather broader than I care to deal with, since it would seem to go far beyond the Administration proposal that is being widely discussed these days, as embodied in the King-Anderson Bill (H.R. 3920 and S. 880).

Accordingly, knowing that I am dealing with a group of actuaries, for whom precision is one of the major tenets of life, I should first define my subject more exactly. I will be concerned with several aspects of financing--first, why it should be done in the manner that I believe desirable; second, how it should be done; and third, the cost aspects and problems inherent in such financing.

I shall not deal with the broad field of medical care, but rather only with the hospitalization and related benefits that would be provided under the King-Anderson Bill. These represent perhaps only about 25% of the total medical costs for persons aged 65 and over (again, a more precise and acceptable term than merely "aged"), but they are the costs that are of the most catastrophic nature and thus most susceptible to, and desirable for, the insurance or broad pooling approach.

Finally, as a matter of precision, I am referring to the proposal as being carried out through the Old-Age, Survivors, and Disability

Insurance system, since properly the term "Social Security" also includes unemployment insurance and public assistance, both of which are legislated in the Social Security Act, even though they are not administered in the Social Security Administration in my Department. Accordingly, the truly precise title of my remarks is really the long one of "Financing Hospitalization and Related Benefits for Beneficiaries and Eligibles Aged 65 and Over under the Old-Age, Survivors, and Disability Insurance System".

Description of Proposed Benefits

As to OASDI beneficiaries, the proposal would provide specific hospitalization and related benefits for all persons who are aged 65 and over and who are entitled to monthly benefits. The term "entitled" means that the individual meets all the statutory provisions governing eligibility for monthly benefits--whether as a worker or as a dependent or survivor--and has filed a proper application, which may be done concurrently with the application for the hospitalization benefits. Persons eligible for the hospitalization benefits include not only those currently receiving monthly benefits, but also persons who are continuing in substantial employment. You might wonder why the hospital benefits are made available to the latter group. The reason is simply that the so-called retirement test for the cash benefits is not suitable as a means of restricting the hospitalization benefits only to truly retired persons.

The hospitalization benefits would also be provided for Railroad Retirement beneficiaries aged 65 and over, and also for most persons aged 65 and over in 1965, and for those attaining this age in the next few

years who are not insured under either OASDI or railroad retirement. The cost for the latter group would be met out of general treasury revenues, while the cost for the Railroad Retirement beneficiaries would be met largely from their own system.

The following benefits would be provided under the King-Anderson bill:

(a) 90 days of semi-private hospital care within a "benefit period", with a deductible of $10 per day for the first 9 days (minimum deductible of $20); the beneficiary can elect, irrevocably, to have either of two other types of protection--(1) a 45-day maximum with no deductible or (2) a 180-day maximum with a flat deductible in an amount equal to $2\frac{1}{2}$ times the average daily hospital cost under the program (except that the deductible will be the customary charges for the particular case if these are less than the amount of the flat deductible).

(b) 180 days of skilled-nursing-facility services within a "benefit period", when such services are furnished following transfer from a hospital and are necessary for continued treatment of a condition for which the individual was hospitalized.

(c) 240 home-health-service visits during a calendar year.

(d) Outpatient-hospital-diagnostic services in excess of a $20 deductible during a 30-day period.

The term "benefit period" means the period beginning with the first day that an individual receives hospitalization benefits and ending with the 90th day thereafter during each of which he has not been a patient in a hospital or a skilled nursing home (such 90 days must occur within a 180-day period).

The remainder of my remarks will not deal with the group of presently aged people who are not insured under social security or railroad retirement but will be directed to the financing of hospital insurance benefits for aged OASI beneficiaries only.

Why the Proposal Should be Financed Through Social Insurance

At least five possible ways exist by which medical-care costs of persons can be financed. These are by no means mutually exclusive, and several--or even all--of them can be used in combination in our democratic society. The first way is by having each individual meet his own costs out of his own income and assets. The second way is to spread the costs among broad groups of individuals through private insurance--including that available from both private insurance companies and from carriers such as the Blue Cross, either under individual policies or under group policies. The third way is to similarly spread the cost through social insurance payments, by paying the suppliers of medical care for the services rendered. The fourth way is through the Government providing a public assistance program to meet the medical costs (or part of them) that people cannot pay themselves. The fifth way is through the Government supplying the medical services, which, it seems to me, is the only way that involves so-called "socialized medicine", whereas the other four methods would not have any significant effect on the practice of medicine as it now exists in this country; this approach, in my opinion, is not desirable, and nothing in the King-Anderson Bill would lead to it.

Now when we turn to the special category of persons aged 65 and over, there are certain particular elements that seem to me to require somewhat different procedures than are applicable to other age groups in the population. As you well know, those aged 65 and over tend to have much lower income on the average than other age groups. A very significant element that makes this differential smaller than it would

otherwise be is the existence of the OASDI cash benefits. Nonetheless, not even a substantial increase in cash benefits would solve the problem completely, because there is the other side of the coin--the very high actuarial costs for individual hospitalization benefits for some persons aged 65 and over so that many in this age group are literally uninsurable, or become uninsurable as their age advances.

Private insurance has done an excellent and comprehensive job among younger persons, but its coverage among those aged 65 and over has not really produced satisfactory results, and in my opinion, it can never do so. It is true that half of the aged population has hospital insurance, but in a large number of instances the protection is only fragmentary and partial. For example, many policies contain a benefit of only $10 a day for room and board, with a maximum duration of 30 days, and with only a few hundred dollars in benefits for other hospital costs. Although these are a help in times of minor hospitalization, they provide relatively little for catastrophic cases. One might say that they furnish about as much protection as if you carried automobile liability insurance with a maximum liability on the part of the insurer of $1,000. Further, many of those who need the protection the most do not have private insurance because either they are high-risk persons or they have too low incomes to be able to afford policies.

Then, too, I believe that most people would like to have the financing of their hospitalization benefits during retirement paid for only out of their current higher earnings when they are working. Social security and only social security offers a ready-build thoroughly tested administrative mechanism that would make this desirable arrangement available

to practically everybody. Virtually no private individual insurance policies are available on this basis. Even if there were wide availability, these policies would not furnish very adequate protection because the benefits provided would be in terms of today's dollars, and the cost of hospitalization several decades hence might well bear no relationship to the benefits provided. Under such policies, then, the longer that the period would be deferred and, in fact, the longer that the individual lived beyond age 65, the less protection he would have relatively. Similarly, there are very serious cost problems for employers that attempt to provide post-retirement hospitalization-benefit protection on a paid-up basis. Even if employers were willing to handle the financing of such protection on a current-cost basis, there would be a large proportion of the population aged 65 and over who would not be covered because by no means all employers would do this. Similarly, the Blue Cross plans have great difficulty in furnishing hospitalization benefits at uniform rates regardless of age (the so-called "community rating" approach)--let alone having "paid-up at retirement" contracts--because experience-rated private-insurance plans can "skim the cream off the top" by insuring only the low-cost young groups in the community.

Accordingly, I come to the conclusion that the only satisfactory solution for the aged is the provision of basic hospital insurance protection through the social insurance system. Once this is done it would be feasible and desirable for aged people to continue individually to meet from current income the smaller costs as they arise and to purchase supplementary protection through private insurance against health costs not

covered by the basic social security plan. The public assistance approach is, in my opinion, unsuitable as the basic governmental attack on the problem of health costs in old age because means test programs are not a satisfactory way of providing broad protection. An assistance program cannot prevent poverty and dependency arising from health costs but can only try to deal with these conditions after they have occurred. Its most appropriate role, therefore, is as a supplement or backstop to a basic social insurance program.

It is true that under the social-insurance approach, not all beneficiaries under the proposal will have "paid for" their benefits in advance, since the vast majority of the current group of beneficiaries will receive protection without making any contributions therefor. This, however, is readily possible--and, in fact, is desirable--under social insurance, so as to take care of today's problems today, while at the same time providing a long-range solution for future generations.

How The Proposal Is Financed

The financing basis of the King-Anderson bill is probably one of the least understood matters currently before the public. On the one hand, many people believe that the financing is to be accomplished entirely by the combined employer-employee contribution rate of ½% that is added to the existing tax schedule for the OASDI system. On the other hand, some understand the financing to be that obtained from both the direct increase in the contribution rate and from all the additional taxes derived from raising the maximum earnings base from $4,800 to $5,200 per year.

According to the first view, the most that an individual employee would contribute toward the hospitalization benefits would be $\frac{1}{4}\%$ of $5,200, or $13 per year. According to the second view, however, the additional contribution for the health benefits on the part of an employee would be $\frac{1}{4}\%$ of $5,200, plus the presently scheduled OASDI contribution rate of 3-5/8% on the additional $400 between $4,800 and $5,200, or a total of $27.50 ($31.50 when the scheduled ultimate rate goes into effect in 1968)--or even twice this much, if the employer contribution is also considered. This second view fails to take into account that higher cash benefits will be paid on earnings above $4,800, and some of the contribution can be viewed as going toward their cost.

As so often happens in human affairs, neither of these extreme views is correct, and the real truth lies somewhere in between, as I shall now discuss. The hospitalization and related benefits and the accompanying administrative expenses would be financed, on a long-range basis, by an increase in the combined employer-employee contribution rate of $\frac{1}{2}\%$--with a corresponding increase in the self-employed rate--and by the reduction in the cost of the OASDI system of cash benefits that results from increasing the earnings base from $4,800 to $5,200.

I am certain that you all appreciate that the latter item results from the weighted nature of the benefit formula--such that relatively higher benefits are paid to those with lower average earnings and vice versa. The gain to the system from raising the earnings base is estimated to be equivalent to the effect of a rise in the combined employer-employee contribution rate of .18% of taxable payroll. This income, in addition

to that from the direct increase in the contribution rate, would be channelled into the Hospital Insurance Trust Fund, which would be established on a basis similar to that of the OASI and DI Trust Funds.

In essence then, the contribution rate applicable to the OASI portion of the system would be reduced by .18% but this would not disturb its actuarial balance because it would have a lower cost as a result of the increase in the earnings base. To put it another way, as the actual mechanism would work out, the total employer-employee tax rate scheduled in the law would be allocated as follows: .50% would go into the DI Trust Fund, .68% would go into the HI Trust Fund, and the remainder would go into the OASI Trust Fund. Thus, the maximum employee contribution for the hospitalization and related benefits under the bill would be .34% of $5,200 or $17.68 per year. Under the bill, this allocation would be continued into the indefinite future, regardless of any further gains to the cash-benefits portion of the program that might eventuate as a result of rising earnings or changes in the earnings base.

Financing Assumptions and Problems

I appreciate that there is some difference of opinion as to the validity of the hospital utilization and similar assumptions involved in our actuarial cost estimates for the King-Anderson Bill. However, we have studied all available data and views on this subject, and we believe that our estimates are valid. It may be noted that there is not a large relative spread between our estimates and others in regard to hospital utilization in the initial years. But let us not go into this matter

here, and let us instead concentrate solely on the question of the effect of economic conditions on the cost estimates and thereby on the financing basis.

Basically, the cost estimates for the hospitalization benefits--like those for the cash benefits--are made on the assumption that earnings and hospital costs will be level in the future. We are, of course, fully cognizant of the fact that this will undoubtedly not be the case, but the cost estimates are equally valid--when expressed in relation to taxable payroll--if we assume that the system is kept up-to-date. Specifically, what I mean by "keeping up-to-date" is that if wages and hospitalization costs rise, then more or less concurrently, the maximum earnings base subject to contributions and the dollar amounts of any deductibles will be increased in proportion with the changes in the general earnings level.

It is further assumed that, over the long run, hospital costs will increase no more rapidly than earnings. This assumption can be realized even though in the next few years hospital costs rise somewhat more rapidly than earnings, if in the long-run future, the increase in hospital costs is somewhat less rapid than that in earnings. This latter assumption can quite readily occur because it is the general historical nature of prices of virtually all items that they rise less rapidly than the earnings level (because of increased productivity).

Hospital costs have been rising much more rapidly than the general level of wages in the past--an annual rate of increase of perhaps 6 or 7% for hospital costs vs. 3 to 4% for wages. A large part of this differential trend has been the result of the fact that in years gone by, the wages of

hospital personnel were very low, and there has been a catching-up period that will, of course, slacken off after a certain point. In the future, it is to be anticipated that increasing productivity will be evident in hospital practices and management so that the rise in hospitalization costs in relation to the rise in the general level of earnings that we have been so accustomed to in recent years will very likely slacken off. One instance of this in the past has been the shortened duration of hospitalization for maternity cases.

Accordingly, I think that it is fair to say that the financing basis underlying the King-Anderson Bill appears to be adequate when viewed in the light of the underlying assumptions as to the system being kept up-to-date with changes in economic conditions. It is not proper to analyze the financing under the unrealistic assumptions that hospital costs will rise forever and that general wages will remain level or that if general wages do rise, the earnings base under the OASDI system would not be adjusted to reflect the facts of economic life.

As actuaries, you are all familiar with the artificial result that would be produced when the benefit cost in the numerator is affected by a high compound rate of increase, while the contribution base in the denominator is affected by either no increase or by a smaller compound rate of increase. Continued far enough, a 7% annual increase in hospitalization costs and only a 4% increase in the general level of wages would mean that eventually a day of hospitalization would take more than a year's salary. Thus, it is equally illogical and unreasonable to make cost estimates and develop a financing basis for a hospitalization-benefit proposal

under assumptions of rising hospitalization costs and rising levels of general wages without at the same time assuming that the financing provisions will simultaneously be kept up-to-date.

HUGH SCOTT
PENNSYLVANIA

RECEIVED
APR 22 1964

United States Senate

WASHINGTON, D.C.

JHS

Medicare

April 21, 1964

Dear Colleague:

I plan to introduce on Friday a bill to provide for the establishment of a Government 65 Health Insurance Program. A draft of the bill is enclosed.

The program is designed to assist our senior citizens aged 65 and over to purchase health insurance policies which contain at least the coverage specified in sections 5 and 6 of the bill.

The Government would provide cash payments to help defray the annual premium cost of the insurance policies. Such payments would amount to whichever of the following is smaller: (1) one-half the annual premium of the policy, or (2) $75 if the policy is a short-term illness benefits policy (as outlined in section 5), or $90 if the policy is a long-term illness benefits policy (as outlined in section 6).

These cash payments may be made directly to the individual beneficiary in reimbursement for the Government's share of the premium cost or, if the beneficiary prefers, directly to the insurance company issuing the policy.

The Secretary of Health, Education, and Welfare would administer the Government 65 Health Insurance Act and would disburse the benefit payments authorized thereunder. I estimate the maximum cost of the Government 65 Health Insurance program during its initial year of operation to be slightly more than $1.1 billion.

My bill recognizes that some people are unable from their own resources to meet all of their health expenses. The bill, therefore, provides for a partnership between the Government, the older citizen, and the health insurance industry of the Nation. It rests primarily on the principle of self-help. It is up to the individual, if he is able, to meet the costs of his medical care. Insurance companies would offer policies designed to make it easier for him to meet his health expenses.

I would welcome co-sponsorship, if you like this approach. Should you wish to join me as a co-sponsor, please notify my legislative assistant, Dick Murphy, at extension 6324 before 5:30 pm, Thursday. I will welcome your interest and your comments.

Sincerely,

Hugh Scott

Hugh Scott

88th CONGRESS
2d Session S. _____

IN THE SENATE OF THE UNITED STATES

Mr. Scott _____ introduced the following bill; which was read twice and referred to the Committee on _____

A BILL

To provide for the establishment of a Government 65 Health Insurance Program.

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 "Government 65 Health Insurance Program Act".

Entitlement to Benefits

Sec. 2. (a) Every individual who--

(1) has attained age 65;
(2) makes application for benefits under this Act; and
(3) at the time such application is made is the beneficiary of a qualified private health insurance policy with respect to which premiums are payable by him (or on his behalf);

shall be entitled to the benefits provided under the Government 65 Health Insurance Program (hereinafter referred to as the "Program").

(b) Benefits provided under the Program to an individual entitled thereto shall consist of one or more money payments, made with respect to any enrollment year, to assist such individual in defraying the premium costs for such year of a qualified private health insurance policy of which he is the beneficiary.

(c) (1) The aggregate of the amounts payable to an individual as benefits under the Program for any enrollment year shall be equal to whichever of the following is the smaller--

(A) one-half of the premium costs of the qualified private health insurance policy of which he is the beneficiary, or

(B) (i) $90, in case such policy is a long-term illness policy, or (ii) $75, in case such policy is a short-term illness policy.

(2) Any payment of benefits under the Program to which an individual is entitled shall be made--

(A) directly to such individual by way of reimbursement, in case there has been paid by or on behalf of such individual the insurance premium on the basis of which he becomes entitled to such payment; or

(B) to the carrier offering the qualified private health insurance policy with respect to which such premium is payable, in case such individual has authorized (in the manner prescribed by regulations) such payment to be made to such carrier.

ADMINISTRATION OF PROGRAM BY SECRETARY OF HEALTH, EDUCATION, AND WELFARE

Sec. 3 (a) This Act shall be administered by the Secretary of Health, Education, and Welfare (hereinafter referred to as the "Secretary").

(b) The Secretary shall have authority to prescribe such rules and regulations as he may deem necessary or proper to carry out the provisions of this Act.

(c) Wherever, in this Act, the term "regulation", "regulations", "rule", or "rules" is employed, such term shall, unless the context otherwise indicates, refer to one or more regulations, as the case may be, or one or more rules, as the case may be, prescribed by the Secretary in carrying out the provisions of this Act.

QUALIFIED PRIVATE HEALTH INSURANCE POLICY

Sec. 4. (a) The term "qualified private health insurance policy" means a policy of health insurance which--

(1) is provided by a carrier or carriers authorized to do business in the State wherein such policy is issued;

(2) is authorized to be issued within such State under the laws and applicable regulations of such State;

(3) is approved by the Secretary as either a "long-term illness benefits" policy or a "short-term illness benefits" policy;

(4) is provided by a carrier which, in areas served by such carrier, offers such policy to all individuals residing therein who are aged 65 or over;

(5) is offered to individuals aged 65 or over on a guaranteed renewable basis;

(6) is provided by a carrier which, in the areas served by such carrier, offers individuals a choice of an approved "long-term illness benefits" policy or an approved "short-term illness benefits" policy, and permits an individual who has been a subscriber of one such policy for one year the option of changing to the other such policy;

(7) contains provisions under which the carrier offering such policy to any individual aged 65 or over agrees not to increase, with respect to such individual, the rate of premiums payable therefor for one year following the date such individual subscribes to such policy.

(b) (1) As used in subsection (a) (5), the term "guaranteed renewable basis" refers to an insurance policy which is renewable at the time it otherwise would expire at the option of the subscriber of such policy and which cannot be cancelled by the carrier except for failure of payment of premiums thereon; except that the reservation by a carrier of the right to terminate an entire policy in a State in accordance with applicable laws and regulations of such State shall not be construed as grounds for disqualifying such policy as being offered on a guaranteed renewable basis.

(2) No insurance policy for purposes of this Act shall be considered to be offered on a guaranteed renewable basis unless increases or decreases in amounts of premiums payable therefor are applied to all subscribers aged 65 or over without regard to health condition, health services utilized or claimed, or other personal characteristics, of the policy holder.

LONG-TERM ILLNESS BENEFITS

Sec. 5. (a) The term "long-term illness benefits" refers to a private health insurance policy under which an individual who is the beneficiary thereof for any enrollment year is entitled to have payment made by the carrier issuing such policy of all the costs incurred by him during such year by reason of his having received the following services which his physician has determined to be medically necessary--

(1) inpatient hospital services (but not for more than 75 days unless such policy so provides);

(2) nursing home care, but not for more than 150 days unless such policy so provides (except that such policy may provide that the number of days for which he is entitled to have the costs of inpatient hospital services paid may be reduced by not more than one day for each two days he receives nursing home care the costs of which are paid under such policy);

(3) surgical services (but not in excess of $300 unless such policy so provides);

(4) physicians' services provided in a physician's office (but not for more than 5 visits,nor more than $5 per visit, unless such policy so provides);

(5) outpatient hospital services, including diagnostic, x-ray and laboratory services;

(6) outpatient surgical services; and

(7) visiting nurses' services (but not for more than 30 days unless such policy so provides).

(b) The Secretary shall approve, as providing "long-term illness benefits", any private health insurance policy which complies with the requirements of subsection (a).

SHORT-TERM ILLNESS BENEFITS

Sec. 6. (a) The term "short-term illness benefits" refers to a private health insurance policy under which an individual who is the beneficiary thereof for any enrollment year is entitled to have payment made by the carrier issuing such policy of all the costs incurred by him during such year by reason of his having received the following services which his physician has determined to be medically necessary--

(1) inpatient hospital services (but not for more than 45 days unless such policy so provides);

(2) nursing home care, but not for more than 90 days unless such policy so provides (except that such policy may provide that the number of days for which he is entitled to have the costs of inpatient hospital services paid may be reduced by not more than one day for each two days he receives nursing home care the costs of which are paid under such policy);

(3) surgical services (but not in excess of $200 unless such policy so provides);

(4) physicians' services provided in a physician's office (but not for more than 3 visits, nor more than $5 per visit, unless such policy so provides);

(5) outpatient hospital services, including diagnostic, x-ray, and laboratory services;

(6) outpatient surgical services; and

(7) visiting nurses' services (but not for more than 10 days unless such policy so provides).

