Medicare WF - [1965?]

FLOOR STATEMENT

Mr. President, on Thursday, August 5, 1965 the President of the United States, Lyndon B. Johnson, went to Independence, Missouri to sign the Social Security Amendments of 1965.

This trip was a warm gesture of gratitude and recognition to Harry S. Truman who as President in 1948 pioneered in the area of medicare legislation. This historic signing took place in the presence of another man who has played a singularly important role in the fight for a health-care law--the Vice President of the United States, Hubert H. Humphrey.

It is indeed appropriate that the Vice President's name appears on the law in his capacity as President of the Senate. It is indeed appropriate that he witnessed the successful culmination of nearly twenty years of effort to bring greater security and wellbeing to our senior citizens.

As Senator from Minnesota, Hubert H. Humphrey either sponsored alone or was a co-sponsor of a medicare bill in every Congress in which he served covering the years 1949-1964. During the first session of the 81st Congress in 1949 the Senator from Minnesota joined in sponsoring S. 1679 which included a comprehensive health-care plan. Again in the 82nd, 83rd, 84th, 85th, 86th, 87th and 88th Congresses, the Senator from Minnesota continued the struggle on this vital program.

When he introduced S. 1511 on February 3, 1959 during the 86th Congress, Senator Humphrey set forth the moral and ethical arguments in favor of medicare under the social security system.

> "One of the most important and pressing social problems which we face today is finding means to insure a life of dignity and decency for our older Americans. We in this great and wealthy country have a social and moral obligation to provide adequate means whereby the elderly may enjoy a decent standard of living and may be free of constant

"anxiety over what will happen in time of serious illness."

Surely these words expressed the feelings of millions of American citizens whose support this year finally transformed medicare from legislation into law.

Mr. President, our Vice President played a truly pioneering role in the development of medicare legislation. Today I rise to thank him and pay tribute to him. I am confident that few laws passed by the Congress in recent years brought him more personal satisfaction.

I ask unanimous consent that a summary of each of the 14 medicare bills Senator Humphrey sponsored during his tenure in the Senate be printed at this point in the record. This record will stand as public testimony to his vision and contribution to assuring that America's elderly citizens have full opportunity for a life of health and dignity in their later years.

[1965?]

SENATOR PAT MCNAMARA
SUITE 255
OLD SENATE OFFICE BUILDING
WASHINGTON 25, D. C.

SUMMARY OF MAJOR PROVISIONS OF S.65 (McNAMARA BILL)
"HOSPITAL INSURANCE BENEFITS ACT OF 1965"

1. Eligibles:

   a. Persons age 65 and over who are eligible for social security or railroad retirement benefits (numbering about 16 2/3 million).

   b. Other persons (except Federal employees who have their own retirement system) who are age 65 and over (about 2 million) or who will reach age 65 prior to January 1, 1971, with the cost of coverage for such individuals being financed from general revenues.

2. Benefits: (payable January 1, 1966, except for post-hospital skilled nursing home care which becomes covered beginning July 1, 1966)

   a. Hospital inpatient services for 45 days in a benefit period without "deductible" charge to the older person.

   b. Post-hospital skilled nursing home care for 90 days in a benefit period. Services are provided upon transfer from a hospital.

   c. Home health services following hospital or skilled nursing home care such as visiting nurse; physical, occupational, and speech therapy; social services; part-time or intermittent services of a homemaker or other home health aide; medical supplies (other than drugs and biologicals) and the use of medical appliances; and medical services provided by a home health agency under arrangements with a hospital. These services, as well as radiation therapy, may also be secured in the out-patient department of a hospital, if deemed advisable by the individual's physician. **(Up to 120 visits per benefit period)**

   d. Outpatient hospital diagnostic services (such as X-ray and laboratory services) subject to a payment by the patient of the first $10 of the total hospital charges during a period of 30 consecutive days.

   e. If the cost estimates prove higher than actual experience and/or income to the Fund is greater than anticipated, the Secretary is authorized, upon recommendation of the Hospital Insurance Benefits Advisory Council to:

      (1) Extend the duration during which payments will be made for care and/or

      (2) Add a new benefit providing payment for some or all the costs of prescribed drugs.

3. Financing:

a. By means of a separate payroll tax, finances a Hospital Insurance Trust Fund established in the Treasury. This tax is completely distinct from Social Security contributions, but would be collected under similar procedures.

b. A total tax of .8 of 1 percent of earnings (.4 employee and .4 paid by employer) would be paid on the first $9,000 of earnings. Self-employed persons would pay .6 of 1 percent on the first $9,000. (Earnings are as defined in the Social Security Act)

By collecting taxes for 6 months prior to the start of benefit payments, a fund of approximately $1 billion would be available at the outset.

c. The funds raised under the financing proposed are deemed by the Chief Actuary of the Social Security Administration as sufficient to cover all the costs of the benefits (and administration) and provide a nominal reserve. Actuarial estimates are based on the assumptions recommended by the Social Security Advisory Council that hospital costs will continue to rise faster than earnings for the next ten years.

d. Illustrative costs.

The cost to employees (.4 of 1 percent) for hospital insurance are shown for various levels of earnings:

Annual Earnings	Annual Cost
$4,000	$16.00
4,800	19.20
5,000	20.00
5,600	22.40
6,000	24.00
7,000	28.00
8,000	32.00
9,000	36.00

4. Administration:

Primary responsibility with the Social Security Administration, with the United States Public Health Service, to the extent practicable, assuming responsibility for relations with the providers of services--such as hospitals, etc.

Payments would be made to hospitals and other providers of services on a cost basis. The cost of hospital services would be based on semi-private accommodations (2,3, or 4-bed rooms).

[1965?]

What Future for Social Security?

by

Merton C. Bernstein*

Hard and crucial decisions about Social Security confront us. At least we should confront them. Since its inception in 1935, Old Age, Survivors' and Disability Insurance has been financed wholly by payroll taxes paid in equal parts by employer and employees. Unless augmented by funds drawn from general federal revenues -- an innovation as unpalatable to many of its staunchest supporters as well as its most carping critics -- benefits will remain woefully inadequate to the needs of the elderly who already comprise about ten per cent of our population. If this transformation is not accomplished or is done only timidly, private pensions must provide substantial supplements to most of our future retirees, a task for which they now are ill-fitted. The great likelihood is that unless basic improvements are made in both public and private systems, an appallingly large majority of the elderly will continue to drag out their last years in poverty. Enactment of the Medicare program will not solve the problem -- indeed, it will crystallize and accelerate the predicament imposed by the limits inherent in the OASDI program as presently constructed. If the public desires improvements in coverage and benefits they must learn more about both the public and private systems and grapple with the dilemmas they pose.

Although a program of social insurance, OASDI financing has been extremely conservative. Both employers and employees pay 3 5/8% (increasing to 4 5/8%

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*Merton C. Bernstein, an attorney, is a labor arbitrator and lecturer at Yale Law School. He is the author of The Future of Private Pensions recently published by The Free Press-Macmillan.

in 1968) of taxable payroll, now set at the first $4,800 of each employee's annual earnings just to pay the benefits now provided. (Any serious analysis yields the conclusion that company "contributions" are a form of employee compensation subtracted from what otherwise is available for wages, salaries and fringes.) In the view of many, most notably Senator Ribicoff, former Secretary of Health, Education and Welfare, the rate of tax is approaching the maximum feasible. Payroll tax increases required by the enactment of Medicare and the small money benefit improvements of the bill passed by the Senate last Fall would bring the combined employee-employer rate to what is regarded as the limit -- 10%; in addition, a boost of taxable payroll to $5,600 a year would be necessary. As the rate of tax is uniform for all, and as it is really inconceivable that low-paid workers can or should be taxed at any higher rate, how are we to finance further OASDI benefit improvements which are urgently, often desperately, needed?

Perhaps most of us do not realize how low benefits are and how great the gap is between them and former wages. Indeed, the gulf between OASDI benefits and a subsistence level of income, roughly $3,000 for a couple and a sparse $1,800 for an individual, is abysmal. On the average retired couples receive $125 a month, an annual total of $1,500. Single men average about $84, for an annual OASDI income of about $1,000. Widows' benefits average a wretched $810 a year. More than 70% of the aged beneficiaries receive less than $100 a month; indeed 43% must struggle to get along on Social Security benefits of $70 or less. Little wonder then that more than 800,000 OASDI beneficiaries must seek Old Age Assistance (OAA) which requires a pauper's oath -- the very thing the Social Security insurance program was supposed to avoid. Their number has been growing and would already be

larger if OAA benefits were available to OASDI beneficiaries between the ages of 62 and 65 and if state-set needs tests were not so stringent.

Even an individual whose average creditable earnings reach the maximum of $4,800 obtains a "primary benefit" which replaces less than 28% of his pre-retirement income. Where the husband has such wages, a couple achieves under 42% of his former income (because, in addition to the husband's benefit, a wife's benefit of another 50% of the primary benefit is payable if she is 62 or over). Had she been working, their combined benefit would be the same and so would replace a smaller portion of their former income. For those with earnings in excess of the maximum creditable, the portion of income replaced is less; the higher the income, the smaller the replacement effectuated. For the great majority with under the maximum creditable earnings, the percentages of former income replaced by benefits are better because the "primary" benefit formula (58.85% of average monthly earnings up to $110, and 21.4% of any excess up to $400) favors them. But obviously the actual cash benefits of practically all fall below the subsistence level.

Future retirees will be somewhat better off, because benefits are geared to average pre-retirement income and so the higher earnings of recent years will be transferred into slightly higher benefits for them. Moreover, as the amount of such earnings creditable for OASDI benefit purposes was raised from $3,600 to $4,800 by the 1958 amendments those with average annual wages or salaries above $3,600 thereafter will achieve higher benefit levels. However, there are offsetting factors, not the least of which are that unemployment reduces the average earnings upon which benefits are based and those forced into retirement before age 65 will have permanently reduced benefits. Chronic unemployment afflicting hundreds of thousands of workers in their 50's

and early 60's will be reflected in lower benefits.

While the enactment of Medicare would help millions of the elderly to meet some of their frequently heavy medical expenses, it would require a total tax rate increase of 1% and a boost of taxable earnings to $5,200. Even if these payroll taxes would meet Medicare costs -- and that is at least debatable -- there soon would be intense, and I believe irresistable, pressure to liberalize health benefits (so as to pay for items of heavy expense not covered by the Administration measure, such as physicians' fees and drugs for those not institutionalized) and to extend Medicare to the 6 million people under 65 eligible for OASDI but not Medicare benefits under the 1964 proposal. Satisfying these demands would require another appreciable boost in taxable earnings. And we have not even taken into account the probable increased costs due to spiraling hospital and medical care charges nor other costly non-medical liberalizations demanded by significant groups.

And so we revert to the question: where are we to get the funds to finance even modest Social Security money benefits, let alone the substantial amounts required to bring money and medical benefits into line with a standard of living of decency and independence? Quite clearly, higher payroll taxes are out of the question, for, with enactment of Medicare, the uniform, hence regressive tax, will go as high as low wage earners can bear. If we are to remain within the "principle" that OASDI payroll tax revenues must pay completely for benefits, future increases must come from raising the amount of wages and salaries that are taxable. How much of a boost would depend upon the benefit increase sought. An aggregate benefit boost of 50% -- which in terms of need is modest -- simply could not be paid for in

this manner even if there is no limit on the amount of earnings subject to this tax. If the limited hospital ~~benefits~~ hospitalization program of the 1964 Senate-passed bill were enacted (with its benefits extended to retirees 62 and over and the disabled), money benefit improvements of 14% would use up all of the funds available from a combined 10% payroll tax applied to all wages and salaries without upper limit.

The dilemma then becomes either to enact whatever modest improvements can be paid for by payroll taxes or to modify the principle that such taxes can be the sole source of revenue for this program. Such a change cannot be made lightly because the OASDI payroll tax pattern has been a key factor in the relative ease with which repeated liberalizations of OASDI have been legislated since 1950. While there was opposition to just about every improvement, it was slight compared to the phalanxes that would have done battle were the financing derived from general revenues, derived in the main from corporate and the more or less progressive individual income tax. Then such improvements would have constituted just another "spending program" in competition for insufficient funds from a usually tight-fisted Congress.

Another alternative, chilling to the liberal heart, is to seek medical care for the aged outside the Social Security system. Such a separation program would be meaningless unless much of its funds came from general revenues but without a means test. The United States has yet to adopt a social welfare program paid for by general revenues which did not include the odious needs test. Furthermore, benefits under these programs have been anything but generous, while suspicion of "chiseling" has led to much restrictive action at the state and local level where eligibility and benefits are set and the programs administered.

If the elderly are to participate in the "Great Society", something has to give; specifically: the Social Security "principle" of beneficiaries paying the whole freight under a tax scheme that is doubly regressive (uniform rates applicable only to the low end of wages and salaries), or we must turn, in part, to general revenues derived under moderately progressive rates without attaching a needs test. Many European countries -- notably Sweden and Britain -- pay for the bulk of their social insurance programs from general tax sources.

There is real question that we are ready for such a move, although last Fall the Senate, without a murmur, included some three million non-OASDI participants in the Medicare program with their benefits to be paid from general revenues without a means test. But that provision would be temporary because before long practically all those turning 65 will qualify for OASDI benefits.

It remains to be seen whether the staunchest advocates of OASDI improvements are willing to risk the future of the program by abandoning the conservative funding "principle" that has eased their task during the last decade and a half and probably was crucial in the adoption of the disability program. (The argument that retirees "pay" for their benefits and so cannot be deprived of them by Congress has suffered a major rebuff in the Supreme Court; hence that reason for resistance seems unrealistic.) Perhaps those most devoted to Social Security will see that the program has little future, at least slight prospect of substantial improvement, unless they move to higher ideological ground. A society such as ours is disgraced by the plight of our elderly and the resources of the entire nation should be mobilized to help provide a decent standard of living upon retirement.

Indeed many European retirement programs, both private and public, provide benefit increases reflecting wage improvements occurring after retirement on the theory that former workers helped build the economic system and are entitled to share equally in its progress. We subsidize less laudable activities which supposedly redound to the general public interest although quite exclusive groups are the direct beneficiaries of the public largesse.

Even with Democratic majorities of two to one in both houses of Congress, I wonder whether we are ready for the bold departures described. If an advance is not made quickly and decisively another opportunity will be long in coming. If a basic and ambitous reconstruction of OASDI and proposed medical care for the aged programs are not accomplished, we had better become reconciled to the long term limits of Social Security and recognize the broad role that must be performed by private pension plans. Then we must turn to the urgent business of rendering them fit to assure broad and meaningful coverage and adequate benefits. As we most often do things by halves -- at best -- probably both courses must be pursued.

But even to proceed by half measures, we must soon choose between a 1930-designed Social Security system and an up-to-date model fit to carry the elderly toward the Great Society.

#

M E M O R A N D U M

January 27, 1965

TO: John Stewart
Special Assistant to Vice President Humphrey

FROM: Harry Wilkinson
Counsel, Senate Subcommittee on Constitutional Rights

SUBJECT: Legislation that Vice President might promote as sound prospect for President's legislative program on law enforcement

RECOMMENDATION: For reasons listed below, Vice President Humphrey should consider promoting bail reform legislation, either by direct communication to President, or merely by being informed about the need for legislation should the promotion efforts stem from other sources:

(1) Influential, broad-based Senate support for bail legislation (S. 646, S. 647, and S. 648) -- Ervin (D.-N. C.), principal sponsor; cosponsors include Johnston (D.-S. C.), Hruska (R.-Neb.), and all but 4 members of the Senate Judiciary Committee.

(2) Bail reform endorsed by press, bar, judiciary, and civil libertarians; yet, will not antagonize persons seeking a more effective system of law enforcement.

(3) Department of Justice is prepared to promote bail reform as part of President's law enforcement program.

(4) Bail reform can be supported on diverse grounds, having a consensus appeal:

-- Enhances respect for law and order; reason - when accused's financial status determines his fate at the bar, law becomes a public mockery.

-- Diminishes criminal activity; reason - bail legislation could permit judge to deny bail temporarily, with safeguards to protect the accused, to persons who constitute a threat to the community.

-- Dovetails with President's poverty program; reason - being unable to afford bail, the impoverished are incarcerated.

-- Eases tax burdens; reason - detention costs are high; moreover, detention usually results in a job loss for the accused whose family often requires welfare assistance.

-- Preserves constitutional principles of the presumption of innocence and equal justice for all; reason - detention without a determination of guilt is punishment; moreover, only persons unable to

afford bail are denied pretrial freedom.

-- Safeguards adversary system of justice; reason - without pretrial freedom, accused cannot adequately prepare his defense.

-- Protects citizens from the stigma, public derision, and inconvenience resulting from incarceration; reason - being held in jail, even if later acquitted, undermines reputation among employers and neighbors.

-- Improves effectiveness of criminal justice; reason - judges, in reaching bail decisions, will be better informed as to the accused's character, community ties, and other factors pertinent to his appearance at trial.

HGW:z

Americans for Democratic Action

MRS. FRANKLIN D. ROOSEVELT
1947-1962

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MORRIS RUBIN
ARTHUR M. SCHLESINGER, JR.
PAUL SEABURY

1341 Connecticut Ave., N.W., Washington, D. C. 20036 DEcatur 2-7754

January 27, 1965

Mr. John Stewart
Assistant to Vice President Humphrey
New Senate Office Building
Washington, D. C.

Dear John:

The attached is the memorandum on the Medicare bill signed by the following:

W. Palmer Dearing, M. D.
Executive Director
Group Health Association of America, Inc.
Washington, D. C.

Frank Furstenberg, M. D.
Medical Director
Outpatient Department
Sinai Hospital
Baltimore, Maryland

George G. Reader, M. D.
Professor of Medicine
The New York Hospital - Cornell Medical Center
New York, New York

The memorandum is signed in their professional capacities as physician practitioners and administrators of medical care programs who have operated and studied the operation of hospitals, health insurance plans, indigent medical care and other elements of the country's medical service system.