(b) The Secretary shall approve, as providing "short-term illness benefits", any private health insurance policy which complies with the requirements of subsection (a).

DEFINITIONS OF BENEFITS

Sec. 7 (a) The term "inpatient hospital services" means the following items furnished to an inpatient by a hospital--

(1) Bed and board (at a rate not in excess of the rate for semi-private accommodations) and includes any special foods necessary to fulfill any diet requirements prescribed by the patient's physician;

(2) General nursing services;

(3) 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;

(4) use of operating, recovery and other special rooms; and

(5) use of laboratory, x-ray, electronic equipment, and other related services for diagnostic purposes; but only, in the case of any individual, to the extent that the aggregate cost of such items does not exceed $30 multiplied by the number of days such individual is an inpatient in such hospital.

(b) The term "nursing home care" means the following items and services furnished by a nursing home to an individual who is an inpatient thereof, after transfer, upon the recommendation of his physician, from a hospital in which he was an inpatient for not less than 72 hours immediately prior to such transfer--

(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 such home or by others under arrangements with them made by such home;

(4) such drugs, biologicals, supplies, appliances, and equipment, furnished for use in the nursing home as are customarily furnished by such home for the care and treatment of inpatients; and

(5) such other services necessary to the health of the patient as are generally provided by nursing homes.

(c) The term "physicians' services" means services provided in the exercise of his profession in any State by an individual legally authorized to practice surgery or medicine by such State.

(d) The term "hospital" means a hospital which is licensed as a hospital in the State in which it is located.

(e) The term "nursing home" means a nursing home which is licensed as such by the State in which it is located, and which (1) is operated in connection with a hospital, or (2) has medical policies established by one or more physicians (who are responsible for supervising the execution of such policies) to govern the nursing home care and related medical care and other services which it provides, and (3) provides nursing care by or under the supervision of one or more registered nurses.

MISCELLANEOUS DEFINITIONS

Sec. 8. For purposes of this Act, the term--

(a) "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 care or services for individuals under health insurance policies in consideration of premiums payable to the carrier;

(b) "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 care or services for the individual who is the beneficiary of such policy, contract, agreement, or other arrangement; and

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

PAYMENT OF BENEFITS BY THE SECRETARY

Sec. 9. (a) The Secretary shall not make any money payment to or on behalf of any individual, as benefits provided by this Act, until he is satisfied that--

(1) such individual is entitled (under section 2 (a)) to benefits under this Act;

(2) such payment is in reimbursement of, or will be used for the purpose of paying, one or more premiums payable for a qualified private health insurance policy of which such individual is the beneficiary.

(b) The Secretary shall establish such procedures as he deems appropriate under which interested parties may obtain a finding by the Secretary as to whether or not a particular private health insurance policy is a "qualified" private health insurance policy for purposes of this Act.

Jane Start file on soc security medicine

THE WHITE HOUSE

WASHINGTON

May 28, 1964

Dear Mrs. Rost:

The President has asked me to reply to your recent letter. I wish to thank you for the confidence and faith which you expressed in your letters of April 1 and April 24 and to respond to your concern about the coverage of physicians under the Social Security program.

This Administration has taken, and will continue to take, an active interest in the problems involved in extending the provisions of the Social Security Act to physicians and their families. During this session, we have urged the Congress to consider a number of bills which would provide Social Security coverage to physicians and Mr. Mills is aware of our interest in this legislation. I am hopeful that the time is not far off when physicians will be included within the Social Security system.

I also wish to thank you for your support on the Medicare bill. As you know, the President has often reiterated his support for a program of hospital services to the aged. In a recent speech, for example, he stated, "These older citizens deserve a decent chance to stay well or to get well, and this Administration, with your support, intends to see that they get that chance."

Sincerely,

Ralph A. Dungan

Ralph A. Dungan
Special Assistant
to the President

Mrs. A. Sander Rost
461 Mountainview Avenue
Orange, New Jersey

NEWSLETTER

Social Security for Physicians

Published by Comm. on Social Security for Physicians. The Physicians Forum • 510 Madison Avenue, New York 22, N.Y.

NATIONAL AND STATE POLLS SHOW THAT A MAJORITY OF PHYSICIANS WANT SOCIAL SECURITY COVERAGE

Two national, scientifically-conducted polls by independent medical publications show a substantial majority of U.S. physicians in favor of Social Security coverage. Results of the July 1961 *Medical Tribune* poll showed *57.7% for physician coverage.* This reinforces the figures in the *Medical Economics* poll (Oct. 1958) which showed *56% in favor of coverage.* In both polls, a cross-section sampling of 5,000 physicians was queried.

19 STATE MEDICAL SOCIETIES FAVOR COVERAGE: ONLY 8 OPPOSED

Of 29 State polls of physicians, a majority in 19 States favor inclusion under Social Security; 8 States are opposed, and in 2 States, the vote is mixed and inconclusive. *(See Table on reverse side.)* Significantly, all but three of these polls were conducted officially by the State Medical Societies of the AMA whose leaders, in most cases, openly urged physicians to vote against Social Security coverage.

The 19 pro-Social Security States have a physician population of *97,100 or 60.9% of all U.S. physicians in private practice.* The 8 States opposing Social Security represent 26,482 or 16.6% of all physicians.

AMA DISREGARDS WISHES OF ITS MEMBERS

The American Medical Association refuses to recognize the results of these national and state polls, nor will it conduct a national poll of its own. It insists that the AMA's House of Delegates is best qualified to judge this issue. And every year, the House of Delegates reaffirms its opposition to Social Security in complete disregard of the results of the State Medical Society polls which, ironically, were held on its own recommendation.

THE "GHOST" VOTE IN THE HOUSE OF DELEGATES

If the members of the House of Delegates were obligated to vote in accordance with the wishes of the physicians they represent, a resolution in favor of Social Security coverage would command a clear majority! The 19 States where a majority of physicians favor coverage are entitled to a total of 110 of the 202 votes of the House of Delegates! *(See Table on reverse side for breakdown.)* The 8 States opposed to Social Security for physicians would be able to muster only 34 votes and could not command a majority even if all the uncommitted States were to join them!

HOW HOUSE OF DELEGATES MANAGES TO FLOUT MEMBERS' DESIRES

The House of Delegates refuses to take roll-call votes on Social Security resolutions; thus, none of its members are "put on the spot" when the proceedings are published. Secondly, the rank-and-file physician does not directly elect his representative to the AMA House of Delegates. The national delegates are elected by County and then State Medical Society conventions, and are thus thrice-removed from direct pressure from the individual physician. It is extremely difficult to dislodge unresponsive delegates on any scale that would make a significant difference in the composition and attitude of the AMA House of Delegates for years to come. Many physicians, frustrated by the high-handed, undemocratic tactics of AMA leaders, have quit the organization. Approximately 25% of the medical profession does not belong to the AMA.

HOW AMA MISREPRESENTS FACTS TO CONGRESS

When, in May 1960, the House Ways and Means Committee, and the House itself, approved a bill to include physicians under Social Security, the AMA House of Delegates, meeting in Miami a month later, "unanimously reaffirmed the AMA's position against Social Security coverage for physicians." *(See clipping from AMA Journal, below.)* The impression it created was that physicians were emphatically opposed to inclusion under Social Security.

J.A.M.A., Aug. 20, 1960

COMMITTEE REJECTS SOCIAL SECURITY FOR PHYSICIANS

The Senate Finance Committee tentatively voted to knock out of a House-passed Social Security [illegible] Committee Chairman Harry F. Byrd (D., Va.) said the decision was made because the American Medical Association had requested the action.

At the A. M. A.'s annual convention in Miami Beach, Fla., in June, the House of Delegates unanimously reaffirmed the A. M. A.'s position against Social Security coverage for physicians.

At hearings before the Senate Finance Committee on June 29-30, 1960, the then AMA president-elect, Dr. Leonard Larson, inserted a letter into the record which made the unsubstantiated and erroneous statement that "it can be concluded from the results [of the State Social Security polls] that a majority of the profession is still opposed to coverage." *(See p. 221, Senate Finance Comm. Hearings on Social Security Amendments of 1960.)*

With these assurances from "Organized Medicine," the Senate Finance Committee deleted the House-approved clause that would have included self-employed physicians under Social Security.

SEE REVERSE SIDE

INDIGENT PHYSICIANS, WIDOWS AND CHILDREN SUFFER UNJUSTLY

In 1956, Congress admitted lawyers, dentists, engineers, osteopaths and others into the Social Security program but locked the door on physicians—primarily because of the insistance of the AMA. Since then, widows and children of deceased physicians have been denied the financial assistance which the survivors of other self-employed professionals receive. Many physicians in their sixties are justifiably bitter because they are being deprived of Social Security benefits which would have made their retirement more comfortable, after a life-time of service.

The fiction persists that physicians and their dependents, somehow, never become indigent. Here are two examples of many that can be cited to show that physicians are not immune from financial and other misfortunes:

- The Physicians Home in New York asks for charitable contributions from physicians every year. In its annual solicitation, it stated, "We expect our requirements for such aid during the current year [1961] will exceed $100,000."
- The Aid Association of the Philadelphia County Medical Society reports "an increase from $19,000 in 1959 to $24,000 in 1960 in funds distributed to the annuitants and beneficiaries."

Why must indigent physicians and their dependents have to depend on charity whereas unfortunate individuals in other trades and professions are entitled to Social Security financial aid, without any loss of self-respect?

25% - 35% M.D.'s HAVE SOCIAL SECURITY COVERAGE; WHY NOT INCLUDE REMAINDER?

Government surveys as well as findings by medical societies indicate that between 25 to 35 percent of the medical profession is presently covered by Social Security. Physicians become eligible by joining as partners in a corporation or working for a private enterprise. Does it make sense to freeze the self-employed family doctor out of the Social Security program? What logical argument can be offered to exclude them, especially since they have shown, through official polls, that they want to be covered?

CONGRESS CAN REMEDY THIS INJUSTICE

The individual physician who wants Social Security protection feels frustrated and helpless. The AMA has turned a deaf ear to his pleas. His only hope is that Congress, on the basis of the evidence, will enact legislation to include self-employed physicians under Social Security.

RESULTS OF STATE MEDICAL SOCIETY SOCIAL SECURITY POLLS

STATES FOR SOCIAL SECURITY (19)

State	In Favor	Opposed	No. of Votes In AMA House Of Delegates
*California	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	277	148	4
New Jersey	2,174	916	6
***New York	--	--	24
Ohio	4,095	2,737	9
Pennsylvania	5,605	3,335	11
Rhode Island	70%	30%	1
South Dakota	155	104	1
Utah	322	188	1
Vermont	65%	35%	1
Washington State	60%	40%	4
West Virginia	436	237	2
			110 Votes – A Clear Majority of the 202 Votes in the AMA House of Delegates.

STATES AGAINST SOCIAL SECURITY (8)

State	Opposed	In Favor	No. of Votes In AMA House Of Delegates
Arkansas	596	1,167	2
Georgia	539	496	3
Illinois	3,301	2,790	11
**Indiana	246	181	5
Minnesota	1,030	817	4
Oklahoma	761	446	2
Virginia	62%	38%	3
Wisconsin	870	854	4
			34 Votes

NOTE: The remaining State Medical Societies, which represent 58 votes in the AMA House of Delegates, have not held Social Security Polls.

*A 1-in-10 poll by Honest Ballot Association
**A 1-in-5 poll by Honest Ballot Association
***Based on county society polls and State Society resolutions.

June 2, 1964

COPY

Fitz
Medicare

MEMO TO: Senator
cc: Bill,
John Stewart

RE: Medicare Bill

FROM: Norman

Several weeks ago on a plane, I sat next to a division chief in the Children's Bureau. In the course of our trip, he and I began to discuss the medicare bill. He acknowledged that he was an old friend of Wilbur Cohen's and then proceeded to say, "I'm disappointed in Wilbur . . . he's about to sell the Medicare program to the insurance companies."

Today, when talking to Ivan Nestingen about something else, he said they were discussing the floor leadership for the bill last night and concluded that you should probably be asked to guide the bill through. Or at least as co-leader.

I then put a direct question. "Is this a lousy bill? Have we gutted it to make it acceptable to the insurance companies?"

The answer is essentially, "Yes." Ivan said, "Well, it is not the bill it once was."

I have discussed this with Bill. It is our opinion that if the bill is an inadequate bill, then you should not be saddled with the responsibility for a bill which can only offend your friends in the labor movement who have devoted so much effort to it and disappoint the active senior citizen groups who have organized for its passage.

This is probably one more example of the conflict which has developed between Ivan and Cohen. In this instance, at least, Ivan is on the liberal side so far as I can tell.

Undoubtedly, there is administration pressure to get out some kind of Medicare bill before election. I would hate to see you trapped, as an administration spokesman, into leading the fight for a bill which makes the insurance companies fat, keeps the aged lean, and diminishes the pressure for a really adequate bill.

I assume Ivan should be protected and not quoted.

COPY

Jill
Medicaid

June 3, 1964

MEMO TO: Senator
cc: Bill
John Stewart

FROM: Norman

Medicare memo no. 2 - amending yesterday's memo -

I had lunch with Clint Fair of the AFL-CIO yesterday and we talked about the medicare bill.

Clint confirms that the bill is being changed, but said the end result will still fall within the guidelines of an acceptable bill.

He says no bill will be recommended by HEW that hasn't had prior approval by the labor movement.

He confirms again that the Nestingen-Cohen internecine warfare is hot.

From the Office of
Senator Pat. McNamara
D., Michigan

FOR RELEASE
Tuesday A.M.'s
July 21, 1964

McNAMARA REPORT CITES INADEQUACY OF PRIVATE HEALTH INSURANCE FOR ELDERLY

WASHINGTON - Three-fourths of all Americans 65 and over either have no private health insurance at all, or are inadequately protected by the policies they have purchased, the Subcommittee on Health of the Elderly of the Senate Special Committee on Aging reported today.

The Subcommittee, headed by Senator Pat. McNamara (D., Mich.), based its findings on an intensive, months-long investigation of the ability of the private insurance industry, including Blue Cross, to meet the health needs of the Nation's 18 million senior citizens.

The study was concerned, Senator McNamara said, with the number of older people actually covered, the adequacy of policies held, and the cost of premiums. It included three days of public hearings in April at which expert witnesses from Government, the commercial insurance industry, consumer groups and other concerned organizations testified. The Report has the unanimous approval of the eight Majority members of the Subcommittee.

A major conclusion was that a program of hospital insurance for the elderly, financed through Social Security, was "the logical course" for the Congress to follow in acting on the unmet health needs of the aged.

Highlights of the 153-page Report include these points:

1: Only 9 million elderly Americans -- one-half of the total -- held any kind of commercial health insurance policy at the end of 1962. This figure is based on the most reliable information available from official Government sources.

2: The health insurance industry's claim that 10.3 million older persons have commercial hospital insurance policies is "an inflated figure, concocted to create the illusion" of great progress in extending coverage to the aged.

"We are convinced," the Report states, "that facts were distorted and manipulated in an effort to create the impression that Congress need consider no further action to meet the hospital insurance needs of the elderly."

3: Only one in four older persons holds adequate hospital insurance under the definition of adequacy established by the American Hospital Association, the yardstick being a policy whose benefits pay at least 75 per cent of hospital costs.

-more-

More than half of all commercial policies held by elderly persons pay $10 a day or less toward hospital room and board charges which cost an average of $20 a day.

4: The adequacy of coverage by Blue Cross plans, which in the past have come closest to meeting the health needs of the elderly, is being seriously impaired as Blue Cross plans employ a variety of devices which reduce the extent of protection. These include such items as deductibles, co-insurance and dollar limits on benefits.

5: The older Blue Cross subscriber is being subjected to a double-barreled pressure of shrinking benefits and rising premium charges, as some Blue Cross plans attempt to shift from the traditional "community rating" principle, to the so-called "experience rating" method which may double premium costs to older persons.

6: The best of the commercial health insurance plans are so expensive that they are beyond the economic reach of most older persons. Although offering only partial protection, these "blue ribbon" policies cost an elderly couple $500 to $600 a year.

Since the median income of aged couples in 1962 was only $2,875 a year, it is obvious the vast majority of them cannot afford these policies.

7: The so-called "State 65" programs, where several insurance companies combine to operate a pooled-risk plan, have made virtually no progress in meeting the health needs of the aged.

"In summary," the Report states, "the extensive data and testimony presented to the Subcommittee led us to the firm conclusion that private health insurance -- with respect to the aged, is losing ground -- not making progress.

"The elderly who now hold private health insurance are having great difficulty in keeping an even inadequate level of protection. They find themselves squeezed between higher premiums and shrinking benefits, as hospital and medical costs continue to climb."

"It is quite clear," the Report concludes, "that the Congress has the responsibility and the obligation to act, and act quickly. It is equally apparent that enactment of a program of hospital insurance financed through Social Security is the logical course for us to follow."

In releasing the Report, Senator McNamara noted that it was based upon new and extensive data heretofore unavailable.

He expressed the hope that the new information would "prove helpful to the Congress and to organizations and individuals interested in meeting the health needs of the elderly."

Separate views were filed by Minority members of the Subcommittee.

Members of the Subcommittee are: Senators McNamara, Engle, Neuberger, Morse, Muskie, Long, Moss, Yarborough, Dirksen, Goldwater, Carlson and Fong.

# # # # #

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ELIZABETH B. SPRINGER, CHIEF CLERK

United States Senate

COMMITTEE ON FINANCE

July 21, 1964

Honorable Hubert H. Humphrey
United States Senate

Dear Hubert:

In accordance with our conversation, enclosed is a copy of the letter I sent to the President on medicare.

Sincerely,

Abe

Abe Ribicoff

Enclosure

HARRY FLOOD BYRD, VA., CHAIRMAN

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ELIZABETH B. SPRINGER, CHIEF CLERK

United States Senate

COMMITTEE ON FINANCE

July 20, 1964

The Honorable Lyndon B. Johnson
President of the United States
White House
Washington 25, D. C.

Dear Mr. President:

The likely House passage of the Mills Social Security bill raises serious practical and political problems on the issue of medicare. The proposed 5% increase in cash benefits is needed, and most Senators would be reluctant to vote against it. Yet the increase in payroll taxes necessary to pay for this benefit increase puts a real squeeze on medicare. I doubt if many Senators want to vote for the big tax increase that would be needed to add hospital insurance on top of the 5% cash benefit increase. So unless something is done this year, the passage of the 5% increase bill may well foreclose all hope of a medicare bill for a long time.

To illustrate the problem, the Mills bill increases the employee's rate from 4.625% to 4.8% and raises the wage base from $4800 to $5400. If medicare were added on top, the rate would go up to 5% and the wage base up to $6600. For a man earning $6600, this means a tax increase of from $222 a year to $330 a year, an increase of $108 or 48%.

I want to suggest for your consideration a way of enacting medicare under these circumstances. In essence I suggest that every person be given a <u>choice</u> at age 65 whether he wants an increased cash benefit <u>or</u> hospital insurance instead. This can be done within a rate of 10% (combined for employers and employees) on a maximum wage base of $5400. This achieves health insurance under Social Security, keeps the cash benefit increase of the Mills bill for those who prefer

COPY

it, and makes medicare available to all but not forced upon anyone.

Specifically, the wage base would be kept at $5400, the same figure used in the pending Mills bill. The employee rate would increase from 4.8% to 5.0%. The person age 65 would have a choice between increased cash benefits of $7 a month or health insurance plus increased cash benefits of $2 a month. The health insurance protection would be 45 days of hospitalization with no deductible. Basically, the health insurance would be paid for almost entirely within the tax increase already set by the Mills bill. This proposal increases an employee's tax by a maximum of only $10.80 a year.

If you are interested in favoring such a proposal, I would be glad to do whatever was thought advisable in the Finance Committee and in the Senate. I recognize that Clint Anderson has assumed the leadership and responsibility for this legislation for some time. Under the circumstances, if you look with favor on this proposal, I would respectfully suggest that Clint should be given the leadership in this matter. If he so desires, I would be pleased to be of help and assistance to him.

In my judgment this is a proposal that can gain support of a majority of the Finance Committee and can pass the Senate. It would be a hard one for Wilbur Mills to reject after Senate passage.

Respectfully,

Abe Ribicoff

1. income levels - tend to tabs cards
2. pressures on Congress —
iron-clad guarantee from Mills —

July 4, 1964

Memo to Senator

From John S. (cc: Bill)

Re: Your role in medicare battle.

As I mentioned briefly to you, Bill Reedy and Jay Constantine, research director of Select Committee on Aging, will attempt to speak with you early this week. They will discuss with you your possible roles in the attempt to amend the social security bill with medicare.

The following points should be noted at this time:

1. There is no acknowledged leader in the Senate in this area who is able to pull the many divergent factions together and keep them in line for this important vote. You appear to be the only person who has the confidence of the President and the ability to handle the Senators. Senator Anderson might want to be the public floor manager, leaving you more free to devise and execute strategy in conjunction with HEW, the White House, and Congress.