Sincerely,

David Cohen
Legislative Representative

DC:km
Enc.

January 27, 1965

Needed Improvements in MEDICARE Bill

King-Anderson is a giant step in assuring defined medical services for the elderly as a matter of right. We physician administrators of medical care have publicly supported its principles. We are convinced from our experience that the modifications we propose will result in benefits more sensitive to human needs and will foster the high professional standards and efficiency within proposed social insurance costs.

I. Benefits - Services

A. Improve and expand preventive and out-of-hospital therapeutic services.

1. Expand outpatient diagnostic services and post-hospital extended care to physician evaluation; expand post-hospital extended care and home health services to include physician visits. This will speed convalescence and rehabilitation and will remove need for hospitalization merely to secure physician care or evaluation.

2. Include as providers of outpatient diagnostic services non-profit group health plans which meet established standards.

3. Eliminate requirement that extended care be contingent on prior hospitalization. A stroke patient, for example, should after physician evaluation be admissible directly to an extended care facility to begin rehabilitation.

4. Expand post-hospitalization care to include continuation of therapy as an outpatient to encourage prompt discharge. For example, radiation following cancer surgery would be covered without requiring the patient to be in a hospital bed.

B. Reduce hospital days; eliminate unnecessary hospitalization; eliminate deductibles.

1. Reduce inpatient hospital services from 60 to 30 days.

This covers 90% of patients stays for the elderly. It reduces the most expensive service and conserves funds to provide more meaningful benefits. Exceptional cases requiring stays longer than 30 days can be supplemented by: medical recertification, use of Kerr-Mills and private hospital insurance.

Experience shows that the upper limit of hospital day benefits tends to become the floor for length of stay. Hospitals have no incentive to discharge patients or transfer them to less expensive facilities. Blue Shield insurance for physicians' care tends to parallel hospital day limits, which gives doctors incentive to keep patients in hospital and receive fees for maximum duration.

2. Utilization review - Strengthen (a) by including on utilization committees persons with knowledge of community health resources; (b) by initiating planning for post-hospital care no later than 10 days after admission.

3. Eliminate deductibles - Physicians alone determine need for hospitalization or diagnostic services. Hospitals may keep patient longer than necessary to collect deductible from Trust Fund. Outpatient deductibles actually increase incentive to hospitalize patient. Experience shows both that deductibles are not a deterrent and administration is complicated.

II. ADMINISTRATION

Provide an administrative structure which emphasizes quality care, efficient use of resources, and service to people rather than mere payment of vendor costs.

A. Advisory Council - Specify professional and consumer representation on Council and provide for periodic reports.

B. Competent technical administration requires the skills and unbiased judgment of persons trained and experienced in health matters. They are needed to pass on the qualifications and otherwise to deal with providers of service on professional matters, to develop effective utilization review, and to foster the organization of services which will provide maximum benefit to recipients.

1. Provide for assignment to the Public Health Service of Federal responsibility for dealing with providers of service on professional standards, evaluation and planning.

2. Provide for assignment to State health departments, which submit plans which meet prescribed requirements, of responsibility for determining whether hospitals, extended care facilities, etc., meet standards established for providers of service, for giving consultation, and other appropriate professional functions.

3. Restrict role authorized for private agencies, which do not have public accountability, to fiscal functions. Do not entrust them with utilization review and other substantive functions.

S/ W. Palmer Dearing, M. D., Executive Director, Group Health Association of America, Inc.

Frank Furstenberg, M. D., Medical Director, Outpatient Department Sinai Hospital of Baltimore, Inc.

George G. Reader, M. D., Professor of Medicine, The New York Hospital - Cornell Medical Center

JGS/ep E&W: health

COPY

January 7, 1965

Mr. David Cohen
Legislative Representative
Americans for Democratic Action
1341 Connecticut Ave., N.W.
Washington, D. C. 20036

Dear Dave:

Thanks so much for your memorandum on the medicare bill. I have not read it yet but I intend to as soon as I can. I gather there will be a little time to work on the bill in Committee, especially if the Rule 22 thing drags on forever.

Best wishes.

Sincerely,

John G. Stewart
Assistant to the
VicePresident-Elect

Americans for Democratic Action

MRS. FRANKLIN D. ROOSEVELT
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MORRIS RUBIN
ARTHUR M. SCHLESINGER, JR.
PAUL SEABURY

1341 Connecticut Ave., N.W., Washington, D. C. 20036 DEcatur 2-7754

December 31, 1964

Mr. John Stewart
Office of Vice President
Elect Humphrey
Washington, D. C.

Dear John:

Enclosed you will find a list of recommendations for improving the Medicare bill approved by the Senate. The group of physicians who approved these recommendations have always supported Medicare legislation in previous years.

Their feeling, however, is that while limiting a medicare program to the aged, there is great merit in improving the bill in order to improve the quality of medical care.

Sincerely,

Dave

David Cohen
Legislative Representative

Enclosures (2)

DC/am

WASHINGTON MEETING, DECEMBER 13, 1964

GROUP OF SELF-APPOINTED PHYSICIAN EXPERTS

RE: MEDICARE LEGISLATION

S. J. Axelrod, M.D.
Director
Bureau of Public Health Economics
University of Michigan
Ann Arbor, Michigan

Dean A. Clark, M.D.
Research Professor of Medical
and Hospital Administration
Graduate School of Public Health
University of Pittsburgh
Pittsburgh, Pennsylvania

W. Palmer Dearing, M.D.
Executive Director
Group Health Association of America
Washington, D. C.

C. B. Esselstyn, M.D.
Executive Director
Community Health Association
Detroit, Michigan

Leslie A. Falk, M.D.
Area Medical Director
UMWA Welfare & Retirement Fund
Pittsburgh, Pennsylvania

Frank F. Furstenberg, M.D.
Medical Director
Outpatient Department
Sinai Hospital of Baltimore, Inc.
Baltimore, Maryland

Sidney S. Lee, M.D.
General Director
Beth Israel Hospital
Boston, Massachusetts

Frederick D. Mott, M.D.
The New York Academy of Medicine
New York, New York

Edmund D. Pellegrino, M.D.
Chairman, Department of Medicine
University of Kentucky Medical
Center
Lexington, Kentucky

George G. Reader, M.D.
Professor of Medicine
The New York Hospital-Cornell
Medical Center
New York, New York

Cecil G. Sheps, M.D.
Professor of Medical and Hospital
Administration
Graduate School of Public Health
University of Pittsburgh
Pittsburgh, Pennsylvania

Meeting of Group of Self-Appointed
Physician Experts

RE: MEDICARE Legislation - health service aspects

This meeting was held in the Gramercy Hotel, 10:30 a.m. to 4 p.m., December 13, 1964. The following physicians participated: S. J. Axelrod, D. A. Clark, E. F. Daily, W. P. Dearing, C. B. Esselstyn, L. A. Falk, F. F. Furstenberg, S. S. Lee, F. D. Mott, E. D. Pellegrino, G. G. Reader and C. G. Sheps. The closing down of a number of airports on the eastern seaboard prevented several other physicians from attending.

There was agreement that the discussion should be based upon the assumption that Federal legislation for the aged will be introduced early in the new year and that payment for hospitalization for a stated period would be its nucleus. The information that was available to the group indicated that the best basis of discussion would be the bill which was passed by the Senate before it dissolved this fall (H.R. 11685, Title II), since it appears that this is the likely starting point for discussion in Administration circles. The underlying question to which the group addressed itself therefore was:

WHAT SHOULD BE ADDED BY WAY OF SERVICES AND/OR PROCEDURES TO PROVIDE A BALANCED PROGRAM OF CARE AND TO IMPROVE THE

LEGISLATION IN TERMS OF FACILITATING THE USE, AND INCREASING THE EFFECTIVENESS, OF THOSE SERVICES THAT ARE MOST CRUCIAL TO THE HEALTH OF THE AGED?

The principle which pervaded the entire discussion and to which all present attached prime importance was that a balanced program of various elements and modalities of care must be made available, simultaneously, or as nearly so as possible, in order to prevent wasteful and harmful overuse and maluse of individual segments of care.

The following specific points were discussed and established:

1. The program should not provide for options of different types of benefits by beneficiaries since it is usually impossible for beneficiaries to be able to make informed decisions, particularly in advance.

2. The program should contain no deductible features because there is no convincing evidence that this achieves any useful purpose and there is evidence that it will tend to make necessary care less accessible.

3. At the outset, the hospital benefit should not exceed 45 days. A reduction of this benefit to 30 days and perhaps even 21, would be acceptable. A shorter hospital benefit would have the effect of stimulating the physician and the hospital to develop plans at an early stage for discharge, rehabilitation, organized home care and other forms of after-care. Another reason for the acceptability of a shorter hospital benefit, in the face of inadequate funds for a fully comprehensive program, is that this would free funds for the support of other crucial health service program elements.

4. The nursing home benefit should be provided for in terms of skilled nursing services of a clearly established and designated level with medical, nursing, rehabilitative and social services adequate for convalescent care, prolonged skilled nursing care, and rehabilitation activity. It is more important to make certain that the standard of service is adequate than it is to insist on a hospital affiliation although hospital affiliations may expedite, but do not necessarily guarantee, the

4. (continued) desirable level of service. In order to make certain that an acceptable number of nursing homes can provide the above standard of service, there should be a waiting period before the nursing home benefit goes into effect, with provision in the legislation for programming and funding of educational, training and other services that are needed to expedite the development of the level of performance required. Since this is much more a matter of the addition of certain services rather than the development of new facilities, a waiting period of 1½ to 2 years should be sufficient for this purpose.

The availability of the nursing home benefit should not be conditioned on prior admission to a hospital. To require such hospitalization would result in many patients being hospitalized unnecessarily solely to qualify for the nursing home benefit. Arrangements for evaluation of patient needs prior to admission can be effectively arranged on an out-of-hospital basis.

5. Organized home care services are also a crucial element of care for the aged and should be a program of care. It should be set forth with that title instead of "Home Health Services" in order to clarify that more is involved than a miscellany of service units. These services should be designated as approved programs meeting definite standards. The approval agency can be national or state. One state, at least, already has such a program (New York). Minimum services to be provided by the home care agency under continuous medical supervision should include nursing and social service. Possible additional services should include laboratory and related diagnostic services, physical, occupational and speech therapy, nutrition services, medical equipment and supplies. It should be required that approved programs be operated by non-profit agencies and the services should be available to the patients in their homes and in foster homes.

6. Ambulatory services - In order to prevent unnecessary hospital admissions and to reduce the length of stay of certain patients, therapeutic services

6. (continued) which are generally available in hospitals should be made available and paid for on an ambulatory basis, wherever this is feasible.

On the matter of diagnostic services on an ambulatory basis, the group was not able to reach full agreement as to policy and procedure. There was a feeling expressed, however, that it would be desirable to make diagnostic services available in hospitals, in group practice clinics and other clinical centers which meet certain established standards and which are operated by non-profit agencies meeting the criteria of the Internal Revenue code, 501 classification.

7. Utilization committees are essential. Though it may be advisable to allow for the postponement of the date of implementation in certain hospitals, a date for full implementation should be definitely set. Although there is substantial experience with utilization committees in hospitals throughout the country, not enough research and evaluation has taken place to make it possible, at the present moment, to be precisely certain about all procedural aspects. For this

7. (continued) reason, specific provision should be made for research and evaluation projects under this legislation aimed at providing such information.

8. The designation of out-of-hospital services not funded by Medicare legislation as an area for insurance activity would appear to exclude governmental activity from this as a principle. While the group believes that it would be desirable to suspend the anti-trust proscription so that insurance carriers could join together to write national contracts, it believes that this should not be done in such a way as to indicate that government has and, by implication, will have no role to play in this whatever. Also, if this general provision is made, it should include medical care service organizations such as comprehensive group practice prepayment plans.

Cecil G. Sheps

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UNITED STEELWORKERS OF AMERICA
1001 CONNECTICUT AVENUE, N. W., WASHINGTON 36, D. C., ME. 8-6929

NATHAN E. COWAN, CHAIRMAN
COMMITTEE ON OLDER AND RETIRED WORKERS

February 18, 1965

MEMORANDUM

TO: John Stewart
Julius Cahn

FROM: Jim O'Brien

Enclosed you will find a section of copy that while admittedly strong, at least gives some indication of how we feel, subject to editing and modification for your needs, the subject of the massive AMA effort on Eldercare can be dealt with. To a degree at least, we feel that presenting the facts, but with a light touch, and exposing the terrible deceit contained in their multi-million dollar campaign can be handled in a manner that is not offensive and yet does not spare them from the consequences of their activities.

In addition, one of the typical ads that they have been using has been photo-copied and is included along with two brief AFL/CIO Social Security Department treatments of developments on the Hospital Insurance front. I have spent a good deal of time discussing all of this with Nelson Cruikshank who is the designated spokesman for George Meany and the Federation in these matters and he asked me to, in his behalf, urge you to deal with this as forcefully as possible.

I intend tomorrow, if I get a chance, to call Jay Constantine at the Senate Committee on Aging, and see if we can get the material dealing with some other phases of Senior problems such as Housing, the McNamara-Fogarty Bill for Commission, etc.

Eldercare

...better care than Medicare

•

Here's why the Herlong-Curtis Eldercare Bill, HR 3727, is the best answer to the health care needs of people over 65

•

MORE BENEFITS FOR THE ELDERLY

Eldercare would provide a wide range of hospital and medical services for the elderly—much more than Medicare.

	ELDERCARE	MEDICARE
Physicians' Care	YES	NO
Surgical Costs	YES	NO
Drugs—in and out of hospital	YES	NO
Hospital & Nursing Home Charges	YES	YES

LESS COST TO THE TAXPAYERS

Eldercare offers *more care* for the elderly who need help, but would *cost less* because it does not provide benefits for the wealthy and well-to-do. Eldercare would *not* require a new payroll tax. It would be financed by federal-state funds through a program that *already* exists.

By contrast, the Medicare tax plan would increase payroll taxes to provide benefits for *everyone* over 65, the wealthy included. Furthermore, the Medicare tax would hit hardest those least able to pay. The $5,600-a-year worker would pay as much tax as the $56,000 executive.

Your doctors, who care for the elderly, support Eldercare because it also assures free choice of physician and hospital . . . provides for protection through Blue Cross, Blue Shield and health insurance policies . . . and lets people over 65 qualify for benefits before illness strikes—without a welfare type investigation.

WRITE TODAY!

Urge your congressman and senators to vote for Eldercare

(The Herlong-Curtis Bill, H.R. 3727)

The American Medical Association

AFL-CIO Department of Social Security
Nelson H. Cruikshank, Director
Washington, D. C.
February 9, 1965

"ELDERCARE ACT OF 1965"

AS PROPOSED BY CONGRESSMEN HERLONG AND CURTIS (H.R. 3727 - H.R. 3728)

This is the bill that is said to represent the proposal currently being advanced by the American Medical Association. It is, in essence, a slight modification of the present public assistance programs for the aged. The bill would authorize Federal matching of State expenditures to assist needy persons 65 years of age and over to pay the costs of health insurance. To participate, a State would have to enter into a contract or other arrangements with private insurance carriers.

Major Provisions

1. Benefits

There is no provision specifying the benefits to be provided, except that, when combined with MAA benefits authorized under the Kerr-Mills Act, they would have to include some in-patient and some out-patient care.

2. Eligibility

Coverage under this program would be available to any person over 65 who lives in a State which chose to participate in the program, and whose income is either below a maximum level set by the State in which he resides, or -- if his income is above this level -- if he is willing and able to pay the required premium.

3. Financing

The bill would provide Federal grants to the States to be matched by State funds. The amount of Federal matching would be increased by five percent over that now available under MAA. The cost of coverage for persons whose income falls below the limit set by the State would be borne entirely by the Federal-State funds. For individuals with incomes above this minimum amount, but below a maximum amount set by the State, public funds would pay a part of the cost, on a sliding scale according to income. Individuals with incomes above the maximum would have to pay the entire cost.

Comments

1. The bill makes no provision for people to contribute while they are working toward paid-up health insurance when they retire.

2. The record of the operation of the Kerr-Mills Act has established beyond a doubt that most States are not in a position to provide sufficient matching funds to finance adequate MAA programs. They can hardly be expected to appropriate the even greater sums required to finance the expanded program contemplated by this bill.

3. Present legislation would permit States to purchase private insurance for the needy aged, using Federal matching funds. No new legislation would be necessary for that purpose. (Under present legislation there is a prohibition on charging a premium to the individual.)

4. The range of benefits that would be provided under this program would be left entirely to the States. The bill requires only that both institutional and non-institutional care be covered -- a requirement that could be met by provision of one hospital day and one physician visit per year.

5. Persons in the lowest income bracket would be covered automatically in those States that choose to set up a program: persons with higher incomes, who would be paying their own premiums, would have the option of enrolling or not enrolling. This method of enrollment guarantees adverse selection. Since persons in the lowest income group are also those who are highest health risks, the premium rate for those who are not automatically covered would probably be prohibitively expensive.

6. The bill provides no assurance of payment to cover the cost of any specified services. A State would be free to negotiate with a commercial insurance company for a cash indemnity program. There would be nothing to prevent the providers of medical services from increasing their costs because of the existence of this insurance. This is a common practice under presently prevailing types of indemnity insurance. Any meaningful insurance would have to assure that the schedules of payments provided would have to be agreed to by the providers of medical care as payment in full for the services rendered. Little meaningful protection is possible under a program which does not assure full payment of covered services.

7. Since commercial insurance carriers can be utilized under this program, there is no protection against heavy administrative expenses, high acquisition costs, and exorbitant profits on the part of the insurers. Government subsidy of commercial insurance is costly and wasteful, without compensating advantages to the insured.

AFL-CIO Department of Social Security
Washington, D. C.
February 1965

Promise Them Anything --

But Give Them Kerr-Mills ...

The American people are on the verge of a major victory. We can reasonably expect that within a matter of months, there will be legislation enacted providing every family in the Nation the protection of hospital insurance for those over 65.