2. A decision putting you in this position is essential if the pro-medicare forces are to be organized in the next two or three weeks. The President ought to communicate this fact to Wilbur Cohen, in particular, and Anderson. Then particular Senators can be selected to handle certain areas of substance in the floor debate, much as we did with civil rights. These briefings could take place the week immediately after the GOP conventions. Some Senators could take reading material home with them during the GOP convention.

Also - some time-table must be set up.

3. The question of whether or not the Finance Committee can be counted on to report out some manner of medicare proposal must be examined. If the normal committee procedures could be followed, this would strengthen the position of the pro-medicare forces. Perhaps the President could achieve the same cooperation with Senator Byrd as he did on the tax bill. At least the social security part of the package would have to be reported by the Finance Committee.

4. Bill Reedy says he is available to help this office in whatever ways you deem desirable. He and Jay Constantine are also pulling together for you some briefing materials on hospital insurance under social security, etc.

5. In short, you are being asked to assume much the same role as you did in the civil rights battle. I'm willing to bet you can win this one too.

[July?. 1964]

WHITE HOUSE FOLDER

MEMO TO SENATOR

From John S.

Re: Administration plans for Medicare legislation.

It would be most helpful if you conld elicit some feeling from the President as to his desires on Medicare legislation in the Senate, timing, persons involved, etc. We are standing by waiting for some indication as to next steps.

Attached is the memorandum outlining the Senators who might wish to be brought into the effort under the joint leadership of Anderson-Humphrey. The first step might be a meeting of Senators Humphrey, Anderson, McNamara and Johnston with the President (perhaps Senator Hill should also be sounded out to attend this meeting.) Then we could start the staff operation similar to the one conducted during civil rights. We really must go into this fight fully prepared, geared up, and organized. This can be done if we get some initial word from the White House.

I am also attaching a memorandum from HEW on the legislative outlook for mèdicare in the Senate

If we are to win, it seems essential that the HEW staff be kept under tight control by the Senator-in-charge, probably yourself. The kind of relationship we established with the Justice Department in civil rights would be the model for the medicare battle.

SENATORS	SUBJECT	STAFF
Anderson, Pell, Ribicoff	Justification and technical defense of the package	Cohen/Wolkstein
McNamara, Johnston, Nelson	Need of the elderly	Arner/Brewster
Randolph, Clark, Muskie, Williams, Neuberger	Inadequacy of alternatives (Kerr-Mills; Blues; Commercial)	Livingston/Constantine/ Fine
Douglas, McCarthy, Gore, Pastore	The economics of Social Security and of the proposal	Ball/Myers
Young, Morse, Metcalf, Church	Attack on A.M.A.'s position	Cruikshank/Bamberger
McGovern, Burdick	Importance in rural areas	Sundquist
Long (Mo.), McIntyre	This approach is the Conservative way	

Other Senators to take overall approach, each emphasizing a different factor: Hart, Hartke, McGee, Yarborough, Bayh, Brewster

RECEIVED
JUL 1 0 1964

July 10, 1964

RECENT LEGISLATIVE DEVELOPMENTS

HOSPITAL CARE FOR THE AGED

Legislative Analysis Memorandum #4-64

Prepared by
Walter A. Hasty, Jr., Assistant Director,
Division of Legislative Services

Now that the House Committee on Ways and Means (June 25) has tabled the King-Anderson bill -- in effect refused to do anything more on the all important issue of Hospital Care for the Aging -- Congressman King and others in the know here in Washington assume that the Senate will amend the Social Security bill when it comes over from the House and add to it the substance of the King-Anderson bill.

The votes to do this are ready, set and waiting in the Senate. What is in doubt at this point is whether there will be time enough in this Session of Congress to have the House agree to the amendments that the Senate will adopt. We use this language deliberately because the House can stall and stall when the Senate sends over something that an influential group in the House doesn't want. To accomplish this tactic successfully, it is absolutely essential to have everyone working hand-in-glove to push the amendments through.

Within a few days, there will be a decision at the highest policy levels as to whether this maneuver can succeed and how it is to be handled.

Everyone in Washington was led to believe that in the final showdown Chairman Wilbur Mills would go along and vote for Hospital Care--but at the crucial moment Mills voted against it. Twelve staunch Democrats stood firm (King, Rostenkowski, Rhodes, Boggs, Keogh, Karsten, Ullman, Burke, Thompson, Griffiths, Bass and Jennings), but Watts, Herlong and Mills held out against it. The ten Republicans on the Committee stood firmly opposed. The pro-Hospital Care side just did not have the votes. Congressman King himself moved to suspend further consideration of the measure that bears his name. He did this so as to keep control of what might finally happen in Committee.

The following is our confidential head count on MEDICARE in the Senate.

Current Analysis of Attitudes of Members of the Senate on Social Security-Financed Hospital Insurance for the Elderly

The following analysis is based primarily on the 52 to 48 vote on July 17, 1962 by which the U. S. Senate tabled -- and thus killed -- the Anderson-Javits amendment to the Public Welfare Law which would have provided a Social Security-financed health care plan. It also includes known attitudes of Senators elected since the 1962 vote.

Senators whose names appear in capital letters are running for reelection in November.

It is realized that all members of the Senate have been subjected to considerable propaganda by the American Medical Association in the past two years. A number of Democratic Senators who voted for Social Security Health care in 1962 are facing difficult elections no matter who the Republican Presidential candidate may be.

It is known that the American Medical Political Action Committee and its state and county affiliates is better financed and better organized to oppose these Democratic Senators this fall and we may possibly suffer some defections from the 1962 vote.

This analysis suggests the possibility that the Senate can add an amendment to the House-passed bill to provide Social Security-financed hospitalization along with a direct increase in cash benefits by a margin of 54 to 46 votes.

It should be noted, however, that the incapacity of Democratic Senators Engle and Kennedy -- because of illness and accident -- would reduce the margin of victory from 52 to 46.

If it is considered that a decisive 60 to 40 majority will be necessary to influence the Senate-House conferees, the best prospects listed in Section C, below plus the following:

Democrats:	Republicans:
Russell (Ga.)	Saltonstall (Mass.)
Talmadge (Ga.)	SCOTT (Pa.)

A. Senators who voted to table the hospital insurance bill when it came before the Senate as an amendment to the Public

Welfare Bill on July 17, 1962 and who are expected to continue their opposition to a Social Security-Financed bill:

Democrats:

BYRD (Va.)
Eastland (Miss.)
Ellender (La.)
Ervin (N.C.)
Fulbright (Ark.)
HOLLAND (Fla.)
Jordan (N.C.)
McClellan (Ark.)
Robertson (Va.)
Russell (Ga.)
Smathers (Fla.)
STENNIS (Miss.)
Talmadge (Ga.)
Thurmond (S.C.) (14)

Republicans:

Aiken (Vt.)
Allott (Colo.)
BEALL (Md.)
Bennett (Utah)
Boggs (Del.)
Carlson (Kans.)
Cotton (N. H.)
Curtis (Nebr.)
Dirksen (Ill.)
Goldwater (Ariz.)
Hickenlooper (Iowa)
HRUSKA (Nebr.)
Miller (Iowa)
Morton (Ky.)
Mundt (S. D.)
Pearson (Kans.)
PROUTY (Vt.)
Saltonstall (Mass.)
SCOTT (Pa.)
Tower (Texas)
WILLIAMS (Del.)
Young (N. D.) (22)

B. Senators elected since July 1962 who are expected to vote in opposition to a Social Security-financed bill:

Democrats:

Walters (Tenn.)

Republicans:

Dominick (Colo.)
Jordan (Idaho)
MECHEM (N. Mex.)
Simpson (Colo.) (5)

C. Senators who voted to table the bill in July 1962 -- and who will probably do so again -- but whose opposition has not been considered so strong as to make them permanent opponents of the measure:

Democrats:

Hill (Ala.)
Long (La.)
Monroney (Okla.)
Sparkman (Ala.)

Republicans:

Fong (Hawaii)

Total number of Senators who are either expected to oppose a Social Security-financed hospital care amendment or who will probably vote to oppose it: 46.

D. Senators who voted against the tabling of the bill in 1962 and who are expected to support an amendment adding Social Security-financed hospital insurance to the House bill:

Democrats:

Anderson (N. Mex.)
Bartlett (Alaska)
Bible (Nev.)
BURDICK (N. D.)
BYRD (W. Va.)
CANNON (Nev.)
Church (Idaho)
Clark (Pa.)
DODD (Conn.)
Douglas (Ill.)
Engle (Calif.)
Gore (Tenn.)
Gruening (Alaska)
HART (Mich.)
HARTKE (Ind.)
Humphrey (Minn.)
JACKSON (Wash.)
Johnston (S.C.)
Long (Mo.)
Magnuson (Wash.)
MANSFIELD (Mont.)
McCARTHY (Minn.)
McGEE (Wyo.)
McNamara (Mich.)
Metcalf (Ore.)
Morse (Ore.)
MOSS (Utah)
MUSKIE (Maine)
Mrs. Neuberger (Ore.)
PASTORE (R. I.)
Pell (R. I.)
PROXMIRE (Wisc.)
SYMINGTON (Mo.)
WILLIAMS (N. J.)
YARBOROUGH (Texas)
YOUNG (Ohio) (36)

Republicans:

Case (N. J.)
Cooper (Ky.)
Javits (N. Y.)
KEATING (N. Y.)
Kuchel (Calif.)

E. Senators elected since the vote of July 1962 who are expected to vote in support of a Social Security-financed hospital insurance bill:

Democrats:

Bayh (Ind.)
Brewster (Md.)
Edmondson (Okla.)
Inouye (Hawaii)
KENNEDY (Mass.)
McGovern (N. D.)
McIntyre (N. H.)
Nelson (Wisc.)
Ribicoff (Conn.)

(9)

F. Senators who voted against the hospital insurance bill as and amendment to the Public Welfare bill in July 1962 but who will probably vote in support of such a measure:

Democrats:

Hayden (Ariz.)
Randolph (W. Va.)

Republican:

Mrs. Margaret Chase Smith (Maine)

One Senator -- Lausche (D-Ohio) -- who voted for the bill in 1962 is now reported to favor a private insurance optional plan along the lines proposed by Republican Representative Frank Bow of Ohio. He should be recorded as a "maybe" vote for the bill.

Total number of Senators who are either expected to vote for Social Security-financed health care, or who will probably vote for it or who "may" vote in its support: 54.

+ + + +

July 10, 1964

RECENT LEGISLATIVE DEVELOPMENTS

"THE SOCIAL SECURITY AMENDMENTS OF 1964"
(H.R. 11865)

Legislative Analysis Memorandum #5-64

Compiled by
Walter A. Hasty, Jr., Assistant Director
Division of Legislative Services

The Ways and Means Committee approved the following changes in the Social Security Program in a new Mills bill (HR 11865), entitled, "The Social Security Amendments of 1964."

1. The bill provides a 5% across-the-board increase in benefits to all persons now receiving social security, effective two (2) months after the day of final passage of the bill. This will mean 20 million persons now receiving social security will automatically receive a 5% increase, probably in their October Social Security check.

Maximum family social security benefits would eventually increase to $300 per month, and maximum individual benefits to $143.40. Cost $900 million.

2. The bill would make 600,000 persons age 72 and over, previously not eligible for social security, now eligible for a benefit of $35 a month. If both a man and wife now qualify they will get $52.50. It would make eligible any person over 72 who has at least three quarters of Social Security coverage since the beginning of Social Security in 1937, instead of the six quarters now required. This reduced minimum number of quarters of coverage required will apply to only those who are 72 or near 72, and this provision will be phased out by 1967. In effect, this provision blankets in most people over age 72, especially many of the older widows. Cost $250 million.

3. 180,000 widows may now elect to receive Social Security at age 60 instead of 62, with a reduced benefit. At age 65 they would

receive 100%. At age 62, widows could receive 82½% of their entitlement, and at age 60 they would receive 71¼% of their entitlement. Cost $150 million.

4. Children who have been receiving survivors benefits under Social Security can continue to receive benefit until age 22 if they are going to an accredited school or college. Previously, it has terminated at age 18. Cost $175 million.

Financing

The bill provides that the tax base will increase fom $4800 to $5400 as of January 1, 1965. It also calls for an increase of .175% as follows:

	Employee-Employer Rate (Each)		Self-Employed Rate	
Years	Present Law	HR 11865	Present Law	HR 11865
1965	3.625%	3.8%	5.4%	5.7%
1966	4.125%	4.0	6.2	6.0
1967	4.125	4.0	6.2	6.0
1968	4.625	4.5	6.9	6.8
1969-70	4.625	4.5	6.9	6.8
1971 and after	4.625	4.8	6.9	7.2

New Groups Included Under Social Security

A. 170,000 self-employed Doctors who previously were excluded may now be included in Social Security.

B. Firemen, policemen and certain other municipal and state employees may elect to be included in the same manner as other state and municipal employees.

Technical Changes

A. The bill transfers some funds from the Social Security Trust Fund to the Social Security Disability Trust Fund to keep the funds in balance.

B. Employees may, for purposes of Social Security coverage, include cash tips that they receive when they are reported to their employer.

THE COMMITTEE DECIDED TO PASS OVER WITHOUT VOTING ON HOSPITAL INSURANCE UNDER SOCIAL SECURITY OR MODIFICATIONS IN THE KERR-MILLS PROVISIONS WITHOUT PREJUDICE TO FUTURE CONSIDERATION OF THESE MATTERS.

A M A STRUGGLES ALONG ON MERE $22 MILLION

Embattled, outnumbered doctors manning the barricades for freedom against the ruthless onslaught of socialism's hordes. This is what the American Medical Association would like to have you think as it wages its war against health care for the elderly under social security.

It's a slight exaggeration.

The embattled, outnumbered AMA, according to the New York Herald-Tribune, fights on bravely with an annual income of $22.5 million, with 900 employees--including a staff of 60 in public relations alone--201,000 members, 13 newspapers, journals and magazines, field representatives and a lobbying operation that accounted for $540,000 last year, and its political arm, the American Medical Political Action Committee.

The bulk of AMA revenue comes from advertising in its publications by drug companies and medical suppliers, $9 million; subscriptions, $2.5 million; dues, $5.5 million.

July 8 1964

MEDICARE IN THE SENATE

The need is to not just pass the bill but to do so in so positive a manner and with the active, informed participation of so large a group of Democratic Senators as to have strong effect on both House and conferees. Can easily be done if a properly and consistently coordinated campaign controlled by a politically ~~young~~ savvy Senator is mounted (as against one run by technical experts from H.E.W. as in 1962).

Essential that Senator Anderson continue to play the front role on floor with Senator McNamara also prominent.

Effective control of all operations should, however, be vested in Senator Humphrey with Olin Johnston serving as his right hand man.

THEREFORE

The President calls in Anderson, McNamara, Humphrey, Johnston.

Having expressed his strong desire to pass bill:

1. Asks Anderson to carry on as champion of bill in Finance Committee and on floor;

2. Asks McNamara to give strong support particularly on plight of elderly as disclosed by McNamara hearings thoughout country and McNamara reports.

3. Expresses his desire to have at least fifteen-twenty Democratic Senators playing an aactive and informed role. Therefore neef for completely coordinated action is obvious and-since Anderson already has his hands full-asks Hubert to take on job of behind the scenes coordinator and master mind.

4. Asks Johnston to aid Hubert, particularly with Southerners, and to play an active role on floor. (Make obvious support from all parts of the Country)

This done, Humphrey can enlist support of and assign the roles suggested on attached sheet to the Senators and staff people listed.

Note: Alternatively, the President might call in all the Senators listed on the attachment thus further highlighting the need for role assignment and coordination.

SENATORS	SUBJECT	STAFF
Anderson, Pell, Ribicoff	Justification & technical defense of the package	Cohen/Wolkstein
McNamara, Johnston, Nelson	Need of the Elderly	Arner/Brewster
Randolph, Clark, Muskie, Williams, Neuberger	Inadequacy of Alternatives (Kerr-Mills; Blues; Commercial)	Livingston, Constantine, Fine
Douglas, McCarthy, Core, Pastore	The Economics of Social Security and of the proposal	Ball/Myers
Young, Morse, Metcalf, Church	Attack on A.M.A.'s position	Cruikshank, Bamberger
McGovern, Bardick	Importance in Rural Areas	Sundquist
Long (Mo.) McIntyre	This The Conservative Way	

Other Senators to take overall approach, each emphasizing a different factor: Hart, Harthe, McGee, Yarborough, Bayh, Brewster

July 30, 1964

Honorable Pat. McNamara
United States Senate
Washington 25, D. C.

Dear Senator McNamara:

This is in response to your letter of July 28, asking me to make a cost comparison between a proposal that would provide hospital benefits with a 45-day maximum to persons aged 65 and over, with a proposal that would provide a broader scope of hospital and related services benefits to this category.

Under the latter proposal, there would be hospital benefits with a 30-day maximum, skilled-nursing-facility benefits after hospitalization (and in any such facilities that meet the definition in S.65), home-health-visits with a maximum of 120 visits, and outpatient-diagnostic services, with a deductible of $20 in a 30-day period (the same as in S.65 and S.880). Furthermore, there would be a maximum of 45 units of coverage, where a hospital day represents one unit, a skilled-nursing-facility day represents one-half unit, and a home-health visit represents one-fourth unit (with no units being assigned to outpatient-diagnostic services). The benefit period would be as defined in S.880. Finally, there would be the possibility of a retirement test in regard to eligibility for these hospital and related benefits--with the cost to be figured both with and without this test.

The estimated level-cost of a hospitalization benefit, with a 45-day maximum and no deductible, is .81% of taxable payroll on the basis of a $5,400 earnings base (and including the additional OASDI eligibles resulting from the "transitional insured-status provision" of H.R. 11865, which passed the House of Representatives on July 29). It should be noted that the underlying assumptions in this cost estimate are that the earnings base will be kept up-to-date in the future so as to bear the same relationship to the general earnings level as $5,400 will in 1965, and that the differential rate of increase of hospital costs over general wage levels will total only 10% over the next 5 or 6 years, and thereafter these two elements will increase at the same rate. The estimated level-cost of the alternative proposal with a broader range of benefits (but a lower maximum on hospitalization) is .80% of taxable payroll, if there is no retirement test--or practically the same as the proposal providing only hospitalization benefits with a 45-day maximum--while with a retirement test such as that in S.65, the estimated level-cost is .77% of taxable payroll.

The estimated number of persons eligible for hospitalization and related benefits who are OASDI eligibles as of the beginning of 1965 is 15.8 million if there is no retirement test applicable to such benefits (in addition, there are 550,000 eligibles under the Railroad Retirement system who are not OASDI eligibles). If there were a retirement test such as that in S.65, the number of eligibles would be reduced by about 900,000.

Since the alternative package of benefits that provides other services than hospital benefits has virtually the same cost as a proposal for only hospitalization benefits with a 45-day maximum, it can also be stated that the cost to general revenues for the "uninsured" aged would be virtually the same under either alternative.

Sincerely yours,

Robert J. Myers
Chief Actuary

DEPARTMENT OF
HEALTH, EDUCATION, AND WELFARE
OFFICE OF THE SECRETARY

From: Wilbur J. Cohen
Assistant Secretary

Attachments will follow

John
Did you order
this?

For Release at 10:00 a.m., EDT.
Thursday, August 6, 1964

Statement
by
Anthony J. Celebrezze
Secretary of Health, Education, and Welfare
Before the
Committee on Finance
United States Senate
Thursday, August 6, 1964
10:00 a.m., EDT.

Mr. Chairman and 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 get 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 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 $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 70's 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 long-run 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 long-run 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 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 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 1/2 of 1 percent, from 3-5/8 to 4-1/8 in 1966 and again in 1968, when the ultimate rate of 4-5/8 percent would become effective. Under the schedule in the bill, the rate in 1965 would be 3.8 percent instead of 3-5/8, in 1966 it would be 4 percent instead of 4-1/8, and the rates would remain below those scheduled in present law until 1971. In 1971 the employee-employer rate would be 4.8 percent--0.175 percent higher than the 4-5/8 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 1-1/2 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. This would bring the total allocation to the disability insurance trust fund to 0.65 percent of taxable wages and 0.4875 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 long-run 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 (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 2.0 percent relative to its total cost.

The Job Left Undone

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 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. They use, for example, three times as many hospital 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. 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 that 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 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 among 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 irresistible 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 long-run 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 which provide for income tax deductions for medical expenses which help those who are relatively well off and laws 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 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.

# # #

88th Congress - Second Session
Report No. 8 - July 27, 1964

LEGISLATIVE ANALYSIS

SOCIAL SECURITY AMENDMENTS OF 1964

H.R. 11865 - Representative Mills

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In view of the extensive background information necessary for a meaningful explanation of the issues involved in the subject matter of this Analysis, the usual brief, detachable Summary of Pro and Con Arguments has been ommitted. However, the major social security proposals of H.R. 11865 and the principal issues involved therein are summarized in the opening, "Introductory Summary" section.

SOCIAL SECURITY AMENDMENTS OF 1964

INTRODUCTORY SUMMARY

The proposed "Social Security Amendments of 1964," incorporated in H.R. 11865, would carry out the recommendations of the House Committee on Ways and Means for additional changes in the Social Security Act, which was enacted originally in 1935. The 1964 proposals are limited to the federal old age and survivors insurance and disability insurance (OASDI) programs.

The new bill, introduced July 1, 1964, by Rep. Mills, Chairman of the Ways and Means Committee, does not contain provisions for hospital care for aged persons financed by social security payroll taxes or for changes in medical assistance for the aged under the Kerr-Mills Act. In this connection, the Committee announced that its approval of H.R. 11865 was "without prejudice to possible action at a future time" on proposals relating directly to hospital care for the aged. The Committee held extensive hearings in November, 1963, and January, 1964, on the hospital-care-for-the-aged bill (H.R. 3320).

Major 1964 Social Security Proposals

The 1964 social security changes of broad application proposed through H.R. 11865 are:

1. An increase of 5 percent across the board in monthly benefits currently payable under the old age and survivors insurance and disability insurance programs.

2. An increase from $127.00 to $143.40 monthly in the maximum individual benefit payable in the future and an increase from $254.00 to $300.00 monthly in maximum family benefits payable in the future.

3. An upward adjustment of tax levies for OASDI purposes through an increase in the annual taxable earnings base from $4,800 to $5,400 and readjustments of tax rate schedules. In 1971 and thereafter the combined employer-employee rate would reach a peak of 9.6 percent. The corresponding self-employment peak rate would be 7.2 percent.

The benefit increases would become payable in the second month after enactment of the bill. However, the tax increases would not become effective until the beginning of 1965.

The five percent increases in benefits for current beneficiaries would increase the minimum "primary" 1/ benefit from $40 to $42 monthly

1/ The "primary" monthly benefit is the benefit amount computed on the basis of the individual's own wage record, as differentiated from survivors' or dependents' benefits.

and the present maximum primary benefit (payable at the average monthly wage level of $400) from $127 to $133.40 monthly. The five percent increases would apply both to persons already receiving benefits and to new beneficiaries. The higher maximum of $143.40 monthly and the $300 family maximum would become available to future beneficiaries only to the extent that they were able to take advantage of the expansion of the annual earnings base to $5,400 to bring their average monthly wage up to the $450 level.

The taxing changes in the bill, as compared with the present law, would increase the amount of OASDI tax owed on a $5,400 wage or salary in 1965 by $62.40 -- from $348.00 to $410.40. Half of this increase, or $31.20, would be in additional taxes withheld from wage or salary checks and the other half would be paid by the employer. For self-employed persons with taxable earnings of at least $5,400 in 1965, the increase over the liability under the present law would be $48.60 -- from $259.20 to $307.80. For 1971 and subsequent years, the combined employer-employee tax liability at the maximum $5,400 earnings level would be increased under the bill by $74.40 -- to the new maximum of $518.40. For the self-employed person, the maximum tax liability in 1971 and subsequent years would be $388.80 -- an increase of $57.60 over maximum tax liability at that time under the present law.

The tax increases are required, according to the Ways and Means Committee, to finance the costs of the benefit and other liberalizations in the bill.

Proposed Changes Having Limited Application

In addition to the benefit liberalizations and financing changes provided by H.R. 11865, the bill contains a series of social security amendments having a more limited application. These include:

1. Payment of a surviving child's benefit (or benefits for child of a recipient of disability benefits) beyond his or her age of 18, the present limit, to age 22 if the child is in school or college.

2. Lowering of the aged widow's benefit eligibility age limit from 62 to 60 years, with the benefits being subject to actuarial reduction.

3. Relaxation of certain eligibility requirements to permit payment of limited amounts of benefits to some persons who have attained age 72 and hitherto have been ineligible for lack of sufficient "quarters of coverage" on the part of the primary beneficiary.

4. Extension of OASDI coverage to self-employed doctors of medicine and interns, plus certain minor coverage extensions.

5. Inclusion of cash tips from customers as "wages" of waiters and other service employees -- thus to make such tips subject to OASDI taxation and to cause them to be counted in the building up of benefit rights.

Details of these and certain other amendments of a technical nature are described in a later section of this Analysis, starting at page 41 .

Development of OASDI System Over Three-Decade Period

The OASDI system had its origin in the 1935 Social Security Act as an old-age benefit program, financed by payroll taxes, exclusively for wage and salary earners. Since then, it has grown into a "social insurance" system that has near-universal coverage of both employed and self-employed persons and that provides retirement, disability, and survivorship benefits for dependents and survivors as well as for the workers themselves.

Through the period, the system has undergone basic changes with respect to coverage, types and amounts of benefits available, conditions of eligibility for benefits, and methods of financing. Currently, the program makes available to more than 19 million people cash benefits in excess of $15 billion annually and is responsible for the collection of approximately an equal amount of taxes from employers, employees, and the self-employed.

The more significant developments in the history of the program are described -- and the present-day functioning of the program is explained -- in the section of the Analysis immediately following this section.

Issues Involved in Proposed Benefit Liberalizations

The general increase in OASDI benefits proposed through H.R. 11865 is described by the House Ways and Means Committee as being necessary at this time because of changes in wages, prices, and other aspects of the economy that have occurred since the last general increase was awarded in 1958. Most beneficiaries depend upon the OASDI checks as their major or sole source of support, the Committee states.

The five percent increase in benefits would represent an increase in costs of approximately $925 million in 1965. The cost of all liberalizations in the bill, including this boost in benefit checks, would be approximately $1.6 billion in 1965. This cost-increase impact would continue to grow in future years as the beneficiary rolls expand and effects of the expansion of the taxable wage base come into play.

Legislated increases in statutory benefit maximums, not including the currently proposed increases, have amounted to approximately 119 percent since 1940. Comparably, the increase in the cost of living, as measured by the consumers price index, has been 121 percent since 1940. Since 1950, the legislated increase in the benefit maximum has been 59 percent. The cost of living has increased 28 percent since 1950.

Benefits actually payable at varied monthly wage levels have been increased over the years by the automatic escalating force of rising wage levels as well as by statutory changes. An analysis made through the use of hypothetical examples indicates that OASDI benefit increases resulting from both law changes and the rise of wage levels have been at percentage rates that are more than double, with certain exceptions, the percentage increase in the cost of living. This is true regardless of whether the comparison is made from a starting date of 1940 or 1950. The principal exception is in the case of persons at higher wage levels where limits on the annual wage base or on maximum benefits have had restrictive effects.

Similarly, the average monthly benefit actually paid to retired workers is shown to have increased by 242 percent since 1940 and by 76 percent since 1950. On this basis of comparison, the rate of the benefit increase shows to be double the percentage increase in the cost of living over the longer period. Over the shorter period since 1950, the percentage increase in the average monthly benefit paid to retired workers is nearly triple the rate of the cost of living increase.

Divergent viewpoints with respect to the proper level of OASDI benefits are reflected through differing concepts of the "floor of protection" that should be afforded by the benefits. Proponents of further liberalization of benefits argue that most individuals are able to save little or nothing and that the benefits should be large enough to assure a meeting of needs of beneficiaries on a relatively comfortable living plane. Critics of repeated benefit liberalizations contend, on the other hand, that the purpose of the "floor of protection" offered by a compulsory social insurance system should be limited to the meeting of essential needs to such an extent as to prevent the great bulk of OASDI beneficiaries from becoming public assistance charges.

Details of the proposed OASDI benefit liberalizations and the issues involved therein are examined in the section of this Analysis starting at page 16 .

Controversial Aspects of OASDI Financing

Differing viewpoints on the soundness of OASDI financing center on basic "social insurance" characteristics of the OASDI system. One of these characteristics is the lack of individual equity in the relationship of benefits received to the amount of taxes paid by or in behalf of

an individual beneficiary. This is exemplified by the fact that some beneficiaries may receive substantially more in benefits, and others substantially less, than the amounts of taxes paid on their earnings. Another characteristic is the postponement into the future of the financing of the bulk of currently accruing liabilities.

In agreeing that there is a lack of direct relationship for an individual between taxes paid and benefits received, supporters of the existing OASDI financing structure contend that the OASDI system properly emphasizes social adequacy at the expense of individual equity.

With respect to a current $325 billion "unfunded accrued liability" of the OASDI system, supporters say that full funding of a social insurance system such as the OASDI is unrealistic and is not required because it may be assumed that the Government and its social insurance system will have perpetual life. The system is actuarially sound, they contend, so long as it continues as it has in the past to be completely self-supporting from the social security taxes paid by covered individuals and employers.

Critics of OASDI financing, on the other hand, contend that the financing structure is unsound because it imposes on present and future workers much of the burden of increased benefit payments to the presently retired. They say that the "succession of election-year liberalizations" have been accompanied by only token tax increases that have been disproportionate to the larger increases in long-range benefit obligations. They state the belief that if future generations are unwilling to honor the unfunded obligations currently being incurred, the system will collapse. They also are critical of the lack of individual equity with respect to the relationship between tax payments and benefits.

These controversial aspects of OASDI financing, as well as details of tax increases proposed through H.R. 11865, are expanded upon in the section of this Analysis starting at page 30 .

OASDI-PROGRAM BACKGROUND

The old age, survivors, and disability insurance (OASDI) system, to which the currently proposed social security amendments are applicable, had its inception in the "federal old-age benefits" program established by Title II of the Social Security Act of 1935. This program essentially was a compulsory pension system with "earned" monthly benefits to be payable to retirees on attainment of age 65. It covered wage and salary earners in most areas of private employment other than agriculture and domestic service. There was no provision for survivors' or dependents' benefits. This was one of three major programs established by the 1935 law. The other two were the system of federal grants for old-age and dependent children assistance (welfare) and the federal-state system of unemployment compensation.

The original pension program was financed by payroll taxes payable by employers and employees at a rate of 1 percent each on individual wages of up to $3,000 per year. The taxes first became effective for 1947 employment. The rates were scheduled to rise to a maximum of 3 percent payable by the employer and 3 percent by the employee for 1949 and subsequent years. Benefit payments were not to start until 1942. Hence, reserves were to be created and adherence to the principle of funding of liabilities was contemplated. This principle soon was abandoned, however, through a series of actions by the Congress. Among these actions were successive "freezings" of the tax rates at the original level of 1 percent each from employers and employees. These rates remained in effect, actually, until 1950, when they were allowed to nudge up to 1½ percent each.

Social Security Amendments of 1939

In 1939, before the original old-age "pensions" became payable, Title II of the Social Security Act was completely rewritten. The new version added dependents' and survivors' benefits and substituted a new formula controlling the monthly benefit amounts. Dependents and survivors made eligible for benefits were wives over age 65, widows over age 65, unmarried children up to age 18 of "insured" workers who had died (regardless of age at time of death), widowed mothers (remaining unmarried) with such children in their care, and dependent parents over age 65.

Another significant feature of the 1939 amendments was the adoption of the "quick start" principle for the payment of benefits. The original old-age benefits, in addition to not being scheduled to start until 1942, had been geared directly to total covered wages (of not more than $3,000 annually) earned by the individual after 1936. For example, 11 years of employment at the maximum covered wage of $3,000 annually would have been required for an individual to qualify for a $40 monthly old-age benefit. Under the "quick start" principle of the 1939 amendments,

however, the benefits became payable with the start of 1940. More significantly, through a shift to an average-wage formula, it was made possible for a $40-plus monthly old-age benefit 1/ to be payable on the basis of a minimum of 3 years of covered employment. 2/ For example, an individual who had been employed at a $3,000 annual wage during the period of 1937 through 1939 could qualify in January of 1940 (if age 65 and retired) for a monthly benefit of $41.20. And if there had been an aged wife, she would have been entitled to an additional $20.60 monthly. 3/

1950 Changes in Program

The next substantial revision of the OASDI program occurred in 1950 when (1) benefits were increased, (2) coverage was extended to include domestic service, farm employment, and the great bulk of persons engaged in self-employment, (3) the privilege of coming under the program was extended on a permissive basis to state and local government employees, and (4) the taxable wage base was increased to $3,600 (starting in 1951) and a new schedule of tax rates was provided. Also, a "new start" was instituted under which new benefit applicants were granted the option of basing benefit eligibility on employment or self-employment occurring after 1950 and, under certain circumstances, were able to acquire eligibility for maximum benefits for their average-wage categories with a minimum of six calendar quarters of earnings subject to OASI taxation. Similarly, computations of benefit amounts were based upon earnings after 1950 unless the utilization of earlier wages either were required for qualification purposes or produced larger benefit amounts. The "benefit increment" of 1 percent for each year of covered employment also was eliminated.

Amendments of Mid-1950's and Early-1960's

Through the remainder of the 1950's and the early 1960's, successive enactments by the Congress accounted for a series of basic changes in the OASI program which included the following:

1/ Under the 1939 formula, the monthly benefit amount as otherwise computed was subject to a 1 percent increment for each year of covered employment in the beneficiary's employment history.

2/ Under certain circumstances, near-maximum levels of benefits for survivors of persons who had died could be attained on the basis of 1½ years of employment.

3/ Significance of the substitution of the "quick start" for the "slow start" is examined further in a later section of this analysis dealing with the financing of the OASDI program.

Benefit liberalizations were extended in 1952, 1954, and 1958. Also, a minor increase in minimum benefits was voted in 1961.

Disability insurance benefits were established in 1956 for persons aged 50 and over and for children aged 18 and over if the child had been disabled before age 18 (thus changing "OASI" to "OASDI"). There had been a forerunner of this broadening of the program in the form of a 1954 amendment that provided a wage record "freeze" under which periods of disability under specified circumstances could be disregarded in the determination of the insured status and the average monthly wage of a benefit applicant. Then in 1958 dependents of disability insurance beneficiaries were made eligible for benefits and in 1960 the age-50 restriction on eligibility for disability benefits was removed.

The old-age benefit eligibility requirement of age 65 was reduced to 62 years for women in 1956 and to 62 years for men in 1961. Actuarial reductions of benefits payable to the "early retirees" and to aged wives and husbands qualifying for benefits at earlier than age 65 were provided.

There were varied relaxations of benefit eligibility conditions during the period. For example, the device under which a specified number of "bad" years of past employment experience may be disregarded in the computation of the average monthly wage was instituted, with the most recent amendment in this respect fixing the number of disregarded years at five. The number of calendar quarters of past covered employment in relation to elapsed time that are required to establish benefit eligibility were reduced, progressively, from one quarter of employment for each two of elapsed time after 1950 or the applicant's age 21 (whichever occurs later) to one for each three quarters and then to one for each calendar year (otherwise, 40 quarters of employment gives lifetime eligibility). Also, the "retirement test" -- amount of earnings of a beneficiary permitted as being non-disqualifying -- has been liberalized progressively.

Coverage of the program was further broadened.

Financing provisions were revised from time to time (in this instance, through amendment of the Internal Revenue Code). In most instances, liberalizations which increased OASDI outgo have been accompanied by changes which increased revenues. The taxable wage base was increased to $4,200 for 1955, and to $4,800 for 1959 and subsequent years. Through tax rate increases, the combined employer-employee of 3 percent in effect in 1950 had been increased to a combined rate of 7.25 percent in effect for 1963 and 1964. The increase in the self-employment rate has been from the starting figure of 2.25 percent in 1951 to 5.4 percent for 1963 and 1964.

Today's OASDI Program

The old age, survivors, and disability insurance program is today a federally operated social insurance system of near-universal proportions from the standpoint of provision of retirement and survivorship income for earners of employment and self-employment income, and members of their families, in the United States. In areas of employment where OASDI coverage does not extend there are, in most instances, special programs of retirement and related benefits.

In the 1963 calendar year, cash OASDI benefit payments totaled more than $15 billion. In February, 1964, over 19 million persons received OASDI benefit payments of one type or another. Lump sum payments were made for an additional 84,200 decedents. OASDI tax collections in the 1963 calendar year, including deposits by states under voluntary agreements for coverages of public employees, totaled more than $15.4 billion. Additional income of the OASDI trust fund in 1963 exceeded $521 million of interest received from the Federal Treasury. Administrative expenses out of the trust fund for the year amounted to $280.6 million.

In 1963, an estimated total 1/ of 90.5 million people had OASDI "insured status." This means that that number either already were drawing benefits or had acquired potential rights to benefits in the future. Balances of funds held in trust for the old age and survivors insurance program and the disability insurance program at the end of 1963 totaled $20.7 billion. These were more in the nature of "working balances" than "reserves," inasmuch as the funds on hand represented only a small fraction of accrued liabilities. 2/

Principal features of the OASDI program as it currently functions are outlined below.

Coverage. With certain exceptions involving relatively small numbers of people, OASDI coverage encompasses generally (1) all types of private employment other than railroad employment; 3/ (2) self-employment

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1/ Long-Range Cost Estimates for Old-Age, Survivors, and Disability Insurance System, 1963, (Actuarial Study No. 38), Social Security Administration, p. 25.

2/ This matter is examined in more detail in the section of this Analysis dealing with the financing of the OASDI system.

3/ Railroad employment is excluded because it is covered under the Railroad Retirement Act. Coverage of the employment of ministers and members of religious orders is not compulsory, but may be "elected" under special arrangements.

in trades, businesses, and professions other than the medical profession; (3) military service and other forms of employment with the Federal Government and its instrumentalities not subject to the Civil Service Act (elected federal officials and employment with the federal legislative branch are excluded), and (4) state and local public employment on a permissive basis. 1/

Insured Status. An individual acquires potential eligibility for OASDI benefits for himself (or herself) and his dependents and survivors by having had the required numbers of "quarters of coverage" of employment or self-employment. A "quarter of coverage" is a calendar quarter in which the individual has been paid at least $50 in covered wages (with certain modifications for farm labor) or has been credited with $100 or more of self-employment income. (A person receiving $4,800 in covered wages in a calendar year or at least $400 in self-employment income is credited automatically with four quarters of coverage for the year.) To be "fully insured," an individual must have acquired any time after 1936 either (1) 40 quarters of coverage, or (2) at least one calendar quarter for each calendar year elapsing after 1950 or after the year of attainment of age 21 (if that occurs later) and up to the year of death or (whichever occurs first) age 62 in the case of a woman and age 65 in the case of a man. In any event, there must have been at least six quarters of coverage. (Any year in any part of which there occurred a defined "period of disability" is not counted as an elapsed year.) To have a "currently insured" status (controlling eligibility for certain of the survivors' benefits), an individual must have had at least six quarters of coverage during the 12-quarter period immediately preceding the quarter in which he died or became entitled to retirement benefits. 2/

Average Monthly Wage. The "average monthly wage" of an individual forms the basis for determination of his "primary" benefit amount -- that is, the monthly benefit to which he is entitled upon his retirement or to which benefits for his survivors are geared. Generally, with respect to current applicants for benefits, the "average monthly wage" of an individual is the monthly average of all wages of self-employment income credited to him after 1950 and before the year in which he died or became entitled to old age benefits -- but with up to five years

1/ Sections 209, 210, and 211 of the Social Security Act should be examined for precise definitions of OASDI coverage. For example, exceptions include services of an individual in the employ of his or her spouse and services of a newspaper carrier under age 18. Generally, income from investments does not qualify an individual for self-employment coverage, although there are exceptions to this rule under specified circumstances.

2/ There are other conditions applicable with respect to disability benefits and to certain circumstances of an isolated character.

of lowest income eliminated from the computation. In any event, there must be at least two benefit computation years. 1/ This general rule is subject to various modifications to fit special circumstances. For example, there are circumstances under which wages credited prior to 1951 may be utilized in the computation. In all instances, the credited wages and self-employment income utilized in the computations may not exceed the annual wage base limits ($3,000, $3,600, $4,200, and $4,800) in effect for the respective years involved in the computations.

Primary Benefit Table. In the earlier years of the OASDI program, the amount of the primary benefit was controlled by a formula spelled out in Title II of the Social Security Act. However, the formula has now been supplanted by a detailed table written into the Act which specifies for each of numerous average-monthly-wage ranges the primary amount that is payable. 2/ The table also specifies the maximum family benefits that are payable at the various average-monthly-wage levels. Likewise, it serves as a means of "converting" previously established benefit amounts into currently payable levels of benefits -- thus extending liberalizations voted by the Congress from time to time to persons already on the rolls as beneficiaries prior to the enactment of the amendments. For new applicants, for example, the benefit table in the present law provides that the minimum monthly primary amount of $40 is payable for an individual with an average monthly wage of $67 or less; that an average monthly wage of at least $156 and not more than $160 produces a monthly benefit of $75, and that an average monthly wage of $399-$400 produces the maximum primary monthly benefit of $127. Similarly, the table specifies that a monthly benefit of not more than $13.48 as determined under statutory provisions of the 1939 Act, or of not more than $37 as determined under 1954 statutory provisions, will qualify the individual involved for today's minimum benefit of $40. As other "conversion" examples, a benefit of $44.89-$45.60 as computed under the 1939 formula, or a $88.40-$89.20 benefit as computed under 1954 provisions, converts into a monthly benefit of $95 under present law -- while a benefit in the $108.00-$108.50 range under the 1954 formula converts into a benefit of $116 monthly under present law.