As the King-Anderson Social Security hospital insurance bill (sometimes referred to as "Medicare") comes closer to final passage, the last-ditch efforts of the opposition become more frantic. The American Medical Association is currently engaged in a most cynical propaganda campaign, in the apparent -- if vain -- hope of fooling enough of the people, for sufficiently long to stop favorable Congressional action on "Medicare" this year. The AMA's campaign is based entirely on empty promises.

FINANCING

AMA Eldercare Empty Promise:

"Less cost to the tax payer."*

Eldercare Fact:

The Eldercare bill would provide Federal grants to the States to be matched by State funds. Most States have not been able to provide sufficient matching funds to finance adequately the MAA programs that already exist. They can hardly be expected to appropriate the even greater sums required to finance the expanded program contemplated by the Eldercare bill. Furthermore, since commercial insurance carriers could be utilized under this program, there would be no protection against heavy administrative expenses, high acquisition costs, and exorbitant profits on the part of the insurers.

If all promised benefits were actually provided, the cost to the tax payer would be many times the cost of the King-Anderson bill.

King-Anderson:

People would contribute an average of less than fifty cents a week while they are working toward paid-up insurance when they retire. Employers would pay a matching amount. Benefits for persons not eligible under Social Security would be paid out of general revenues.

BENEFITS

AMA Eldercare Empty Promise:

"Eldercare would provide a wide range of hospital and medical services for the elderly -- much more than medicare."*

Eldercare Fact:

Eldercare authorizes a wide range of benefits. Actual benefits would be determined by the States, and limited by the availability of State funds. The requirement of the bill that both institutional and non-institutional care be covered could be met by the provision of one hospital day and one physician visit per year.

King Anderson:

King-Anderson provides protection against the greatest burden of health expenditures in old age -- those related to hospitalized illness. Every eligible person regardless of which of the fifty States he lives in would be entitled to:

60 days of hospital benefits
60 days of post-hospital extended care
240 home health visits
out-patient diagnostic services

ELIGIBILITY AMA Eldercare Empty Promise:

Eldercare "lets people over 65 qualify for benefits before illness strikes -- without a welfare type investigation." *

Eldercare Fact:

Benefits under Eldercare would be available only to those persons over 65 who (1) live in a State which is willing and able to participate in the program, and (2) can prove their incomes are below an amount specified by the State in which they reside, or can pay the required monthly premium after they have retired.

King-Anderson:

Eligibility at age 65 would be automatic.

*From advertisement of the AMA, February 8, 1965

Jill - medicaid

NAL, MONDAY, AUGUST 2, 1965

Johnson

for our files

Mills and Medicare

How Federal Health Insurance Plan Evolved in Congress

8-2-65

By ARLEN J. LARGE

WASHINGTON—"There is hereby created on the books of the Treasury of the United States a trust fund to be known as the 'Federal Supplementary Medical Insurance Benefits Trust Fund.' "

That particular passage from H.R. 6675, the medicare bill, shoves Uncle Sam squarely into the health insurance business, purveying a policy covering doctor bills for the aged. A year ago the idea would have sounded preposterous to the weary combatants in medicare's trenches, slugging for a far less ambitious goal — Government-paid hospital room and board.

The step-by-step story of how the medicare bill was drastically broadened in scope deserves telling, if only for the ironies involved. The Federal doctor-bill insurance section was conceived by some of the most conservative Republicans in Congress, and fervently embraced by the American Medical Association's great one-time ally, Rep. Wilbur Mills of Arkansas. Nothing else dramatizes how swiftly the fortunes of legislation can change, and how important are the personalities of the legislators. Much of President Johnson's widely touted success with Congress is due to his skill in judging personalities—in this case knowing when to get a bit tough with the powerful Mr. Mills and when, later, to give him his head.

The story properly starts last Nov. 4, the day after LBJ's Presidential and Congressional landslide. At his Arkansas office, Mr. Mills listened in astonishment to a telephone report from Washington on the casualty list of conservative House members. Down went three Republicans on his own 25-man Ways and Means Committee, where medicare advocates had been trying vainly since 1957 to build a majority. More important, Democrat Mills obviously could no longer threaten House floor defeat for any medicare bill that might be blasted out of Ways and Means over his objections; he used to be able to count on 242 anti-medicare votes in the 435-member House.

Guarding Against Slipup

An associate of Mr. Mills was once asked why the chairman's speeches to Arkansas audiences began to sound increasingly pro-medicare last fall and winter. "Mene, Mene, Tekel," was the smiling reply—a cryptic suggestion that Mr. Mills, like the Old Testament's King Belshazzar, saw the Handwriting on the Wall.

Because Mr. Mills remained in Arkansas during the October-January adjournment period, the Administration had to conduct most of its post-election medicare negotiations by long-distance phone. At first the chairman thought it might be sufficient to promise Lawrence O'Brien, the President's chief lobbyist, that the Ways and Means Committee would indeed get right to work on medicare in January and report a bill favorably to the House.

But Mr. Johnson, Mr. O'Brien and House Speaker McCormack decided to take no chances on a slipup. For insurance they determined to add two more of their party members to the Ways and Means Committee's 15 Democrats, cutting back the Republican membership to eight. This went down hard with Mr. Mills, who as chairman usually has the final say on his committee's affairs.

His protests weren't heeded, and some who were closely involved think this show of Administration firmness convinced Mr. Mills in December that the game really was up. Later, he cheerfully seemed willing to put the best face on the committee's Democratic enlargement, telling others that it would help solve the problem of finding good committee assignments for all those new freshmen.

Meanwhile, officials back in Washington were busy during December drafting the medicare bill to be introduced in the new Congress. It would contain the old checklist of Government-paid hospital, nursing home and visiting-nurse care for the elderly, plus a 7% increase in Social Security cash pensions. (A pension increase had died in a deadlocked House-Senate conference committee last October.)

Administration drafters made a daring decision on the amount of taxes needed to finance these benefits. They specified a combined employer-employe payroll tax rate of 10.4% by 1971—breaking through the old 10% "ceiling" which former Health, Education, and Welfare Secretary Abraham Ribicoff once predicted was the limit of taxpayer tolerance. (The combined rate currently is 7.25%.) Fear of crossing what some people called the "Ribicoff Rubicon" had forced medicare backers to whittle back their proposed hospital benefits in previous years. The demand for higher cash pensions threatened to absorb much of the remaining layer of supposedly tolerable taxes.

However, the Senate last September had actually approved a medicare-pension increase bill requiring a 10.4% combined tax rate. Planners of the new bill thus gambled that the Ribicoff Rubicon had been symbolic-

Mont.), likewise lined up the number S. 1 for the companion version, sponsored by Sen. Anderson (D., N.M.).

So when Congress convened in January everything was all set: A cooperative-sounding Mr. Mills promised the President that Ways and Means would report a bill to the House by March 15; the committee was safely packed with new pro-medicare votes; the draft legislation provided generous hospitalization and cash for the elderly, financed with a higher tax than had been thought possible.

The exact list of medical benefits the poker-faced Mr. Mills would support, however, remained a question. His Arkansas speeches, while accepting the principle of benefits financed by compulsory payroll taxes, had sounded rather stingy about the kind of care to be provided. All during February Mr. Mills kept a parade of medical lobby groups moving through his closed committee room, probing exhaustively into the detailed operations of hospitals, nursing homes, visiting nurse associations and the like.

The Mills Imprint

The chairman's committee associates recognized the signs. Mr. Mills, jealous of his reputation as a careful legislator, was trying to give the House a medicare bill as bug-free as possible. More subtly, he appeared to be determined to put his own personal stamp on the measure, demonstrating that he was no mere White House tool.

"He didn't want medicare to be the King-Anderson bill any more," recalls one participant at those tedious February committee meetings. "If it was going to pass at all, he wanted it to be the Mills bill."

The chairman did manage some minor tinkering during this period. He decided the Department of Health, Education, and Welfare had underestimated the probable rising trend of hospital wage costs, so the tax was moved still higher. The pain of socking employers and employes with a towering 11.3% combined tax rate was eased by spreading the increases over a 21-year period. The shortage of nurses prompted a cutback in the Administration's proposed visiting-nurse benefits. But Mr. Mills clearly was looking for something more dramatic.

The answer came from outside the committee room. An alarmed, even panicky, American Medical Association was spending big money for TV and newspaper promotion of its rival "eldercare" plan. Though eldercare was mainly a spruce-up of the existing Kerr-Mills program, the AMA advertising heavily stressed the fact that the Administration bill didn't cover doctor bills. The ads carried checklists showing all the things eldercare would provide and all the things medicare wouldn't.

Though eldercare at no time had a chance of replacing the Social Security approach, the AMA campaign had some Democrats worried. Overselling of medicare all those years had led to widespread public belief that the bill provided comprehensive coverage. "A lot of people in my district thought all this stuff was in the bill already," said one urban House Democrat at the time. "I hated to think of facing all those disappointed voters at the next election."