Types of OASDI Benefits. The different types of OASDI benefits that are payable, and their amounts in relation to primary benefits

1/ It is to be noted that the average monthly wage is computed through the dividing -- after the five lowest-income years have been eliminated from the computation -- of total credited wages by the number of elapsed months. Hence, the "divisor" may include periods of time for which there were no credited wages.

2/ The primary amount for an aged beneficiary is that payable for an age-65-or-older start of benefit payments. If benefits are claimed at ages 62 through 64, the payments are subject to actuarial reduction.

in instances of dependents' and survivors' benefits, are outlined below. In instances where references are to "old-age" benefits or "aged" beneficiaries, an eligibility requirement is that the beneficiary has attained at least age 62. However, the amounts of primary old-age benefits and of aged wives' and husbands' benefits (but not aged widows' or widowers' benefits) are geared to age-65 entitlement and are subject to actuarial reduction in instances of earlier-than-age-65 qualification. The types of benefits are as follows:

Old-age benefits -- payable to retired, "fully insured" individuals on the basis of their own wage and self-employment income credits, in the amounts of the primary benefits for which they qualify (subject to actuarial reduction for "early retirement").

Aged wife's benefit -- equal to one-half of husband's primary amount.

Aged husband's benefit -- equal to one-half of aged wife's primary amount and payable in instances in which he had been receiving at least half of his support (in accordance with prescribed regulations) from his wife.

Child's benefit -- payable in instances of an unmarried, dependent, under-age-18 child of an individual entitled to old-age or disability benefits, or of such a child of a person who has died fully or currently insured, in amounts of (1) one-half the primary amount if the parent is living, or (2) three-fourths of the primary amount if the parent is deceased. (The child may retain eligibility beyond age 18 if disabled.)

Aged widow's benefit -- payable while she remains unmarried, in the amount of 82½ percent of the primary benefit of her deceased husband.

Aged widower's benefit -- payable while he remains unmarried, and if he had been receiving at least half his support from the deceased wife, in an amount equal to 82½ percent of the deceased wife's primary benefit.

Mother's benefit -- payable to the widow or divorced wife of an individual who died currently or fully insured, provided she remains unmarried and has in her care a child of the deceased husband who is entitled to a child's benefit, in an amount equal to three-fourths of the deceased husband's primary insurance amount.

Aged parent's benefit -- payable if the parent or parents had been dependent upon a son or daughter who died in fully insured status, at a rate of (1) 82½ percent of the primary amount of the deceased son or daughter if there is only one parent drawing benefits, or (2) 75 percent of the primary amount if both parents are beneficiaries.

Disability benefits -- payable after a six-month waiting period, in same amounts as other OASDI benefits, to permanently disabled women under age 62 and men under age 65, and to their wives, husbands, children, and dependent parents. The benefits payable to the disabled person are the primary amounts based upon his own wage record. Social security work credit for at least five years out of the last ten years preceding the onset of disability is an eligibility requirement. "Disability" is defined to mean inability to engage in any substantial gainful activity by reason of any medically determinable physical or mental impairment. (Disabled persons older than the specified age limits would be eligible for old-age benefits.)

Lump-sum death payment -- payable in the amount of $255 or three times the primary benefit amount, whichever is smaller, upon the death of a fully or currently insured individual.

The above descriptions of types of OASDI benefits are general in character and do not include explanations of numerous technical restrictions and conditions that enter into eligibility for the payments. Also, it is to be noted that an individual otherwise qualifying for both a dependent's benefit and for a primary benefit in his own right (as in the case of an aged man and wife, both of whom have worked in covered employment) would be entitled to receive only the larger of the two benefits -- not both.

Limitations on Family Benefits. The aggregate amounts of OASDI benefits payable to a single family, based upon the wage credits of one individual, are limited to amounts set out in the table of benefits in Section 215 of the Social Security Act. Such family limitations are applicable, for example, in instances of a widowed mother left with several children in her care. The family maximums at the various average-monthly-wage levels in most instances are more than double the corresponding primary benefit amounts (except in the lower benefit ranges) on which they are based. Under present law, the smallest family maximum is $60 monthly, applicable at the minimum primary benefit level of $40. At the primary

benefit level of $105 monthly, the family maximum is $240. The top family limit in the benefit schedule is $254 monthly, applicable at the primary benefit levels of $109 through $127. Where the aggregate family benefits otherwise total to more than the specified maximums, it is required that the benefits be reduced so as to fall within the family limits. 1/

Benefit Reductions on Account of Work. Although retirement by an individual from this normal work activities generally is a condition precedent to qualification for old-age benefits, complete retirement is not required. Certain amounts of earnings will not affect benefit eligibility, while under other conditions the earnings may result only in reductions of benefits. The effects of earnings on benefits are applicable not only to old-age benefits, but also to benefits receivable by dependent and survivors. The rules, in general, are: (1) Earnings from employment or self-employment have no effect on benefits payable to persons (and their dependents) who have attained age 72; (2) benefits are payable in full for any month in which the beneficiary did not earn more than $100 in wages or did not engage in any substantial amount (generally, not more than 45 hours per month) of self-employment, regardless of amounts of earnings in other months of the year; (3) when wages of a beneficiary exceed $1,200 in a calendar year, benefits payable to the beneficiary and (if he is the primary beneficiary) his dependents for months in which he earned more than $100 or engaged in substantial self-employment are subject to reductions in the amounts of $1 for each $2 of the first $500 of "excess" earnings, and of dollar for dollar of earnings over $1,700 in a year; and (4) if a retired worker and his dependents are receiving payments, amounts of benefit deductions because of earnings are withheld from total family benefits -- but if a person receiving benefits as a dependent or survivor works, only his own benefit check is affected. Also, in the case of a person under age 72 who works outside the United States after qualifying for benefits, the benefit check is withheld for any month in which he works more than seven calendar days.

OASDI Taxation and Financing. The first $4,800 in a year of wages paid to an individual in OASDI-covered employment or of earnings from OASDI-covered self-employment, with certain specified exceptions, 2/ is subject to taxation under the Federal Insurance Contributions Act. In the case of employment wages or salaries, half of the tax is paid by the employer and the other half is paid by employees through the withholding process. In the case of self-employment income, the individual

1/ Certain exceptions to this general rule are set out in Section 203(a) of the Social Security Act.

2/ For example, wages of less than $50 in a calendar quarter paid to a domestic service worker in a private home are excepted.

is taxed at a rate equal to approximately three-fourths of the combined employer-employee tax rate. Tax rates in effect in 1964 are 3.625 percent payable by the employer, 3.625 percent payable by the employee (or combined total of 7.25 percent), and 5.4 percent payable by the self-employed individual. The tax rates are scheduled under present law to rise to combined employer-employee rates of 8.25 percent in 1966 and 9.25 percent for 1968 and subsequent years -- and in the case of self-employment taxes, to 6.2 percent in 1966 and 6.9 for 1968 and subsequent years. If an individual has worked for more than one employer in a year and the total taxed wages exceed $4,800, the amount of the employee tax on wages in excess of $4,800 is returnable to the employee involved. Tax funds collected are appropriated automatically to separate old age and survivors insurance and disability insurance trust funds, with the latter fund receiving the equivalent of ½ of 1 percent of wages and 3/8 of 1 percent of self-employment earnings. Benefits and administrative expenses are paid out of the trust funds. Reserves in the trust funds are invested in interest-bearing obligations of the Federal Government or in obligations guaranteed as to principal and interest by the Government. The Treasury pays interest to the trust funds at a rate (computed each month) equal to the average market yield of all marketable interest-bearing obligations of the Government which form a part of the public debt and are not due or callable until more than four years after the monthly interest-computation date.

OASDI BENEFIT LIBERALIZATIONS UNDER PROPOSED BILL

Benefit liberalizations for OASDI beneficiaries that would be provided by the proposed social security amendments of 1964 are accounted for by a combination of (1) the five percent (with fractional variations) across-the-board increase in currently paid benefits and (2) the raising of the limit on "counted" wages and self-employment income from $4,800 to $5,400 per year.

The five percent increase would be payable for the second month following the enactment of the bill, for both present beneficiaries and for newly qualifying beneficiaries. The additional increases extended through the expansion of the annual wage base would be available only to persons who have wage or self-employment income after 1964 in excess of $4,800 annually. The effects on benefits of the wage base expansion would be gradual.

The new "eventual" maximum benefit provided in the bill of $143.40 monthly, for persons with earnings in the $450 top bracket of counted average monthly wages, compares with an eventual maximum of $127 monthly under present law. Under terms of existing law, as it would be amended by the pending bill, the full amount of the new maximum benefit could become available only to persons who reached age 21 in 1959 or later and who maintained in years after 1964 a record of credited wages or self-employment income of $5,400 annually. The same rule would be applicable with respect to the proposed new top figure for maximum family benefits, which would be increased by the bill from $254 to $300 monthly. 1/

Costs of Benefit and Other Liberalizations

The dollar-amount cost in the 1965 calendar year of the proposed five percent increase in benefits is estimated in the House Ways and Means Committee report accompanying H.R. 11865 at $925 million. 2/ The 1965 costs of all liberalizations in the bill, including the benefit increases, is estimated at $1.6 billion. These figures do not include any cost effects of the expansion of the wage base, which will not begin to appear until after 1965.

1/ The opportunity to qualify for the maximum benefits allowable under the proposed bill would be long delayed with respect to old-age benefits, but an aged-21 entrant into covered employment in 1959 or later years could qualify in a relatively short period, under optimum circumstances, for the new maximums for himself or his family in the event of his disability or death.

2/ House Report No. 1548, p. 29.

The increased costs occasioned by the bill are reported by the Committee as being a "level-cost" equivalent of 0.54 percent of taxable earnings. 1/ For the five percent benefit increase alone, the level-cost increase is reported to be 0.42 percent of taxable earnings.

The Committee report does not show estimates of dollar-amount cost effects of the proposed amendments for years beyond 1965. However, for 1970 the $22.8 billion total of expenditures for OASDI benefits estimated by the Committee (including effects of the proposed amendments) is $2.7 billion higher than corresponding expenditures for 1970 under estimates, based upon provisions of the present law, in the 1963 annual report of the Board of Trustees of the OASDI Trust Funds. For the year 2000, the anticipated benefit expenditures under the law as it is proposed to be amended are $3.6 billion higher than the corresponding present-law estimates of the Board of Trustees. 2/

Proposed New Schedule of OASDI Benefits

H.R. 11865 would accomplish its benefit liberalizations, technically, through the writing of a new benefit schedule into Section 215 of of the Social Security Act. The schedule is detailed and lengthy. It sets out not only the primary monthly benefit amounts payable at various levels of average monthly wages, but also the 5-percent-increased benefits for current beneficiaries and the increased family benefit limits applicable for the various ranges of average monthly wages.

Illustrations of the effects of the proposed benefit increases, at selected levels of average monthly wages and for different categories of beneficiaries, are presented in the accompanying Tables 1 and 2. 3/

1/ Ibid., p. 17. The "level-cost" is a measurement of the estimated cost into perpetuity, on a "level" basis, in terms of percentage of taxable payrolls.

2/ Estimates are intermediate-cost basis. Source of the OASDI Board of Trustees data is House Document No. 236 (88th Congress, 2d Session), pp. 49-50. Differences between expenditure estimates of the Ways and Means Committee and the earlier estimates of the OASDI Board of Trustees do not necessarily reflect exact estimates of cost increases due to the proposed amendments.

3/ These illustrative tables are taken from the report of the House Committee on Ways and Means, House Report No. 1548, p. 7.

TABLE 1

ILLUSTRATIVE MONTHLY OLD-AGE BENEFITS PAYABLE UNDER PRESENT LAW AND H.R. 11865

Average monthly wage	Worker 1/		Man and wife 1/	
	Present Law	Bill	Present Law	Bill
$67 or less	$40.00	$42.00	$60.00	$63.00
100	59.00	62.00	88.50	93.00
150	73.00	76.70	109.50	115.10
200	84.00	88.20	126.00	132.30
250	95.00	99.80	142.50	149.70
300	105.00	110.30	157.50	165.50
350	116.00	121.80	174.00	182.70
400	127.00	133.40	190.50	200.10
450	*	143.40	*	215.10

* Not applicable under present law.

TABLE 2

ILLUSTRATIVE MONTHLY SURVIVORS' BENEFITS PAYABLE UNDER PRESENT LAW AND H.R. 11865

Average monthly wage	Widow aged 62, widower, or parent		Widow and 2 children	
	Present Law	Bill	Present Law 2/	Bill 3/
$67 or less	$40.00	$42.00	$60.00	$63.00
100	48.70	51.20	88.50	93.00
150	60.30	63.30	120.00	120.00
200	69.30	72.80	161.70	161.70
250	78.40	82.40	202.50	202.50
300	86.70	91.00	236.40	240.00
350	95.70	100.50	254.10	260.40
400	104.80	110.10	254.10	281.40
450	*	118.40	*	300.00

* Not applicable under present law.

1/ Age-65-or-over qualification for benefits.

2/ Payments are shown in this column in certain instances as exceeding by 10 cents the prescribed family maximums. This is permissible under an interpretation of provisions relating to rounding of benefit entitlements to the next higher multiple of 10 cents.

3/ In some instances, amounts payable for the month after the month of enactment would be somewhat different from the amounts shown here.

Committee Statement in Support of Benefit Increases

The House Ways and Means Committee justifies the OASDI benefit liberalizations it recommends, as well as the accompanying expansion of the taxable wage base, as being in recognition of changes in the economy of the Nation that have occurred since the last general upward adjustment of the benefits in 1958. The Committee's statement in this respect is as follows:

> Your committee believes that a general increase in social security benefits is necessary at this time. Nearly 20 million people now get social security checks, and for the overwhelming majority of these people -- disabled and aged retired workers, aged wives and widows, and orphaned children and their widowed mothers -- the benefits are the major source of support; for a great many, they are the only source.
>
> The last general benefit increase was enacted in 1958 and was effective with benefits payable for January 1959. Since that date there have been changes in wages, prices, and other aspects of the economy. 1/

Benefit Liberalizations Since 1939

As already indicated, the old-age benefit formula of the original 1935 Social Security Act was supplanted, before benefit payments started, by the revised formula of the 1939 amendments, which also added dependents' and survivors' benefits. Hence, for practical purposes, the benefit formula of the 1939 enactment represented the starting point of OASDI benefits. The subsequent benefit liberalizations applicable throughout the benefit schedule have been those provided by amendments enacted in 1950, 1952, 1954, and 1958.

The effects on monthly OASDI benefits of the successive benefit increases approved by the Congress are shown, for selected average monthly wage levels, in Table 3. Also shown are the corresponding increases under the proposed 1964 amendments. The table is illustrative only and therefore incomplete as to the numerous categories of benefits available at various average wage levels.

As indicated by Table 3, the minimum primary benefit has been increased over the years from $10 to $40 monthly. Correspondingly, the primary benefit at an average monthly wage level of $100 has increased from $36.25 monthly under the 1939 formula (for a person with 45 years of covered employment) to a currently payable benefit of $59 -- while at the average monthly wage level of $250, the benefit increase has been from $58 (for the person with 45 years of coverage) to $95.

1/ House Report No. 1548, pp. 6-7.

Under the 1939 formula, $58 was the maximum monthly benefit amount that could have been received by a beneficiary after working 45 years in covered employment. For a beneficiary with a minimum covered employment period of 1½ years, the "maximum" figure would have been $40.80. Under the present law, by reason of expansions of the annual wage base and other benefit liberalizations, the maximum primary benefit now is $127 monthly -- and is scheduled for the eventual maximum figure of $143.40 under the proposed amendments.

TABLE 3

ILLUSTRATIVE MONTHLY OASDI BENEFITS PAYABLE
UNDER VARIOUS AMENDMENTS OF THE SOCIAL SECURITY ACT

Average Monthly Wage	1939 Act (after 45 years of coverage) 1/	1950 Amend-ments	1952 Amend-ments	1954 Amend-ments	1958 Amend-ments2/	Proposed 1964 Amendments
		Primary Benefit for Workers				
Minimum	$10.00	$20.00	$25.00	$50.00	$40.00	$42.00
$100	36.25	50.00	55.00	55.00	59.00	62.00
250	58.00	72.50	77.50	88.50	95.00	99.80
300	*	80.00	85.00	98.50	105.00	110.30
350	*	*	*	108.50	116.00	121.80
400	*	*	*	*	127.00	133.40
450	*	*	*	*	*	143.40
		Total Benefits Payable to Family				
Minimum	20.00	40.00	45.00	50.00	60.00	63.00
$100	72.50	80.00	80.00	82.50	88.50	93.00
250	85.00	150.00	168.75	200.00	202.40	202.40
300	*	150.00	168.75	200.00	240.00	240.00
350	*	*	*	200.00	254.00	260.40
400	*	*	*	*	254.00	281.20
450	*	*	*	*	*	300.00
		Old-Age Benefits for Man and Wife				
Minimum	15.00	30.00	37.50	75.00	60.00	63.00
$100	54.40	75.00	82.50	82.50	88.50	93.00
250	87.00	108.75	116.25	133.25	142.50	149.70
300	*	120.00	127.50	147.75	157.50	165.50
350	*	*	*	162.75	174.00	182.70
400	*	*	*	*	190.50	200.10
450	*	*	*	*	*	215.10

* Not applicable because of statutory limits on defined "average monthly wage." The last figure shown in the column would be the benefit amount payable at the indicated earnings level.

1/ Under the 1939 law, the benefit amount depended partially upon the number of years of past covered employment. This was because of the benefit increment of 1 percent for each year in which credited wages of the beneficiary amounted to $200 or more.

2/ As modified by 1961 amendment which increased minimum benefits only.

Total family benefits payable under the several versions of OASDI benefit formulas, together with amounts of old-age benefits payable to a retiree and his wife, also are illustrated by Table 3.

Table 3 does not show, except as partially reflected by increases in the benefit maximums, the effects on benefit rights of employed individuals of either (1) the upsurge of wage rates since 1939 or (2) changes of a liberalizing character that have been made in conditions of benefit eligibility and in methods of computing the average monthly wage. For example, a manufacturing production worker's wage of $100 monthly in 1940 had grown, on the average, to $404 monthly in 1964. Also, benefits payable now to new beneficiaries may be based upon wages earned after 1950, with the five years of lowest earnings in the period since 1950 being left out of the computation.

Under the 1939 version of the benefit formula, the primary monthly benefit was computed on the basis of (1) 40 percent of the first $50 of average monthly wage, (2) plus 10 percent of any of the next $200 of average monthly wage, (3) plus a benefit increment of 1 percent for each year of past covered employment in which there were wages of at least $200.

In 1950, the primary benefit formula was changed to the basis of (1) 50 percent of the first $100 of average monthly wage, (2) plus 15 percent of any of the next $200 of such monthly average. The annual benefit increment was abandoned.

The formula adopted in 1952 provided for a primary benefit of 55 percent of the first $100 of average monthly wage, plus 15 percent of any of the next $200. Under the 1954 amendments, the formula change was to 55 percent of the first $110 of average monthly wage, plus 20 percent of any of the next $240 of the monthly wage average. In 1958, the present detailed benefit table (except for an increase in minimum benefits in 1961) supplanted the formula.

Limits on amounts of annual wages (and self-employment earnings after 1950) that "counted" toward establishment of benefit rights were $3,000 in 1937 through 1950, $3,600 in 1951 through 1954, $4,200 in 1955 through 1958, and $4,800 thereafter.

Relationship of Benefits to Cost of Living and Wage Growth

One of the matters to which attention normally is given when a liberalization of OASDI benefits is under consideration is that of the relationship of benefit levels to changes that have occurred in wage rates and in the cost of living as reflected in the consumers price index. For example, as previously quoted, the Ways and Means Committee refers to the fact that since the last general increase in OASDI benefits in 1958, "there have been changes in wages, prices, and other aspects of the economy."

For the purpose of comparison of benefit increases with the rising trends of earnings and the cost of living, there are two "natural," alternative starting dates. One is 1940, when the then-OASI benefits first became payable. The other is 1950, when the more modern-day version of the benefit structure was established.

With reference to these alternative starting dates, increases in the consumers price index 1/ have been as follows:

Consumers price index, 1940 average	48.8
Consumers price index, 1950 average	83.8
Consumers price index, May, 1964	107.8
Percentage increase, 1964 over 1940	121%
Percentage increase, 1964 over 1950	28%

Correspondingly, increases in earnings levels as measured by one large group of wage earners -- production workers in manufacturing -- have increased over the same periods as follows: 2/

Average weekly earnings, 1940 average	$ 24.96
Average weekly earnings, 1950 average	58.32
Average weekly earnings, Jan.-Mar., 1964 . . .	100.82
Percentage increase, 1964 over 1940	304%
Percentage increase, 1964 over 1950	73%

As previously indicated, increases over the period since 1939 in OASDI benefits payable are generated by two main factors. First, to the extent permitted by limits on amounts of wages counted for OASDI purposes, the rise in earnings levels has served as an automatic escalator of OASDI benefits. Secondly, liberalizing changes in the benefit formula and in the method of computing the average monthly wage (particularly the use of the years of higher earnings after 1950) have been made legislatively.