Republicans sensed an opening. Last February and March was the height of the search, by the new image-conscious House GOP leadership, for "constructive Republican alternative proposals." Rep. Byrnes of Wisconsin, ranking Republican on Ways and Means, therefore worked up a plan designed to out-sparkle medicare. A Federal insurance policy would cover the elderly's hospital bills, doctor bills, prescription drugs, ambulance rides—everything. It would satisfy Republican ideology by being voluntary and by gearing the beneficiary's premiums to his past earnings level. The Federal subsidy for the insurance, however, would cost the Treasury more than $2 billion annually.

On Tuesday, March 2, Mr. Byrnes was explaining his plan at a closed-door meeting of the Ways and Means Committee. Mr. Mills was all set to attack the GOP plan's cost estimates and denounce the scheme as a budget-buster. But when he asked the opinions of Wilbur Cohen, HEW's head lobbyist, and Robert Myers, the Social Security Administration's actuary, both upheld the Byrnes plan's cost arithmetic. Moreover, as the explanation continued, such medicare supporters as Reps. Keogh of New York and Jennings of Virginia began to look interested. Finally, a participant who was watching Chairman Mills witnessed something remarkable:

"You could see the light bulb flash on in his mind."

A Dramatic Splash

Why not, Mr. Mills suddenly interjected, graft the Byrnes plan for doctor-bill insurance on top of the Social Security-medicare plan for hospital benefits? Here at last was the dramatic Millsian splash, the antidote for the AMA ads, the way to prevent Congress from someday burdening the Social Security

ally crossed last year, and that Congress would no longer fear imposing an above-10% tax.

Besides composing formal text, officials carefully arranged those small touches of parliamentary gloss designed to underscore medicare's top-priority status in the new session. A bill's number supposedly is assigned on a first-come basis, but Speaker McCormack agreed well before opening day that the House version of medicare, to be sponsored again by Rep. King (D., Calif.), would have the prestigious tag of H.R. 1. In the Senate, Majority Leader Mansfield (D.,

Notable & Quotable

King Whitney, Jr., president, Personnel Laboratory, Inc., Stamford, Conn., in a talk on psychological testing before the American Association of Industrial Management in New York:

Testing, unlike fresh air, is not good for everybody. There are people who are better off not trying to use it. By and large these are employers who find it difficult or even anathema to try to analyze others, even when they are trying to select them for jobs. They simply are not disposed to weigh strengths and weaknesses . . . and they prefer to think of applicants as either "good" or "bad" for jobs, with no in-betweens. Exposing this kind of person to an in-depth study of another human being can be opening a Pandora's box—he just doesn't know how to deal with what confronts him.

system with doctor bills.

When the meeting was over, Mr. Cohen swiftly reported the surprise turn to President Johnson, who approved. But for the President to embrace the doctor-bill plan with an immediate public endorsement would smother the new Mills zest for medicare. So the White House kept mum. There was no reproach as the chairman's March 15 deadline was missed; the committee needed more time to perfect its medical blockbuster.

Democratic members walked around the House corridors looking very pleased with themselves. "We've got everything in this bill except transportation expenses for the doctors to go to England, where there's not so much socialized medicine," laughed one. "We're going through the AMA checklist and filling in all the blanks," boasted another.

On March 23 the committee's work was finished, and something happened which Mr. Johnson had been angling for all along. Rep. King's original H. R. 1 was thrown away. The committee's freshly drafted bill was formally introduced and given the number H.R. 6675. Its sponsor: Wilbur Mills. Not till then did the President heap praise on the unsolicited new section.

Only minor changes were made by the Senate in the Ways and Means product, which now is law. No one knows whether it will work well for elderly patients, or regiment the doctors, or bleed white the Treasury and the Social Security system. But Mr. Mills has once again given Congressional connoisseurs some pointers in legislative agility. If you need travel money for that trip to England, doctor, you know the man to see.

MEDICARE AND SOCIAL SECURITY

Here's First of Full Report on Benefits

By JOHN TROAN

This is the first of 14 articles which will give our readers a complete run-down on the benefits of the Medicae program.

YOU are richer than you realize.

As a worker, you have in the files of Social Security headquarters an account in your name which may be worth—right now — more than a $123,000 estate.

For instance, if you should die and leave a growing family, your widow and children may be able to collect up to $309.20 a month in Social Security benefits.

Likewise, if you should become disabled or if you still have young children when you retire, you could collect maximum family benefits of $309.20 a month.

¶ Return

This is equal to a three per cent annual return on a capital investment (or bank account) of $123,700.

Furthermore, this income is guaranteed. It is risk-proof. And it is tax-free.

Even if your family is grown when you retire, you and your wife may collect as much as $203.90 a month. This is equal to an annual income of three per cent on an investment of more than $81,500.

And your stake in Social Security is rising. In 1967, maximum family benefits will climb to $368 a month—equal to an annual income of three per cent from an estate worth $147,200.

¶ Something New

But this isn't all. For something new has now been added to Social Security. Besides paying cash benefits, Social Security next year will start paying hospital bills and help take care of some other medical expenses.

This new wrinkle to Social Security is often called Medicare.

Government experts figure it would cost more than $18 month to buy, on the open market, a policy duplicating the full Social Security health package—if you could find anybody who would sell you such insurance.

For persons 65 or older, Medicare will provide:

- Up to 90 days of care in a hospital for a single illness, with the patient paying the first $40, plus $10 for each day after the first 60.
- Up to 100 days of care in a nursing home for the same sickness, with the patient paying $5 for each day after the first 20.
- Up to 100 visits a year to the patient's home, following hospitalization, by part-time nurses, physical therapists and similar health aides.
- Hospital diagnostic tests on a non-overnight basis, with the patient paying the first $20, plus one-fifth of the remainder.
- Care in a psychiatric hospital will be covered under certain conditions. But nobody will be able to draw more than 190 days of such care during his lifetime or more than 90 days at one stretch.

In general, Medicare won't pay for doctor bills, private-duty nurses or drugs prescribed outside a hospital or nursing home.

¶ Delay

The nursing-home benefits will start Jan. 1, 1967; the others, July 1, 1966. They'll be financed by higher Social Security taxes that take effect next Jan. 1.

The Social Security law has been changed also to make it possible for persons past 65 to buy special health insurance providing additional benefits after June 30, 1966.

This supplemental insurance is optional. Its cost: $6 a month for each person, with the Federal Government paying half of the premium out of the regular U.S. Treasury. For those who choose to buy it, the supplemental insurance will help cover:

- Doctor bills, in or out of a hospital.
- Dentist bills for surgery on the jaw or other facial bones required by accident or disease.
- Visits by part-time nurses and other health personnel to a patient's home under conditions not covered by the basic Medicare plan.
- Up to $250 worth of psychiatric care a year outside a hospital.
- Various other health benefits not provided by Medicare, including diagnostic tests outside a hospital, ambulance service, artificial limbs, and rental of medical equipment (such as a wheelchair).

With supplemental insurance, the subscriber will have to pay the first $50 of his medical expenses each year and one-fifth of the rest. The insurance will cover the balance.

¶ Special

In addition, the Social Security law contains special provisions concerning free health benefits for persons who aren't drawing welfare checks but are too poor to pay their medical bills.

This is known as the Kerr-Mills program. A state may—but doesn't have to—set up its own Kerr-Mills program, with the Federal Government supplying most of the money from the regular U. S. Treasury.

When this program was originally established only persons 65 or older could get such "medical relief." As of Jan. 1, 1966, andy state can expand the program to include needy children under 21 and their parents; also, needy persons of any age who are blind or otherwise disabled.

Meanwhile, Social Security cash benefits have been raised. In most cases, these increases date back to Jan. 1, 1965. Under the new scale, monthly Social Security checks range like this:

For a retired worker—$35 to $135.90 (and eventually to $168).

For a retired couple—$51.70 to $203.90 (eventually $252).

For a disabled worker—$44 to $135.90 (eventually to $168).

For a widow — $35 to $112.20 (eventually to $138.60).

For a child — $22 to $102 (eventually to $126).

Maximum for one family — $309.20 (eventually $368).

Social Security also makes lump-sum death payments. These range from $132 to $255.

(NEXT: Who qualifies for what benefits, and when.)

Local Medicare Set at $131 Million

The District will receive an estimated $15 million in benefits under the new Social Security and Medicare program next year, Maryland $54 million and Virginia $62, million, according to Social Security estimates.

It was also estimated that of the District's share, $7 million will be in Medicare payments to 79,000 persons; of Maryland's, $23 million to 264,000 persons; and of Virginia's, $31 million for 330,000 persons.

MEDICARE AND SOCIAL SECURITY

Who Qualifies for Benefits?

This is the second of 14 articles which will give our readers a complete run-down on the benefits of the Medicare program.

By JOHN TROAN

BORN before 1903? You're assured of Medicare benefits even if you've never paid a cent in Social Security taxes.

However, those born in 1903 or later must have credit for a certain amount of work under Social Security to qualify for health benefits upon reaching age 65.

This working period ranges from 1½ to 10 years. Generally, the older you are the less Social Security coverage you'll need. Also women need fewer "credits" than men.

¶ Excluded

Some people are excluded from Medicare — chiefly Federal workers and their dependents who are enrolled in the health plan established for them by the Federal Employes Health Act of 1959.

Also excluded: • Aliens who haven't been admitted to the United States for permanent residence; • other aliens who haven't lived in the United States continuously for the five years just before filing a Medicare claim; • members of subversive organizations, and • persons convicted of such high crimes as sabotage, espionage and sedition.

But if a Federal employe or an alien who would otherwise be excluded happens — because of some previous employment — to be entitled to Social Security or Railroad Retirement benefits, he's eligible for Medicare.

Medicare benefits start July 1, 1966. At the same time, extra health benefits become available to persons who buy supplemental insurance thru the U.S. government.

¶ Supplement

This supplemental health insurance will be offered to anyone 65 or older who is eligible for basic Medicare benefits. Also, to Federal employes who can't qualify for the basic benefits.

Under the Social Security law, the so-called Kerr-Mills program offers needy persons past 65 free health benefits even if not on relief. But these have nothing to do with previous employment under Social Security, and each state sets its own rules. This program is to be expanded after this year, chiefly to include needy children under 21 and their parents. (More about that in a later article.)

To draw cash benefits, credit for a certain amount of work under Social Security is required.

Social Security credits are called "quarters of coverage." A quarter is any three-month period beginning Jan. 1, April 1, July 1 or Oct. 1. Ordinarily, a worker who is paid at least $50 in such a period gets credit for one quarter of coverage.

¶ Credit

If you work for yourself, you get credit for a full four quarters a year provided your net earnings are at least $400. Otherwise, no credit.

Self-employment has been covered by Social Security since Jan. 1, 1951; most other work, since Jan. 1, 1937.

Once you add up 40 quarters of covereage — equal to 10 years of work under Social Security — you are "fully insured."

Men born after 1925 and women after 1928 need 40 quarters to be "fully insured." For older workers, the requirement is lower. The minimum is six quarters — for men born before 1893 and women born before 1896.

To Draw a Pension

This table shows the "quarters of coverage" needed to get Social Security retirement checks. All "quarters" earned since Jan. 1, 1937, count.

Year Of Birth	Quarters Needed Men	Quarters Needed Women	Year Of Birth	Quarters Needed Men	Quarters Needed Women
1889 or earlier	3	3	1910	24	21
1890	4	3	1911	25	22
1891	5	3	1912	26	23
1892	6	3	1913	27	24
1893	7	4	1914	28	25
1894	8	6*	1915	29	26
1895	9	6	1916	30	27
1896	10	7	1917	31	28
1897	11	8	1918	32	29
1898	12	9	1919	33	30
1899	13	10	1920	34	31
1900	14	11	1921	35	32
1901	15	12	1922	36	33
1902	16	13	1932	37	34
1903	17	14	1924	38	35
1904	18	15	1925	39	36
1905	19	16	1926	40	37
1906	20	17	1927	40	38
1907	21	18	1928	40	39
1908	22	19	1929 or later	40	40
1909	23	20			

*Reduced to 5 in 1966.

To Get Medicare

The table below shows how many "quarters of coverage" are needed to qualify for Medicare benefits (chiefly hospital and nursing-home care) under Social Security.

Year Of Birth	Quarters Needed Men	Quarters Needed Women
1902 or earlier	0	0
1903	6	6
1904	9	9
1905	12	12
1906	15	15
1907	18	18
1908	21	19
1909 or later	Same as for retirement benefits	

¶ Retirees

A new provision applies specifically to retirees and widows 72 or older. They may qualify for benefits with as few as three quarters of coverage.

For disability benefits, the rules again differ. Generally, a person who is so disabled he can't work may draw such benefits provided the disability is expected to last at least 12 months (or to result in death) and he has Social Security credit for at least five years of work during the 10 years preceding disability. For some persons blinded before age 31, as little as a year and a half of Social Security credits may now be enough to make them eligible.

Where there are young children survivors' benefits are payable if a worker was "currently insured" even tho not "fully insured" when he died. To be currently insured a worker must have had six quarters of coverage — 1½ years — during the three years preceding death.

NEXT — How, where and when to file for Social Security health benefits.)

All of the valuable information contained in this series, PLUS additional details and charts are available in a new 80-page book for permanent reference. To order, use the coupon below.

MEDICARE AND SOCIAL SECURITY

Your Passport to Health

This is the third of 14 articles which will give our readers a complete run-down on the benefits of the Medicare program.

By JOHN TROAN

YOUR passport to Medicare will be a wallet-sized card resembling the kind Blue Cross subscribers carry.

It will signify you are eligible for basic Medicare benefits provided under Social Security. It also will show whether you have bought supplemental health insurance entitling you to additional benefits.

The cards will be mailed by the Social Security Administration before July 1, 1966 — when such benefits become available.

¶ Automatic

If you're eligible for Medicare and already getting monthly Social Security checks, you'll automatically get a form on which you may sign up for supplemental insurance. You then will receive a health card showing whether you have taken out supplemental coverage or can draw only the basic Medicare benefits.

A similar procedure will be followed with persons receiving monthly Railroad Retirement or Civil Service retirement benefits. Eligible persons on regular welfare rolls also will be advised by mail.

What about other folks who may be entitled to Medicare benefits?

If you're past 65 and have worked long enough under Social Security to rate monthly retirement checks but you haven't applied for them (because, for example, you're still working), go now to your Social Security district office and file an application to establish your eligibility for Medicare.

¶ Register

"enrolling" people for supplemental insurance.

The first such "enrollment" — for persons who will be 65 before Jan. 1, 1966 — will start Sept. 1.

This enrollment period will end March 31, 1966. Should you fail to sign up for supplemental insurance by then, you won't have another chance until Oct. 1, 1967.

Others may enroll during a seven-month period starting with the third month before the 65th birthday. For example, take a person who will be 65 on May 10, 1966. He could enroll for the supplemental insurance from Feb. 1, 1966, thru Aug. 31, 1966.

¶ Time Factor

Basic benefits (except for nursing-home care) begin July 1, 1966. The supplemental insurance takes effect one to three months after you sign up for it—but in no case will it go into force before July 1, 1966. (So hang on to any health protection you may have in the meantime.)

There also will be general enrollment periods for people who want to buy supplemental insurance after having missed a chance to do so, or who want to re-enroll after dropping out. These will be held the last three months of every odd-numbered year starting with 1967.

You may drop your supplemental insurance at the end of any such enrollment period. Or the overnment can drop you after a 90-day grace period if you fail to pay premiums.

If you drop out, you may sign up again for supplemental insurance during any general enrollment period which begins within three years after you quit. If you drop out a second time, you're out forever.

¶ Premium

The monthly premium will be $6 a person. Of this, the Federal Government will pay half. Premiums start July 1, 1966, or the monh insurance becomes effective—whichever is later.

If you're drawing monthly Social Security, Railroad retirement or Civil Service retirement benefits, the Government will withhold your share of the premium from your check. Otherwise you'll have to pay the premiums on

The premium will be a bit higher for persons who fail to buy the insurance during their first enrollment period. The same goes for dropouts who re-enroll.

The premiums may be changed by the Government every two years, beginning Jan. 1, 1968. This will depend on how much money is needed to cover benefits and administrative costs and to maintain an adequate kitty.

NEXT — How, where and when to file for Social Security cash benefits.)

Average $40 a Day

Hospital Bills Soar

By Scripp-Howard Newspapers

For the first time in history, hospital bills in the U.S. now average more than $40 a day.

Latest figures released by the American Hospital Association show it costs patients an average of $40.40 a day to stay in a "voluntary, non-profit, short-term, general hospital" — the kind most people go to for care.

The figures are for the year which ended last Sept. 30. Since then, hospital bills have continued to climb under pressure of increasing payroll and other costs.

LATEST INCREASE

The latest increase marks the 18th year in a row that hospital bills have gone up — every year since the AHA began keeping tabs on them. The average daily hospital bill for the previous year was $37.96.

The figures cover hospital "extras" as well as room and board. But they don't include doctors' fees.

Despite an increase of more than six per cent in one year, the AHA noted, hospital bills failed to keep pace with actual costs. Thus, hospitals were able to stay in the black only by supplementing patient income with contributions, grants and interest on endowments.

$42.47 A DAY

According to the AHA, it cost such hospitals a record $42.47 a day to care for each patient. The year before, costs averaged $39.87.

The AHA attributed most of the increase to larger payrolls. In general, hospitals now have more employes — and pay them more — than ever.

Back in 1946, when the AHA started such record-keeping, it cost the ordinary hospital an average of $10.04 a day to care for each patient.

Patients are being discharged faster. The average stay now is 7.6 days compared to 8.8 days in 1946.

Nevertheless, the hospital bill for a single stay, now averages more than $307 compared to less than $90 in 1946.

MEDICARE—SOCIAL SECURITY

Documents Needed to Apply

This is the fourth of 14 articles which will give our readers a complete run-down on the benefits of the Medicare program.

By JOHN TROAN

THREE types of monthly payments are available under Social Security:

- Retirement benefits.
- Survivors' benefits.
- Disability benefits.