With respect to a possible straight-out comparison of legislated benefit increases with cost-of-living or earnings increases, it is to be noted from Table 3 that the maximum primary old-age benefit of $58 monthly that would have been payable under 1939 law after a lifetime of work (45 years) has increased to a maximum under present law of $127 monthly. That represents an increase since 1940 in maximum benefits payable of 119 percent.

1/ Data reflecting indexes on basis of 1957-59 = 100, from U.S. Department of Labor.

2/ Source: U.S. Department of Labor.

Similarly, the increase in the statutory maximum under the 1950 amendments of $80 monthly to the present-law maximum of $127 represents a 59 percent increase.

On the basis simply of percentage changes in the OASDI statutory benefit maximums, the 119 percent increase in the maximums since 1940 is slightly less than the 121 percent cost-of-living increase over the same period. On the other hand, a comparison for the period since 1950 shows that the 59 percent increase in the benefit maximum is more than double the 28 percent cost-of-living increase.

These "straight-out" comparisons of statutory maximums, however, are limited to the maximum benefit aspect only. They fail to reflect other aspects of increases in benefits actually payable.

A more definitive examination of increases in benefits payable under the present law and proposed bill, as compared with benefits potentially payable under benefit formulas and earnings levels of 1940 and 1950, may be made through the use of hypothetical wage-level examples. Involved in this process are (1) selection of 1940 and 1950 average-monthly-wage-level examples; (2) adjustment of these wage levels to reflect percentage increases in average weekly earnings of production workers in manufacturing; (3) an assumption of qualification for old-age benefits in early-1965, and (4) actual computation of amounts of benefits that would be payable under varied assumptions. 1/

For a person qualifying for benefits in 1965, the "computation years" controlling his average monthly wage (and therefore his benefit amount) would be 1956 through 1964. This is on the assumption of optimum circumstances under which those were the years of his highest earnings during the period of 1951 through 1964. For purposes of earnings utilized in the hypothetical examples, therefore, only the starting years of 1940 and 1950, and the computation years of 1956 through 1964, would be involved. For these years, average weekly earnings of production workers in manufacturing, together with year-to-year percentage increases involved, were as shown in Table 4.

1/ Results of such an examination would be applicable generally only as to persons who are to become beneficiaries -- and not as to persons already on the beneficiary rolls. However, as benefits have been liberalized from time to time for future beneficiaries, comparable liberalizations have been extended, through conversion tables and other means, to persons already qualified for benefits.

TABLE 4

AVERAGE WEEKLY EARNINGS OF PRODUCTION WORKERS IN MANUFACTURING

Year	Average Weekly Earnings	Percent Increase Over 1940	Percent Increase Over 1950
1940	$ 24.96	--	--
1950	58.32	134	--
1956	78.78	216	35
1957	81.59	227	40
1958	82.71	231	42
1959	88.26	254	51
1960	89.72	260	54
1961	92.34	270	58
1962	96.56	287	66
1963	99.38	298	70
1964 1/	100.82	304	73

1/ For January-March, 1964.
Source of data: U.S. Department of Labor

Examples to be utilized in the examination of effects on OASDI benefits of both law changes and the rising wage trend may be identified as follows:

Example A -- 1940-start wage of $50 monthly
Example B -- 1940-start wage of $100 monthly
Example C -- 1940-start wage of $250 monthly
Example D -- 1950-start wage of $100 monthly
Example E -- 1950-start wage of $200 monthly
Example F -- 1950-start wage of $250 monthly

For purposes of Examples A, B, and C, dealing with 1940-start wage levels, the assumption is made that the 1940-start wages would rise, for the 1956-through-1964 benefit computation years, to the extent shown in Table 4 of the percentage increases over the 1940 level of average weekly earnings of production workers in manufacturing. Under this assumption, the "inflated" wages on a monthly basis, under Examples A, B, and C, would be as follows:

Year	Monthly Earnings Under Example A ($50 start)	Example B ($100 start)	Example C ($250 start)
(1940)	$ (50.00)	$ (100.00)	$ (250.00)
1956	158.00	316.00	790.00
1957	163.50	327.00	817.50
1958	165.50	331.00	827.50

Continued

Year	Monthly Earnings Under Example A ($50 start)	Example B ($100 start)	Example C ($250 start)
1959	$ 177.00	$ 354.00	$ 885.00
1960	180.00	360.00	900.00
1961	185.00	370.00	925.00
1962	193.50	387.00	967.50
1963	199.00	398.00	995.00
1964	202.00	404.00	1010.00

The next required step is the conversion into credited annual "wages" for OASDI purposes of the computation-years monthly earnings recorded above. This is a simple "12-times" process except in instances where OASDI annual wage base limits are applicable. The results are as follows:

Year	Annual Wages for Benefit Computations Example A	Example B	Example C
(1940)	$ (600.00)	$ (1200.00)	$ (3000.00)
1956	1896.00	3792.00	4200.00*
1957	1962.00	3924.00	4200.00*
1958	1986.00	3972.00	4200.00*
1959	2124.00	4248.00	4800.00*
1960	2160.00	4320.00	4800.00*
1961	2220.00	4440.00	4800.00*
1962	2322.00	4644.00	4800.00*
1963	2388.00	4776.00	4800.00*
1964	2424.00	4800.00*	4800.00*

* Annual wage base limit applicable.

The final step in the examination involves (1) totaling of credited wages for the 1956-1964 computation period; (2) calculation of average monthly wage (dividing total credited wages by 108); and (3) determination of monthly benefits payable under present law and the proposed 1964 amendments as compared with benefits payable on a static-wage basis under the 1939-law benefit formula.

Static, or unchanging, wage levels are utilized in the application of the 1939 benefit formula because the purpose of the examination is to determine the extent to which OASDI benefits may have increased since 1940 as the result of both law changes and wage rises. Therefore, the starting point of the comparison must utilize non-inflated wages. However, in the calculation of the 1939-formula benefit, the annual 1 percent benefit increments for a 25-year period (1940 through 1964) are included.

The results of the calculations described above are as follows:

	Example A ($50 monthly wage start)	Example B ($100 monthly wage start)	Example C ($250 monthly wage start)
Total wages for 1956-1964-	$ 19,482.00	$ 38,916.00	$ 41,400.00
Average monthly wage	180.38	360.33	383.33
Monthly benefit payable on 1939-law basis--static wage	$ 25.00	$ 31.25	$ 50.00
Monthly benefit under present law--rising wages	80.00	118.00	123.00
Monthly benefit under H.R. 11865--rising wages	84.00	123.90	129.20
Percentage increase, present-law basis over 1939 basis	220%	278%	146%
Percentage increase, proposed-law basis over 1939 basis	236%	296%	158%

The percentage increases shown above (ranging from 146 to 278 percent) for examples of benefits payable under present law and the proposed bill, as compared with benefits payable on a static-wage basis under the 1939 benefit formula, compare with the consumers price index increase of 121 percent since 1940. The increase in average weekly earnings of production workers in manufacturing over the same period was 304 percent.

It is to be noted that the percentage increase in benefits payable under Example C ($250 monthly wage start) is appreciably smaller than in the case of the other two examples. This is because of the effect of the annual wage limits for OASDI purposes. A factor that contributes toward making the percentage increase less for Example A than for Example B is the heavier weighting given in benefit formulas to low-level wages. (The benefit based on a $50 monthly wage has maximum low-wage weighting under the 1939 formula. Effects of this weighting tend to disperse as the wage inflates.)

For purposes of Examples D, E, and F, pertaining to increases in OASDI benefits since 1950 by reason of law changes and rising wage levels, the data showing monthly earnings as inflated to reflect the rise of wage levels are omitted here. However, the data as to annual wages credited for OASDI purposes in benefit computation years would be as follows:

Year	Annual Wages for Benefit Computations: Example D ($100 monthly wage start)	Example E ($200 monthly wage start)	Example F ($250 monthly wage start)
(1950)	$ (1200.00)	$ (2400.00)	$ (3000.00)
1956	1620.00	3240.00	4050.00
1957	1680.00	3360.00	4200.00*

* Annual wage base limit applicable.

Continued

Year	Annual Wages for Benefit Computations: Example D ($100 monthly wage start)	Example E ($200 monthly wage start)	Example F ($250 monthly wage start)
1958	$ 1704.00	$ 3408.00	$ 4200.00*
1959	1812.00	3624.00	4530.00
1960	1848.00	3696.00	4620.00
1961	1896.00	3792.00	4740.00
1962	1992.00	3984.00	4800.00*
1963	2040.00	4080.00	4800.00*
1964	2076.00	4152.00	4800.00*

* Annual wage base limit applicable.

Under the calculations as previously described, the comparisons for Examples D, E, and F would be as follows:

	Example D ($100 monthly wage start)	Example E ($200 monthly wage start)	Example F ($250 monthly wage start)
Total wages for 1956-1964	$ 16,668.00	$ 33,336.00	$ 40,740.00
Average monthly wage	154.33	308.66	377.22
Monthly benefits payable on basis of 1950 law--static wage	$ 50.00	$ 65.00	$ 72.50
Monthly benefits payable under present law--rising wages	74.00	107.00	122.00
Monthly benefits payable under H.R. 11865--rising wages	77.70	112.40	128.10
Percentage increase, present-law basis over 1950 basis	48%	65%	68%
Percentage increase, proposed-law basis over 1950 basis	55%	73%	77%

The percentage increases in benefits as shown above compare with a 28 percent increase in the consumers price index since 1950 and with a 73 percent increase over the same period in average weekly earnings of production workers in manufacturing.

The foregoing analysis shows that for the representative wage-level examples as selected, and under assumptions as stated, OASDI benefit increases resulting from both liberalizing law changes and the escalating effect of rising wage levels (as measured by earnings of production workers in manufacturing) have been at rates that are near-double to more than double, with one major exception, the percentage increases in the cost

of living. This is true regardless of whether the comparison is made from a "starting date" of 1940 or 1950. One large group of beneficiaries for whom the benefit increases would appear to have been at a lesser rate are those at higher wage levels where limits on the annual wage base have had a restrictive effect.

The benefit increases, on the other hand, are shown generally to have fallen somewhat behind the rate of increase of weekly earnings of production workers in manufacturing.

It is to be noted that this examination of the effects of law changes and wage-rate increases on OASDI benefits is based on the assumption of certain optimum circumstances, such as that of unbroken employment by the "beneficiaries" in the examples during the benefit computation years of 1956 through 1964. Also, it assumes that the beneficiary in each instance would have benefitted from rising wage levels in exact proportions to the rise in the average weekly earnings of manufacturing workers.

The hypothetical-basis analysis, on the other hand, does not give effect to increases in past earnings of an individual, "live" beneficiary that resulted from experience and seniority on the job. Such wage growth of an individual due to on-the-job experience and seniority are significant factors inasmuch as present law, for benefit computation purposes, "counts" only employment occurring since 1950 (except in unusual circumstances) and further permits the disregarding of the five years of lowest earnings since 1950. Similarly, the analysis does not measure liberalizing effects of statutory increases in amounts of earnings allowable to persons who are drawing benefits.

Increases in Average Monthly Benefits Paid

Results of the foregoing analysis are confirmed, in a broad sense, by data pertaining to increases in the average monthly amounts of benefits actually paid.

In 1940, the average monthly amount of primary benefits being paid to retired workers (the largest and most representative group of beneficiaries)at the end of the year was $22.60. The corresponding average monthly benefit amount at the end of 1950 was $43.86. For March of 1964 the corresponding average payment was $77.22. 1/

Thus it is shown that from the end of 1940 to March of 1964, the average monthly benefit being paid to retired workers increased by

1/ Source of data: Social Security Bulletin, U.S. Department of Health, Education, and Welfare, Vol. 27, No. 7, Table 7.

242 percent. For the period of the end of 1950 to March of 1964, the increase amounted to 76 percent. These percentage increases in the average monthly benefits paid compare (except for slight discrepancies in time-bases) with the cost-of-living increases of, respectively, 121 percent and 28 percent.

Divergent Viewpoints on the "Floor of Protection" Concept

Students of the social security system that has been developed in the United States generally agree that the basic purpose of the OASDI program is to provide a floor of economic protection which becomes available in the event of the death, disability, or retirement of the family breadwinner. The benefits available under the program do not constitute a complete substitute for individual savings and private retirement and insurance programs, it is agreed, but rather are intended to serve as the underpinning upon which the individual may build through his own providence. However, disagreement develops on the question of how high the "floor of protection" should be.

Proponents of further liberalization of OASDI benefits generally point to the high cost of comfortable living, argue that great masses of individuals are able to save little or nothing, and espouse the viewpoint that OASDI beneficiaries are entitled to share fully in the general rise in living standards. They contend that an objective of the program should be to spare beneficiaries of any dependence on their children or on public or private charity. They reject the idea that OASDI benefits will be "adequate" if they simply keep pace with rising living costs. Their general approach is that OASDI, to the extent possible, should meet the aspirations of beneficiaries and prospective beneficiaries for high-level benefits that assure a meeting of retirement, disability, and survivorship needs on a relatively comfortable living plane.

Critics of repeated benefit liberalizations contend, on the other hand, that the purpose of the "floor of protection" offered by a compulsory social insurance system should be limited to the original purpose: meeting minimum needs to such an extent as to give reasonable assurance that the great bulk of OASDI beneficiaries will not become public assistance charges. They question whether it is the proper function of a public social insurance system to compel an individual and his employer to "buy" more than such a minimum amount of protection. They argue that the availability of "high-level" OASDI benefits would tend to invite people not to exercise providence in their own behalf. From a practical standpoint, critics of benefit liberalizations express the viewpoint that the current popularity of the OASDI system rests principally on the fact that in these early years of the program's existence the benefits have been "bargains," with the full costs being shunted into the future, and that this popularity will disappear when full costs of high-level benefits fall on future generations. Hence, they believe all proposals for benefit increases should be scrutinized with care to determine whether they are warranted under their concept of the public purpose of the OASDI system.

OASDI FINANCING CHANGES UNDER THE PROPOSED BILL

The upward adjustments of tax levies for OASDI purposes that would be provided by H.R. 11865 are required, according to findings of the House Ways and Means Committee, to finance additional costs occasioned by the bill and to improve slightly the actuarial status of the OASDI trust funds.

The immediate effect of the proposed taxing changes would be to increase OASDI revenues in 1965 approximately $1.6 billion over amounts estimated to be receivable under present law provisions. The tax increases occasioned by the bill would be expected to grow beyond that figure in subsequent years.

Taxing Changes Under Bill

As indicated in the introductory section of this Analysis, the principal financing changes that would be provided by the proposed 1964 social security amendments are (1) an expansion of the annual taxable earnings base for 1965 and subsequent years from the present level of $4,800 to a new limit of $5,400, and (2) readjustments of applicable tax rates to provide, as compared with rates scheduled under present law, increased rates for 1965, lowered rates for 1966 through 1970, and increased rates for 1971 and subsequent years.

In addition, the bill would reallocate to the disability trust fund 0.15 percent of taxable wages and 0.1125 percent of taxable self-employment income which presently goes to the old age and survivors insurance trust fund. This will bring the total allocation to the disability fund, for years after 1964, to 0.65 percent of taxable wages and 0.4875 percent of self-employment income. The purpose of the reallocation, as explained, is to shore up income of the disability insurance trust fund to meet expenditures that are running higher than originally anticipated.

If the new social security bill is enacted, the combined employer-employee tax rate for OASDI purposes will increase from 7.25 percent payable on a maximum wage base of $4,800 in 1964 to a rate of 7.6 percent on a $5,400 maximum base in 1965. Since the combined payroll levy is split evenly between the employer and the employee, the rate increase applying to each would be from 3.625 percent to 3.8 percent. For 1971 and subsequent years, the combined employer-employee rate would be 9.6 percent applicable to a maximum wage base of $5,400 under the bill, as compared with a combined rate of 9.25 percent on a maximum base of $4,800 under present law. The complete schedule of proposed new rates for future years, as compared with the schedule under present law, is detailed in Table 5.

TABLE 5

PROPOSED CHANGES IN OASDI WAGE BASE AND TAX RATES FOR FUTURE YEARS

Years	Taxable Wage Base		Employer-Employee Rate 1/		Self-Employed Rate	
	Present Law	Proposal	Present Law	Proposal	Present Law	Proposal
1965	$4,800	$5,400	3.625	3.8	5.4	5.7
1966-1967	4,800	5,400	4.125	4.0	6.2	6.0
1968-1970	4,800	5,400	4.625	4.5	6.9	6.8
1971 and after	4,800	5,400	4.625	4.8	6.9	7.2

1/ Rate payable by each.

Maximum dollar-amount effects from combinations of the proposed expansion of the wage base and readjustments of tax rates for future years are shown in Table 6. As indicated here, the maximum annual employer-employee tax would be increased from $348.00 to $410.40 for 1965 and from $444.00 to $518.40 for 1971 and later years. For the self-employed person, the maximum levy would be increased from $259.20 to $307.80 for 1965 and from $331.20 to $388.80 for 1971 and subsequent years. There also would be increases in maximum amounts payable in the years of 1966 through 1971. However, it is to be noted that for these years, because rates scheduled under the bill are lower than under the present law, the actual taxes payable on wages and self-employment income below an approximate annual level of $4,900 would be lower under the proposed bill than under the present law.

TABLE 6

COMPARISON OF MAXIMUM ANNUAL TAX PAYMENTS MADE UNDER PRESENT LAW AND PROPOSAL

Years	Maximum Payable by Employer and Employee--Each		Maximum Payable by Employer-Employee--Combined		Maximum Payable by Self-Employed	
	Present Law	Proposal	Present Law	Proposal	Present Law	Proposal
1965	$174.00	$205.20	$348.00	$410.40	$259.20	$307.80
1966-1967	198.00	216.00	396.00	432.00	297.60	324.00
1968-1970	222.00	243.00	444.00	486.00	331.20	367.20
1971 and after	222.00	259.20	444.00	518.40	331.20	388.80

Table 7, which follows, may be utilized for comparisons of taxable wage bases, rates, and maximum amounts payable for OASDI purposes in past years with the proposed schedules for future years.

TABLE 7

TAXABLE WAGE BASES, TAX RATES, AND MAXIMUM ANNUAL TAX PAYMENTS FOR OASDI PURPOSES -- 1937 THROUGH 1964

Years	Taxable Wage Base	Total Employer-Employee Rate *	Self-Employed Rate	Maximum Annual Tax Payable by Employer and Employee-Each	Employer-Employee Combined	Self-Employed
1937-1949	$3,000	2.0%	%	$ 30.00	$ 60.00	$
1950	3,000	3.0		45.00	90.00	
1951-1953	3,600	3.0	2.25	54.00	108.00	81.00
1954	3,600	4.0	3.0	72.00	144.00	108.00
1955-1956	4,200	4.0	3.0	84.00	168.00	126.00
1957-1958	4,200	4.5	3.375	94.50	189.00	141.75
1959	4,800	5.0	3.75	120.00	240.00	180.00
1960-1961	4,800	6.0	4.5	144.00	288.00	216.00
1962	4,800	6.25	4.7	150.00	300.00	225.60
1963-1964	4,800	7.25	5.4	174.00	348.00	259.20

* The separate employer rate and employee rate, in each instance, is one-half of the combined rate shown here.

As indicated by Table 7, the maximum annual tax payable for OASDI purposes has grown from a combined employer-employee amount of $60 in 1937 to $348 in 1964. For self-employed persons, the increase in the maximum amount payable has been from a starting figure of $81 in 1951 to $259.20 in 1964.

Estimated OASDI Income, Outgo, and Balances Under H.R. 11865

Under actuarial projections reported by the Ways and Means Committee of progress of the combined OASDI trust funds under the Social Security Act as it would be amended by H.R. 11865, it is estimated that the balances in the funds will dip slightly in 1965 from an expected total of $20.3 billion at the end of 1964 and then will grow to a total of $29.9 billion in 1970, to $92.8 billion in 1990, and to $125.4 billion at the turn of the century. Under the estimates, expected tax collections and other contributed income (from state and local governments and reimbursements for military service credit) will grow from $18.5 billion in 1965 to $41.1 billion in the year 2000.

These and other OASDI financing projections are detailed in Table 8. For projections into the long-range future, "intermediate-cost estimates" are utilized. These intermediate-cost estimates represent an average of "high-cost" and "low-cost" estimates. The estimates assume that after the Social Security Act has been modified by the proposed 1964 amendments, it will remain unchanged.

TABLE 8

ESTIMATED PROGRESS OF COMBINED OASDI TRUST FUNDS UNDER SYSTEM AS MODIFIED BY H.R. 11865*

Intermediate Cost Estimates

Calendar Year 1/	Taxes and Contributions 2/	Interest on Funds	Benefit Payments	Other Expenses 3/	Balances of Funds
1962	$ 13,105	$ 594	$ 14,461	$ 694	$ 20,705
1963	15,640	587	15,427	792	20,715
1964	16,447	606	16,651	839	20,278
1965	18,546	609	18,705	845	19,883
1970	25,830	961	22,752	894	29,874
1980	30,971	2,140	28,937	691	66,949
1990	35,448	3,036	35,866	617	92,839
2000	41,115	4,093	39,680	625	125,414

* In millions of dollars.

1/ Actual data for 1962-1963; estimated for other years.

2/ Includes contributions from state and local governments and reimbursements for additional cost of noncontributory credit for military service.

3/ Comprised of administrative expenses and railroad retirement financial interchanges.

Source of data: Report of the Ways and Means Committee on H.R. 11865, (House Report No. 1548), pp. 30-31.

For the old age and survivors insurance program only (excluding disability insurance), the intermediate-cost, long-range estimates in dollar amounts have been extended in the Ways and Means Committee report through the year 2020. By that year, under the estimates, it is anticipated that the OASI fund balance will have grown to $246.9 billion (from $121.5 billion in the year 2000). The precipitous increase in the fund balance estimated for the period from the turn of the century to the year 2020 is predicated principally on an anticipated dip from 1995 to about 2010 in the relative proportion of aged persons in the population. This dip is expected to result from the low rate of births in the 1930's and, if it materializes, it will result in lowered benefit costs for a period of years after 1995.

With respect to long-range estimates of OASDI income and outgo, the Ways and Means Committee comments:

> It will, of course, be recognized that the figures for the next two or three decades are the most reliable . . . since the populations concerned -- both covered workers and beneficiaries -- are already born.

> As the estimates proceed further into the future, there is, of course, much more uncertainty -- if for no reason other than the relative difficulty in predicting future birth trends -- but it is desirable and necessary nonetheless to consider these long-range possibilities under a social insurance program that is intended to operate in perpetuity. 1/

Dimensions of the uncertainties of the long-range estimates are indicated by low-cost and high-cost estimates -- of which the intermediate-cost estimates shown in Table 8 are averages -- reported by the Committee.

Under the low-cost estimates, the combined balances of the OASDI funds would rise to $92.9 billion in 1980, to $170.6 billion in 1990, and to $307.6 billion in 2000. Under the high-cost estimates, in contrast, the old age and survivors insurance fund would drop to $44.3 billion in 1980, would decrease further to $26.7 billion in 1990, and would be exhausted in 2000 -- while the disability insurance fund would be exhausted before 1980.

With respect to the possible materializing of either the low-cost or high-cost projections, the Ways and Means Committee states:

> In actual practice, under the philosophy in the 1950 and subsequent acts . . . . the tax schedule would be adjusted in future years so that none of the developments of the trust funds shown (in the low-cost and high-cost estimates) would ever eventuate. Thus, if experience followed the low-cost estimate, and if the benefit provisions were not changed, the contribution rates would probably be adjusted downward -- or perhaps would not be increased in future years according to schedule. On the other hand, if experience followed the high-cost estimate, the contribution rates would have to be raised above those scheduled. 2/

"Level-Equivalent" Measurements of OASDI Financing

Instead of relying solely on dollar-amount projections of OASDI income and expenditures, actuaries associated with the system employ also the "level-equivalent" measurements of both costs and income

1/ Committee Report (House Report No. 1548), pp. 29-30.

2/ Ibid., p. 33.

productivity of taxing schedules. The level-equivalent of the tax rates, for example, is that constant percentage of taxable payrolls and self-employment income which, if collected from the present on into perpetuity, would be calculated to produce the same amount of income as the graded schedule of tax rates in the law. Similarly, the level-equivalent of benefit costs measures such costs into perpetuity in terms of a level percentage of taxable wages and self-employment income. Adjustments are made for interest earnings of the trust funds, for differences in rates applying to payrolls and self-employed income, for administrative expenses, and for other relevant factors.

According to data in the Ways and Means Committee report, the level-equivalent rate of OASDI benefit costs would be increased by the pending bill from 9.36 percent applicable to a $4,800 wage base under the present law to 9.61 percent applicable to a $5,400 wage base under the proposed amendments. The corresponding level-equivalent rate of contributions is shown as being increased from 9.12 percent under the present law to 9.41 percent under the proposed bill. 1/ These level-equivalent rates pertain to intermediate-cost estimates.

Under this method of measurement of the long-range balance between OASDI income and outgo, an estimated "deficit" of 0.20 percent is shown. However, the Ways and Means Committee points to an improvement of 0.04 percent in the calculated deficit (which was 0.24 for the present law) and states that the continuing disparity "is well within acceptable limits."

Basic Characteristics of OASDI Financing

Throughout the history of the OASDI system in the United States, the method by which it is financed has been an object of controversy. Much of this controversy has centered on aspects of its identity as "social insurance" which, unlike private insurance, does not preserve individual equity. Another of its characteristics which stirs discussion is its postponement into the future of the financing of the great bulk of its currently accruing liabilities.

The original 1935 Social Security Act gave materially greater recognition to the principle of individual equity and to the placement of old-age benefit financing on a fully funded basis than is true of the OASDI system today. Then, benefit amounts depended upon the total of taxed wages of the individual during his period of covered employment, rather than upon the average wage during a shortened period, and the benefit rights matured slowly while reserves to finance the benefits were being built up. These concepts largely were set aside, however, by the "quick starts" of the 1939 amendments and the delaying for more than a decade of any increase in the payroll tax rates.

1/ Ibid., p. 20.

The Chief Actuary of the Division of the Actuary, Social Security Administration, describes basic characteristics of the present-day OASDI system as follows:

> The Old-Age, Survivors, and Disability Insurance system established by the Social Security Act is clearly social insurance. It is a national program covering virtually the entire working population, and no direct relationship exists between contributions paid and benefits received. To put it another way, OASDI emphasizes social adequacy at the expense of individual equity. 1/

The Chief Actuary expands upon the subject of relationship between tax contributions and benefits as follows:

> The benefits that a new entrant (into OASDI-covered employment) 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 they will get. For those now on the rolls, it is likely that they would have paid, at most, for about 10% of the benefits actually payable to them. 2/

A further observation from the same source is:

> The fact is that people retiring today have by no means "purchased" their benefits. Accordingly, if the system is to pay far more to the present retirants and those coming up to retirement age in the next few decades than their contributions could buy, and if it is to be self-supporting from worker and employer contributions, then some people necessarily will be getting less than the value of the combined employer-employee contributions. 3/

1/ Robert J. Myers, Chief Actuary, Social Security Administration, The Proceedings of the Conference of Actuaries in Public Practice, Volume IX, 1959-60.

2/ Robert J. Myers, in statement made available from his office entitled, "The Actuarial Financing Basis of the OASDI System."

3/ Ibid.

The reasoning of the Chief Actuary of the Social Security Administration with respect to matters covered by the above quotations is that the lack of direct relationship between tax payments and benefits is a characteristic of social insurance and is not unlike the situation in some contributory private pension plans whereunder persons retiring in early years of the operation of the plan pay for only a small proportion of their benefits because much of their pensions comes from prior-service credits. It is said, also, that the employer's contribution must be viewed as being pooled for the benefit of all covered employees rather than as being assigned to individual employees.

With respect to the lack of reserves which would provide full funding of OASDI accrued liabilities, available data show that the "unfunded accrued liability" of the OASDI system currently is approximately $325 billion. 1/ This figure is based on the assumption that there would be no more new entrants into the OASDI system in the future, but all persons now covered would continue to be covered, with taxes being paid on their earnings, and that all present beneficiaries and all new beneficiaries arising from the now-covered group would be paid the prescribed benefits. Under this circumstance, the OASDI trust funds would need to have approximately $345 billion on hand now instead of the approximately $20 billion available.

OASDI officials describe as a "misconception" the view that the system's financing is unsound because liabilities are not funded. In the financing of the OASDI system, they say, it is assumed that there always will be new, working entrants and that both the Government and its social insurance system will have perpetual life.

Position of House Ways and Means Committee

The House Ways and Means Committee states that by reason of the tax increases provided in H.R. 11865, the increases in costs from liberalizations in the bill "will be adequately financed and the program will continue to be self-supporting on a sound actuarial basis." 2/ The Committee further states:

> The Congress has always carefully considered the cost aspects of the old-age, survivors, and disability insurance system when amendments to the program have been made. In connection with the 1950 amendments the Congress stated the belief that the program should be completely self-supporting from the contributions of

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1/ Ibid.

2/ Committee Report (House Report No. 1548), p. 2

> covered individuals and employers . . . . The Congress has always very strongly believed that the tax schedule in the law should make the system self-supporting as nearly as can be foreseen and, therefore, actuarially sound. 1/

The position of the Committee with respect to the funding of accrued liabilities parallels that of OASDI officials. The Committee's statement is:

> The concept of actuarial soundness as it applies to the old-age, survivors, and disability insurance system differs considerably from this concept as it applies to private insurance and private pension plans, although there are certain points of similarity with the latter. In connection with individual insurance, the insurance company or other administering institution must have sufficient funds on hand so that if operations are terminated, it will be in a position to pay off all the accrued liabilities. This, however, is not a necessary basis for a national compulsory social insurance system . . . . It can reasonably be presumed that, under Government auspices, such a social insurance system will continue indefinitely into the future. The test of financial soundness, then, is not a question of whether there are sufficient funds on hand to pay off all accrued liabilities. Rather, the test is whether the expected future income from tax contributions and from interest on invested assets will be sufficient to meet anticipated expenditures for benefits and administrative costs. 2/

Opposition Viewpoints on OASDI Financing

Two members of the House Ways and Means Committee, Representatives James B. Utt and Bruce Alger, do not accept the majority views of the Committee. They describe their opposition viewpoint broadly as follows:

> The bill, H.R. 11865, amending the Social Security Act, should not be enacted. The bill enlarges the social security tax burden imposed

1/ Ibid., p. 18.

2/ Ibid.

> on present and future wage earners to pay increased benefits to the presently retired who have for the most part already received in benefits many times their contributions to the OASDI trust funds. The bill aggravates the existing inequities in the system resulting from the program's arbitrary and unrealistic benefit eligibility qualifications. The bill, by creating a more costly program without correcting the system's shortcomings, increases the validity of the basic objection that the program is compulsory and not voluntary. 1/

Representatives Utt and Alger take the position that the OASDI system does not possess "actuarial and financial soundness." They state the belief that the "succession of election-year liberalizations" have been accompanied by only token increases in the system's current tax receipts and that these tax increases have been "grossly disproportionate to the larger increases in benefit obligations of the system." They regard the amount of the unfunded accrued liabilities as being an "alarming" funding gap which is made wider by benefit liberalizations. They also criticize the system for its lack of individual equity with regard to the relationship between tax payments and benefits.

With respect to the "unfunded obligations," the opposition viewpoint is stated as follows:

> As the unfunded obligations of the system increase in the years ahead, the danger that the program will be the basis for socializing all economic activity and resources becomes extremely grave. The increasing actuarial imbalance strongly suggests that deliberate policies to foster inflation will be an inevitable recourse by the Government to make it possible for social security taxes to defray the growing total benefit cost. Such inflationary policies will have the effect of increasing pressures for future benefit liberalization and an unmanageable cycle of benefit and tax increases could well ensue.
>
> If future generations are unwilling to honor the unfunded social security obligations incurred today, the program will collapse. If, on the other hand, the program is continued in perpetuity,

1/ Separate views of Representatives James B. Utt and Bruce Alger, in House Report No. 1548, p. 54.

then we have obligated the future income of future generations in willful disregard of the fact that those generations will have obligations of their own to meet out of their own productivity and out of their own taxes. 1/

Criticism of the social security bill also is expressed on the grounds of interrelationship between the proposed social security tax increase and the second stage of the individual income tax reduction scheduled to occur in 1965 under the Revenue Act of 1964. An example is cited of an individual taxpayer who, married and with two children, would have his income tax reduction more than cancelled out by the social security tax increase if he were at an annual self-employment income level of $5,400. 2/

1/ Ibid., p. 56.

2/ Ibid., p. 57.

MISCELLANEOUS LIBERALIZING AMENDMENTS OF H. R. 11865

The substantive contents of amendments to the Social Security Act proposed by H. R. 11865, other than those providing OASDI benefit liberalizations and financing changes, are outlined below.

Child's In-School Benefits to Age 22

The bill would provide for the payment of a child's OASDI benefits until the child reaches age 22, provided the child is attending school (including a vocational school or college) as a full-time student after he reaches age 18. (Section 3 of bill.)

This provision would become effective for the month following the month of enactment, or September, 1964--whichever is later. It is estimated by the House Ways and Means Committee that 275,000 children would receive additional benefits in 1965 in the total amount of $175 million under this provision.

The bill does not provide for the continuation of the mother's benefits in the case of a child over 18 receiving benefits because he is attending school. The Committee's reasoning was that there is less need to pay benefits to the mother in such cases, since she is not required to stay at home to care for the child to the extent that she may have been when he was younger.

The Ways and Means Committee said it believes that "a child over 18 who is attending school full time is dependent just as a child under 18 or a disabled older child is dependent, and that it is not realistic to stop such a child's benefits at age 18."

Benefits for Widows at Age 60

H. R. 11865 would provide (in Section 4) for the payment of benefits to widows beginning at age 60 at their election, with the benefits payable to those who claim them before age 62 being actuarially reduced to take account of the longer period over which they will be paid. This provision would be effective immediately following the month of enactment.

In the first full year, 1965, it is estimated by the Ways and Means Committee that 180,000 widows will take advantage of this provision and receive $150 million in benefits. However, the Committee states that the amount of the actuarial reduction is sufficient to assure that over the long run there will be no additional cost to the social security system as a result of the earlier payment of the benefits. If a widow chose to claim her benefits starting at age 60, her benefit would be reduced by five-ninths of 1 percent for each month in which it was paid before

age 62. The reduced benefit at age 60 would amount to 71½ percent of the deceased husband's primary benefit, as compared with the 82½ percent benefit payable if the widow waited until she attained age 62.

The Ways and Means Committee views the eligibility-age reduction for widows as being justified because women who are widowed in their late fifties and early sixties often are denied employment because of their age.

Critics of the change tend to regard it as another step toward progressive lowering of the retirement age for OASDI benefits purposes. While granting that there is a trend toward earlier retirement under private pension plans, they question whether it is the function of a governmental social insurance system to encourage earlier retirement at a time when medical science is lengthening the life span and continued productive work by an individual into his later years is considered by many as socially desirable.

Benefit Eligibility for Certain Persons Over Age 71

Section 5 of H. R. 11865 contains the amendments under which an estimated 600,000 aged persons not eligible under the present law would qualify for benefits. The explanation of the amendments provided in the Report of the Ways and Means Committee is as follows:

> A special provision would liberalize the eligibility requirements so that certain aged people who do not meet the work requirements in present law could qualify for benefits on the basis of as few as three quarters of coverage. Upon attaining age 72, a worker or widow who qualifies under these provisions would get a monthly benefit of $35; a wife who qualifies would get a benefit of $17.50.
>
> Men and women workers. To accomplish the above, a new concept of "transitional insured" status under the bill would provide that these oldest workers will receive benefits with only three quarters of coverage, as contrasted with the present requirement of six quarters. For those workers who are not quite so old, the quarters of coverage requirement would increase until the requirement merges with the present minimum requirement of six quarters.
>
> The following table illustrates the operation of the "transitional insured" status provision for workers:

Transitional insured status requirements for worker's benefits:

Men		Women	
Age (in 1965)	Quarters of coverage required	Age (in 1965	Quarters of coverage required
76 or over	3	73 or over	3
75	4	72	4
74	5	71	5
73 or younger	6	70 or younger	6

Thus, to be eligible for benefits an individual must both (1) meet the above coverage requirements, and (2) have attained age 72.

Wives. A wife's benefits would be payable at age 72 to the wife of a worker who qualified for benefits under the transitional provisions if she attained age 72 before 1968.

Widows. Any widow who is age 72 or over in 1965, if her husband died or reached age 65 in 1954 or earlier, can get a widow's benefit if her husband had at least three quarters of coverage. Present law requires six quarters.

If the husband died or reached 65 in 1955, the requirement is four quarters. If he died or reached 65 in 1956, the requirement would be five quarters. If he died or reached 65 in 1957 or later, the minimum requirement would be six quarters, the same as present law.

For widows reaching age 72 in 1966 and 1967, there is a grading-in of coverage requirement of four or five quarters of coverage respectively. Widows reaching age 72 in 1968 or after would be subject to the requirements of existing law of six or more quarters of coverage.

The table below sets forth the requirements as to widows:

Transitional insured status requirements for widow's benefits:

Year of husband's death (or attainment of age 65, if earlier)	Present quarters required	Proposed quarters required for widow attaining age 72 in-- 1965 or before	1966	1967
1954 or before	6	3	4	5
1955	6	4	4	5
1956	6	5	5	5
1957 or after	6	6	6	6

Persons affected, benefits, and effective date. These provisions would become effective for the second month after the month of enactment. It is estimated that 600,000 individuals will be added to the social security benefit rolls by this provision, with such benefits totaling about $250 million in 1965. 1/

OASDI Coverage Extensions

Extensions of coverage of the OASDI system provided in the proposed 1964 social security amendments are explained in the following excerpts from the Ways and Means Committee Report:

> Physicians who are self-employed and interns. To complete coverage of professional groups, the bill would provide for the coverage of physicians who are self-employed and interns. Self-employed physicians would be covered for taxable years ending after December 31, 1964. Interns would be covered beginning on January 1, 1965. About 170,000 doctors and interns would be covered by this provision. (Section 8 of bill.) (OASDI coverage of self-employed physicians has been omitted from coverage extensions in past years largely as the result of opposition to coverage expressed by physicians through their professional organizations.)

1/ House Report No. 1548, pp. 3-4.

> Policemen and firemen. The general exclusion in existing law relating to the coverage of policemen and firemen in retirement systems would be removed. Coverage could thus be made available in all states--but only on the initiative of the state or local government and under the present referendum provisions--to policemen and firemen in positions covered under state or local government retirement systems. However, policemen and firemen could not be brought under coverage as a part of a group which included persons in positions other than policemen and firemen positions. This amendment would be effective with respect to modifications of state agreements approved after November 30, 1964. (Section 11 of bill.)
>
> Division of retirement systems. Alaska and Kentucky would be added to the list of 17 states that may cover state and local government employees under the divided retirement system provision. This amendment would be effective upon enactment. (Section 12 of bill.) (This amendment refers to permission for a state or local government retirement system to be divided into two parts--with one part consisting of positions of members desiring social security coverage and the other part consisting of positions of members not desiring coverage.)
>
> Certain hospital employees. Coverage would be extended to certain hospital employees in California whose positions were removed from a state or local government retirement system. In general, the coverage provided under this special provision begins on January 1, 1962. (Section 14 of bill.)
>
> Extension of time for election of coverage. Another opportunity would be provided, through 1965, for the election of coverage by people who originally did not choose coverage under the divided retirement system provision. (Section 13 of bill.) 1/

Treatment of Tips as Wages

Treatment of tips received by service employees as "wages," for benefit-rights and tax purposes, is provided by Section 9 of the proposed social security bill. The tips would be so treated regardless of whether they were received directly from customers by an employee in the course of his employment--or were received through his employer. This amendment would be effective as to tips received after 1964.

1/ Ibid., p. 5.

Under the bill, the employee would be required to report to his employer in writing the amount of tips received and the employer would report the employee's tips along with the employee's regular wages. Tips received by an employee amounting to less than $20 a month in connection with his work for any one employer would not be covered.

The employer would be responsible for collecting the employee's share of the social security taxes on tips, paying his (the employer's) share of the tax, and including the tips with his report of wages only if the employee reported in writing the tips to him within 10 days after the end of the month in which the tips were received, and then only to the extent that he had available unpaid cash wages of the employee, or funds the employee turned over to him for that purpose, that were sufficient to cover the employee's share of the tax. The employer would have no liability with respect to tips which were not reported to him within the time specified in the bill. In such a case the employee would be liable for the employee tax which should have been paid and, unless he could show reasonable cause for failure to report to the employer, for an additional amount equal to such tax.

The House Ways and Means Committee states in its Report that coverage of employees' tips will provide better protection under the social security program for more than a million employees and their dependents. It reports that on the average approximately one-third of the work income of these employees is in the form of tips. The amount of tips received by employees who regularly receive tips is estimated by the Committee at more than $1 billion annually.

The Committee report does not elaborate on possible enforcement problems, such as those involved in verifications of the accuracy of amounts of tips reported. The self-reporting by employees, to their employers, of income from tips will involve additional OASDI tax liability for both the employers and their employees, but at the same time will increase the potential OASDI benefit rights of the employees. The proposed social security change does not affect the current personal income tax liability on the tips, on a self-reporting basis, but it will provide the Bureau of Internal Revenue (for possible use in the collection of personal income taxes) with records of amounts of income from tips reported by individuals, through their employers, for social security purposes.

Computation of Self-Employment Income from Agriculture

A social security change affecting farm operators, provided by Section 10 of the new bill, is one dealing with optional methods of reporting farm income for OASDI purposes. The change is explained by the Ways and Means Committee as follows:

Under present law, persons with net earnings from farm self-employment have the following option in reporting for social security purposes: (a) If annual gross income from agricultural self-employment is not over $1,800, either actual net earnings or 66 2/3 percent of gross income may be reported; (b) if gross income from agricultural self-employment is over $1,800 and net earnings are less than $1,200, either net earnings or $1,200 (two-thirds of $1,800) may be reported; and (c) if the annual gross income is more than $1,800 and net earnings are $1,200 or more, actual net earnings must be reported.

The bill approved by your committee would retain the present option in the reporting of farm self-employment income but would raise the level of income which may be reported under the gross income option by increasing the $1,800 figure to $2,400 and the $1,200 figure to $1,600.

Thus, persons with agricultural self-employment would be permitted to use the following option in reporting their earnings from agricultural self-employment for social security purposes: (a) If annual gross income from agricultural self-employment is not over $2,400, either actual net earnings or 66 2/3 percent of gross income may be reported; (b) if gross income from agricultural self-employment is over $2,400 and actual net earnings are less than $1,600, either actual net earnings or $1,600 may be reported; and (c) if gross earnings are more than $2,400 and net earnings are more than $1,600, the actual net earnings must be reported. 1/

Automatic Recomputation of Benefits

Section 6 of H. R. 11865 provides for an automatic annual recomputation of OASDI benefits payable to persons who already are on the beneficiary rolls. If they have had new earnings which would increase the benefit amount, the increase would come to them automatically. Under the present law, recomputations must be requested individually by the beneficiaries.

Many people already qualified for benefits fail to request recomputations after they have had earnings that would increase their benefits, according to the Ways and Means Committee Report. Under the bill, the increases would come to them under these circumstances without their having to request recomputations. Also, according to the Committee, the change would assure that no one would be disadvantaged by applying for benefits at age 65, although expecting to continue working for a time, rather than waiting until a somewhat later age. Sometimes when they wait until a later age, it is said, the delay in applying for benefits turns out to be disadvantageous to them.

1/ Ibid., pp. 14-15.

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July 28, 1964

Mr. Robert J. Myers, Chief Actuary
Social Security Administration
Department of Health, Education and Welfare
Washington 25, D.C.

Dear Mr. Myers:

As you know, there has been some discussion of amending H.R. 11865 in terms of adding a benefit of 45 days of hospital care without deductible to be provided to those persons who would qualify under the King-Anderson definition of eligibility. The hospital benefit, it is said, might be elected by the eligible individual in lieu of the 5-percent increase in cash benefits provided under H.R. 11865.

I would appreciate your providing me, as soon as possible, with comparisons of the costs of providing the flat 45 day hospital benefit with the proposal outlined below:

1. Maximum of 45 units of coverage during benefit period:

hospital day	--	1 unit
skilled nursing home day	--	½ unit
home health visit	--	¼ unit

2. Limits on specific benefits during a benefit period:

hospital	--	30 days
skilled nursing home	--	60 days
home health visits	--	120 visits

3. Outpatient diagnostic services would be covered on a basis comparable to that in the McNamara bill (S. 65) and no unit charge made.

4. Skilled nursing home care and home health visits would be provided in facilities and on the basis outlined in the McNamara bill.

5. "Benefit period" as defined in the King-Anderson bill (S. 880).

6. Cost of package (a) <u>including</u> the retirement test in S. 65 and (b) <u>excluding</u> the retirement test.

7. Cost to general revenues of providing this package to the "uninsured" aged compared with cost of providing the 45-day hospital benefit.

With all good wishes,

Sincerely,

PAT. McNAMARA

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United States Senate

COMMITTEE ON FINANCE

RECEIVED
AUG 12 1964

August 11, 1964

The Honorable Hubert H. Humphrey
1313 New Senate Office Building
Washington 25, D. C.

Dear Hubert:

Following up our previous conversations, I am enclosing an outline of the "free choice health insurance proposal I have spoken to you about.

I have told Clint Anderson that I do not plan to introduce this proposal unless it appears that the King-Anderson bill cannot succeed. I will await further advice from Clint and yourself on this point.

Sincerely,

Abraham Ribicoff

Enclosure

RIBICOFF PROPOSAL

FREE CHOICE HEALTH INSURANCE

1. A choice to all social security beneficiaries at age 65 of the following options: (a) $2 a month increase in cash benefits plus health insurance, or (b) $7 a month increase in cash benefits.

2. The beneficiary would automatically receive health insurance plus the $2, unless he elected to take the $7 instead.

3. The health insurance benefits would be:

   (a) 90 days of hospitalization with a slight deductible or 45 days of hospitalization with no deductible.

   (b) 30 days of skilled nursing home care (under a broad definition of qualified nursing homes).

   (c) 30 home health visits such as visiting nurse.

4. Those over 65 not covered by social security would be given health insurance benefits financed out of general revenues.

5. Specific provisions that administration of the program to the largest extent possible be turned over to a national private organization. Presumably, Blue Cross would be the only organization that could perform the needed services of dealing with the hospitals.

6. The health insurance plan would include a cost-sharing device to guard against the possibility that hospital costs would in the future increase faster than wages generally. If after 1968, hospital benefits become more costly than the trust fund can finance them, the differential would be paid for by the beneficiary. At such time, Congress could act to increase the wage base and avoid cost-sharing, but at least if such action were not taken, the program would continue to be actuarially sound and the trust fund would be secure, despite increasing hospital costs.

7. The program would be financed by raising the eventual contributory rate to 5.0% on a wage base of $5400.

8. All cost estimates for this program are based on the cost assumptions worked out by Chairman Mills and the H.E.W. actuaries in connection with estimates of prior proposals.

9. This proposal would replace the 5% cash benefit increase of H. R. 11865 (which ranges from $.80 to $6.40). Other provisions of H. R. 11865 would not be affected with the one exception that the continuation of children as social security beneficiaries through age 22 if in college would be modified so that they would be continued through age 21 if still in high school.

Miller Stumps Maine, Hits Medicare Proposal

By PAUL HOPE
Star Staff Writer

BANGOR, Me., Sept. 9—Republican vice presidential nominee William E. Miller strongly rapped the administration's medicare program today but stressed that Senator Goldwater believes in the social security system.

Speaking to a breakfast meeting in Bangor, the New Yorker heatedly denied that Senator Goldwater would do anything to destroy the social security system. Social security is an important issue in New England where there are large numbers of older people.

He claimed that the position of the G. O. P. presidential candidate on social security is being deliberately misrepresented.

"It would be a catastrophe if the election should result in a victory for the opposition because our positions were misunderstood or misrepresented," he said.

Assails Reports

Mr. Miller said there have been many reports that Senator Goldwater believes in a voluntary system of social security.

"Senator Goldwater has said no such thing. He doesn't say so now, he never said so. If Senator Goldwater were not solidly behind the social security system. Gen. Eisenhower would not be supporting Senator Goldwater today."

But he said that he and Senator Goldwater are against the addition of a medical care program to the social security system.

He said addition of medicare would ultimately result in the "complete destruction" of the social security system.

Earlier Took Stand

Senator Goldwater commented on social security earlier in the year when he was campaigning in New Hampshire during that State's Republican presidential primary. On January 7, in Concord, he said, according to the Associated Press:

"I would like to suggest one change, that social security be voluntary, that if a person can provide better for himself, let him do it. But if he prefers the Government to do it, let him. I wouldn't change it, but I believe he should be able to indicate his choice if he wants it. Or if he doesn't, let him say no to his employer. I think we will come to that in 1970."

In Keene, N. H., on January 22, he said: "I think we would be better off with social security as a voluntary setup."

In Ossipee, N. H., on January 23, Senator Goldwater said: "I have said social security might be better as a voluntary system. All I'm suggesting is that the Federal Government take a look at this whole thing."

Viewed as Contract

Speaking in Charlestown, N. H., on February 18, he said: "Social security is a contract between you and your Government and I don't believe in breaking contracts."

The next day, in Hanover, N. H., Senator Goldwater said, "I don't know where this voluntary business crept in."

Mr. Miller began his campaign tour of New England today in a county whose G. O. P. chairman has resigned rather than support the Goldwater-Miller ticket.

The Penobscot County chairman, Lewellyn R. Michaud, resigned last week, stating that in good conscience he could not support the ticket.

An aide to Mr. Miller said the candidate apparently was not aware the county was without a chairman when he arrived here last night for a four-State campaign swing.

Representative Clifford R. McIntire, who is running for the Senate against Democratic Senator Muskie, said Mr. Michaud's resignation will have no effect on campaign plans.

Explains Resignation

Mr. McIntire said the county committee will meet tonight to select a new chairman.

In a letter to the committee, Mr. Michaud said: "It is with sad heart and much discomfort that I find myself in a position of being unable to support the national ticket."

He said he thought it would be "hypocritical for me to continue as chairman."

Speaking to a small turnout at the city hall in Portland at noon. Mr. Miller criticized President Johnson's honeymoon with leaders of organized labor.

Right-to-Work Issue

Noting a news article that said labor intends to spend $12 million to elect Democrats to Congress to fight the right-to-work laws, Mr. Miller said that when President Johnson was campaigning for the Senate and vice presidency at the same time in 1960, he praised the right-to-work law of Texas as the "most valuable economic measure on the lawbooks of Texas."

At a press conference last night, Mr. Miller lashed out at Senator Fulbright, Democrat of Arkansas, who yesterday called Mr. Miller "foul-mouthed."

Senator Fulbright, chairman of the Senate Foreign Relations Committee, said Senator Goldwater's policies likely would lead to war and that Mr. Miller's attack Saturday on Senator Humphrey, Democratic vice presidential candidate, was "foul-mouthed vituperation."

"Senator Fulbright still seems to be in a never-never land," Mr. Miller said.

"World of Myths"

"If Senator Fulbright considers that reviewing my opponent's record for the benefit of the American people is, in his words, "foul-mouthed vituperation," it is only new proof that Senator Fulbright continues to live in his own little world of old myths and unrealities."

Mr. Miller also criticized Senator Fulbright's position on foreign policies.

"Retreat, retreat, retreat has been his cry, and sure enough the frontiers of freedom have been pushed back," he said.

File - Medicine

SENATE SPECIAL COMMITTEE ON AGING
ROOM G-233, NEW SENATE OFFICE BUILDING
WASHINGTON, D. C.
Phone - 225-5364

FOR RELEASE
WEDNESDAY P.M.
September 2, 1964

WASHINGTON - September 2. The Senate Special Committee on Aging today issued a report in which it recommended a variety of actions to provide improved services for America's elderly. The report was filed for the Committee by Senator George A. Smathers, (D.-Fla.), the Committee's Chairman. Senator Smathers said that the report was developed by the Subcommittee on Federal, State and Community Services, under the Chairmanship of Senator Edward M. Kennedy, (D.-Mass.). The program approved by the Committee contains 15 specific recommendations, as follows:

1. Providing Federal financial assistance for statewide and community planning and coordination of programs for the elderly.

2. Federal grants to public and private agencies and organizations and individuals to conduct research and development projects in the field of aging.

3. Federal grants for the specialized training of persons employed in or preparing for employment in programs relating to the aging.

4. Federal grants for paying one-half the costs of constructing senior centers.

5. Enactment of legislation to help alleviate the problems of senior citizens displaced from their homes by public improvements.

6. Making senior centers and other facilities which serve senior citizens eligible for surplus foods.

7. A food stamp program for senior citizens whose economic status prevents their attaining a nutritionally adequate diet.

8. Creation of a National Senior Service Corps to provide an outlet for energies of civic-minded seniors in community-service activities.

9. Providing Federal employees approaching retirement age an opportunity for preretirement counseling.

10. Federal grants to States to assist in establishing basic-education programs for the elderly.

11. Federal grants to assist land-grant colleges in establishing or expanding general extension education for senior citizens who wish to further their education at the college level.

12. Permitting states to make old-age assistance payments on behalf of a recipient to a responsible relative or other third person where the recipient is unable to manage his own money because of a physical or mental condition.

13. Establishment of State commissions or committees on aging in states which have no such state agencies.

14. Seeking special discounts for senior citizens on transportation and recreational facilities where such appears to be good business practice.

15. Encouraging high school students and other young people to "adopt grandparents" from among senior citizens who are in need of sustained contact with a younger person.

"Senator Kennedy and his subcommittee have done a magnificent job in formulating this 15-point program," Smathers said, "It is a program which will provide a maximum of needed services to America's elderly at a minimum cost to the taxpayers. The Committee will now follow through with strenuous efforts to put its recommendations into effect."

Minority views were filed by the Republican members of the Committee on Aging; Senators Everett M. Dirksen, (Ill.), Barry Goldwater, (Ariz.), Frank Carlson, (Kansas), Winston L. Prouty, (Vt.), Kenneth B. Keating, (N.Y.), and E. L. Mechem, (N.M.). Senator Hiram L. Fong (Hawaii) filed a separate statement of individual views.

* * * * * *

ADA legislative newsletter

David Cohen
Legislative Representative

SD - Social Security

Second Session
88th Congress

Issue Number 16
September 10, 1964

(Approximately every two weeks we summarize events in Congress as an information service to assist you in national affairs activities. We include brief analyses of legislative proposals together with factors of timing and politics as we see them. Subscription rate is $5 per year.)

"MEDICARE"

Since President Johnson's renomination liberals have had to outmaneuver the conservatives in Congress. Success in enacting "medicare" will ultimately depend on such maneuvering, The liberals not only have their usual foes (Minority Leaders Dirksen and Halleck and House Rules Committee Chairman Smith) but also Congressman Mills (D-Ark.), the powerful Chairman of the House Ways and Means Committee.

CITIZEN ACTION - WRITE YOUR CONGRESSMAN TODAY SUPPORTING SOCIAL SECURITY FINANCED HOSPITAL INSURANCE, NURSING HOME CARE, OUTPATIENT DIAGNOSTIC SERVICES, HOME HEALTH VISITS FOR PERSONS OVER 65. KEY VOTE LIKELY SEPTEMBER 18.

The "medicare" issue provides insight into how Congress operates. Enactment of "medicare" will involve departing from usual congressional procedure. This requires special parliamentary moves to protect "medicare" from the House and Senate conferees, a majority of whom oppose "medicare".

The House Democratic leadership will probably seek support for a motion requiring Democratic members of the House Ways and Means Committee to support the principle of prepaid hospital care for the elderly in conference.

A. "Medicare" - Historical Background

In 1949 when President Truman first proposed a comprehensive universal health insurance program, the need for some prepaid medical insurance program has been discussed in the halls of Congress. In the late 1950's, under the aegis of the Forand bill, the idea of health insurance for the aged received strong support from Senior Citizens groups, organized labor and ADA. The American Medical Association and private insurance companies vociferously opposed "medicare". After the 1960 Democratic Convention Senator Kennedy and Majority Leader Johnson attempted in the Senate to adopt a "medicare" proposal but failed by a vote of 51 to 44. In the late 1950's the House Ways and Means Committee also bottled up "medicare". Chairman Mills opposed prepaid health insurance for the aged. Mills was supported by all the Republicans on the Committee and enough conservative Southern Democrats to form a majority.

As a substitute for prepaid health insurance for the aged Chairman Mills and the late Senator Kerr (D-Okla.) fashioned the Kerr-Mills Substitute which is financed from general revenues. The Kerr-Mills law provides inadequate medical treatment for the indigent elderly. To receive medical treatment such citizens must take a pauper's oath.

In testimony before the House Ways and Means Committee, Dr. Frank Furstenberg testifying for ADA, stated that:

> "Health care for our elderly is nothing less than an earned social right. It is essential to living a full life in dignity. And our older American citizens should not be faced with the ignominious choice of letting their illnesses go untended or take a means test, as required in the Kerr-Mills Act. Many aged persons refuse to accept Kerr-Mills medical care because it is welfare medicine. Mr. Chairman, it is an understatement to suggest that the Congress in approving Kerr-Mills underestimated the spunk, pride and enterprising nature of many of our elderly. They want medical care but only with dignity. That is why the Kerr-Mills Act at best has only reached three to four per cent of the aged."

Once in 1962 the Administration attempted to get a vote on "medicare" in the Senate by attaching it as an amendment to a minor revenue bill. The amendment failed by a vote of 52 to 48.

Just recently, the House approved a needed increase of 5% in Social Security benefits but did not consider "medicare". All 10 Republicans on the Ways and Means Committee and 3 Southern Democrats, including Chairman Mills, opposed hospital care for the aged financed by Social Security. Indeed it took strenous work by the Administration to prevent Mills from increasing Social Security benefits by more than 5% -- a Mills device, to prevent "medicare" legislation for another five years.

B. "Medicare"- Legislative Tactics

The House operates under procedures which do not permit amendments to revenue bills once they have reached the House floor. (Amendments to House bills are often decided in 5-10 minutes.) This is a needed rule since it prevents many vested interests from getting special tax privileges and other privileges when the House is considering complicated revenue legislation. Complicated legislation should not be discussed without benefit of detailed debate and careful committee consideration.

However Senate rules permit non-germane amendments to legislation. Thus although the Senate Finance Committee is a graveyard for all liberal legislation, such as tax reform and "medicare", it is still possible to bring the measure to the floor for a vote and have adequate debate. The Senate Finance Committee, like the House, approved a similar bill for increasing Social Security benefits. On two separate votes it rejected the Gore-Anderson-Javits compromise on "medicare" and the weaker Ribicoff optional plan on "medicare". Essentially the Ribicoff amendment permits a person receiving Social Security to choose between increased Social Security payments or hospitalization benefits. The hospitalization benefits are not as extensive as provided in the Gore-Anderson-Javits proposal.

The Amendment adopted by the Senate provides the following hospitalization, nursing home, outpatient diagnostic service, and home health visit benefits.

In hospitalization all persons 65 and over would have the option of choosing from

three plans. A 45 day plan of hospital care for each sickness involves no deductable payment. A 90 day plan involves a deductable of $10 a day for 9 days with a minimum of $20. A 180 day plan involves a larger deduction on a formula basis. If an individual has been out of the hospital or nursing home for 90 days a new benefit period would start.

A nursing home benefit provides up to 60 days of care after transfer of a hospital to a nursing home affiliated with a hospital approved by the Secretary of Health, Education and Welfare.

The outpatient diagnostic service program covers X-rays and other tests usually performed by hospitals with a $20 deductable for each 30 day period.

Home health visits entitle the beneficiary to 240 visits a year including skilled nursing and other theraputic services.

The Social Security tax is initially increased to a rate of 4.2% for both the employee and the employer of all earnings up to $5,600. Self-employed persons have an increased rate of 6.3% on a maximum of $5,600. The effective date is January 1, 1965.

The Administration wisely pursued the Gore-Anderson-Javits substitute. Senators Gore (D-Tenn.) and Douglas (D-Ill.) were towers of strength in debate. The Javits contribution to the bill involved allowing private insurance companies to provide a low cost supplementary policy to meet doctors and surgeon bills for those not covered by the Social Security proposal. Though the bill would have been more preferable without the Javits compromise, it gained five liberal Republican votes and made the difference on approving the Gore substitute which carried by only five votes.

The opponents of "medicare" fearing that its supporters had a chance of victory also "sweetened" the Social Security benefits by increasing them over and beyond both the Finance Committee's original proposal as well as the House bill. Liberal Democrats had to face a serious choice: whether to accept the principle of health care for the aged financed by Social Security or the increased Social Security benefits which although desirable would have prevented "medicare" legislation. The liberal Democrats made their choice. Five liberal Republicans and all Northern and Western Democrats supported the Administration except Senator Lausche (D-Ohio). The supporting Republicans were Case(N.J.), Javits (N.Y.), Keating (N.Y.), Kuchel (Calif.), Smith (Maine). All Southern Democrats opposed the Administration except Johnston (S.C.). Thus by a vote of 49-44 the Administration won support for its medical care program in the Senate.

Under normal circumstances a bill differing between the House and the Senate is resolved in conference. However the Republican conferees in the House and Senate vehemently oppose "medicare." Chairman Mills is also opposed to prepaid health care. Mills opposition includes the Ribicoff optional plan.

The Democratic conferees also present a dreary picture. Three of the five Senate Democratic conferees oppose the bill approved by the Senate. Of the 14 conferees 9 oppose prepaid health care for the aged. Left to its own devices the Conference Committee would eliminate "medicare" quickly. The Senate conferees are honor bound to support the will of the majority of the Senate only in the early phases of the conference negotiations.

Thus the Administration and House Democratic leadership has to take the important step of requiring the House Democratic conferees to support the principle of prepaid

health care. If the complicated parliamentary maneuver works Chairman Mills will be obligated to support the principle of "medicare". The net effect will be to increase the assurance that some form of Social Security health insurance will pass Congress.

C. Conclusion

The "medicare" story is another example of unfair congressional procedures. The obstinancy and arbitrariness of Chairman Mills has prevented a vote for four years on the merits of "medicare" despite the program having priority support of the Kennedy-Johnson Administration.

And even if "medicare" passes both Houses, extraordinary procedures must be resorted to since a majority of the powerful Conference Committee in both Houses opposes "medicare".

Republicans opposed to "medicare" reflect the majority of their own party. But the seniority practices of Congress result in the minority conservative wing of the Democratic Party holding the decisive votes in conference. These Democrats do not reflect the will of their party.

This illustrates why ADA's rules reform would require a majority of the Conference Committee of the House and Senate to support the majority views of each House.

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