To draw any of them, you must apply at a Social Security district office. For the nearest office, inquire at your post office or check under "Social Security Administration" in your phone directory.

¶ Age

You must be at least 62 years old to get a retirement benefit. But you can never draw your full retirement benefit unless you wait until you are at least 65 to start collecting it.

When you apply for your retirement benefit you should take along:

- Your Social Security card, or some record on which your Social Security number appears.
- Your income-tax "withholding statement" (Form W-2) for the previous year. (Or if you are self-employed, a copy of your last Federal income-tax return.)
- Some proof of your age.

The best proof of age is a birth certificate, or a baptismal certificate issued shortly after birth.

If you don't have either, you may use some other document to establish your age. Such as a certified hospital birth record; a signed statement from the midwife or doctor who attended your birth; a marriage record showing your age when married; a child's birth certificate which happens to show your age; a family Bible; a military discharge paper; an immigration or naturalization record; a passport; a vaccination record; an old insurance policy; a certified union record; an employment record showing your age; a record from a foreign church or government; or a license, permit or voting record showing your age.

Generally, the older the document the better. And if you don't have any other satisfactory evidence of age, you may ask the U.S. Census Bureau to check its records for you. The fee: $4.

If you qualify for retirement benefits, your wife also may be eligible — provided she is at least 62. In such case, she must prove her age and her relationship to you (a marriage certificate will do). She also should produce her own Social Security card, if she has one, so the Government can figure out whether she qualifies for a higher benefit on the basis of her own work record or yours.

Even if she's under 62, your wife may draw a retirement benefit provided you have in your care a child who is under 18 or is incapable of self-support due to a disability incurred before age 18. In such event, the child also would be eligible for monthly benefits. So proof of the child's age (or disability) would be required.

¶ Support

Where a wife draws a retirement benefit on her own, her husband also may qualify — provided he is at least 62 and can prove he depends on her for at least half of his financial support.

You may apply for retirement benefits three months before reaching retirement age (to avoid delay of payments) or any time thereafter. But retirement checks can't be dated back more than 12 months.

In case of death, the widow may draw survivors' benefits provided she is at least 60 — or has in her care at least one child who is under 18 or was disabled before age 18.

To claim survivors' benefits, a widow must submit her husband's death certificate, his Social Security card or a record of his Social Security number, her marriage certificate, and proof of her age. Also, birth certificates of any children eleigible to draw such payments.

¶ Students

Incidentally, an unmarried child aged 18 thru 21 who is still in school may now qualify for retirement or survivors' benefits but the mother doesn't. Again, evidence of the child's age is needed — as well as proof the child is a full-time student in a college or other bona fide school (including vocational school).

Survivors' benefits also may be drawn by the parent or widower of a deceased worker provided the individual is at least 62 and depended on the worker for at least 50 per cent of financial support.

In event of death, a lump-sum benefit also is payable. This goes to the widow or widower — who must present a death certificate to claim it. If no spouse survives, the lump-sum death benefit may be claimed by the person who paid the burial expenses. In such instances, a receipted funeral bill as well as a death certificate is required.

To draw disability benefits, the worker must establish total disability which is expected to last at least 12 months or to result in death. If you're unable to apply at a Social Security office, the agency will send someone to take your application personally.

If you qualify, disability benefits would be payable also to your wife if she is at least 62 or is caring for a child under 18 or one disabled before 18. Benefits would be payable also to such children plus any child under 22 who is still in school.

NEXT: Hospital benefits under the basic Medicare plan.)

Important Documents

Here's a check list of important documents you should have on hand for Social Security purposes:

- Husband's Social Security card (or a record showing his Social Security number).
- Wife's Social Security card (or a record showing her number).
- Proof of husband's age.
- Proof of wife's age.
- Your marriage certificate.
- Copy of your latest income-tax "withholding statement" (Form W-2). Or, if you are self-employed, copy of your last income-tax return.
- Birth certificate of each child for whom a benefit is sought.
- Certified copy of adoption order (if child is adopted).
- Death certificate of worker who dies.
- Receipted funeral bill if somebody other than widow or widower claims lump-sum death benefit.
- Divorce papers (where applicable.)

Also, if you should become so disabled that you can't work, it is a good idea to keep a list of doctors who have treated you as well as hospitals, clinics and other institutions where you have been treated.

MEDICARE—SOCIAL SECURITY

The Hospital Services

This is the fifth of 14 articles which will give our readers a complete run-down on the benefits of the Medicare program.

By JOHN TROAN

MEDICARE is somewhat of a misnomer. The Social Security health-care plan for the aged could be more aptly tagged "Hospicare." For hospital care is the heart of this benefit program.

Basically, Medicare will provide up to 90 days of hospital care for each "spell of illness" to a person 65 or older.

A "spell of illness" begins the day a patient is admitted to a hospital or nursing home. It ends once a patient has been outside a hospital and outside a nursing home for 60 straight days.

¶ Obligation

Medicare won't cover the full hospital bill. The patient will have to pay the first $40. And if he stays longer than 60 days during any "spell of illness," he'll have to pay $10 for each additional day he remains in the hospital.

The patient also will have to pay for the first three pints of blood he might receive — unless he gets donors to replace the blood. After the first three pints, transfusions will be paid for by Medicare.

Coverage will apply to patients in psychiatric and tuberculosis as well as in general hospitals. But if a patient is already in a mental or TB hospital when he becomes eligible for Medicare, the time he has spent there will be counted against the 90-day limit for a "spell of illness."

Further, no person will be able to draw, during his lifetime, more than a total of 190 days of care in a psychiatric hospital.

¶ Special

A special provision applies to Christian Science sanitoriums operated or certified by the First Church of Christ, Scientist in Boston. Medicare will cover up to 120 days of care for a single stay in such an instiution, with the pateint paying the first $40, plus $10 for each day after the first 60 and $5 for each day after the first 90.

Medicare also will cover persons who go to a hospital on a non-overnight basis for X-rays and other diagnostic tests. Such "outpatients" will have to pay the first $20 for services rendered in any 20-day period, plus one-fifth of the balance.

The initial "deductibles" will be in effect thru 1968. After that, they may be raised each year if necessary to keep pace with increasing hospital costs.

Hospital benefits, which start July 1, 1966, include:

• A semi-private room (two to four beds), tho a doctor may order a private room for "medical reasons."

• Regular hospital nurses (but not private-duty nurses).

• Use of regular hospital equipment, supplies and appliances, such as oxygen tents, wheelchairs and crutches.

• Prescribed drugs which are o. k.'ed by the hospital's medical staff or approved by any one of four "medical Bibles" specified in the law.

• Services of hospital residents and interns — doctors — getting on-the-job experience under approved training programs.

Services of other physicians will not be covered by the basic Medicare plan.

¶ Certification

For Social Security to pay anything, however, a physician must certify it was medically necessary to put the patient in a hospital. If the patient stays longer than 19 days, the doctor will have to recertify need for continued hospital care at intervals specified by the government.

Care in a psychiatric or tuberculosis hospital will be covered only if a doctor certifies the patient needs special treatment which can be "reasonably expected to improve" his condition — or, in the case of TB, render the disease "noncommunicable." This rules out Medicare coverage for ordinary custodial care in TB and mental institutions.

In an emergency, a pateint could be treated in any hospital. He could even be taken to a hospital outside the United States provided the emergency occurs in this country and the foreign hospital is "closer or substantially more accessible" than any "adequately equipped" hospital in the United States. (But if the emergency arises outside the United States, Medicare won't pay.)

In nonemergency cases, Social Security will pay only if the patient goes to a hospital which signs a Medicare agreement with the Federal Government.

To do this, ahospital must subscribe to a physician-controlled "utilization review" committee which will check on admissions to prevent needless use of hospital facilities and services.

Psychiatric and TB hospitals also must be approved by the Joint Commission on Accreditation of Hospitals, aprofessional rating agency. Other hospitals must be so accredited or prove they meet standards similar to those required for such "accreditation."

NEXT: Nursing Home benefits.)

To order your copy of "What You've Got Coming from Medicare and Social Security," use the coupon on Page 57.

MEDICARE — SOCIAL SECURITY

100 Days in Nursing Home

By JOHN TROAN

Under the Social Security Medicare program, you'll be able to get up to 100 days of care in a nursing home for each "spell of illness."

The first 20 days will be paid for by the Government. After that, you must pick up part of the bill — by paying $5 for each additional day you remain in the nursing home.

This means you can get 20 "free" days in a nursing home for a single illness, plus 80 "cut-rate" days.

When It Starts

Nursing-home benefits will start Jan. 1, 1967 — six months after hosptial and home-health benefits begin.

To qualify for nuring-home benefits, you must spend at least three days in a hospital and enter the nursing home within 14 days after leaving the hospital.

However, if you have to return to a nursing home after discharge you may do so without going into a hospital again — provided you re-enter the same nursing home, or get into another one, within 14 days.

Doctor O. K.'s It

In any event, your doctor must certify (and recertify at intervals specified by the Government) that you need skilled nursing care for the same condition which was being treated in the hospital.

(If a new ailment develops while you are in the nursing home, that will be covered by Medicare provided you still were being treated for the original illness at the time.)

What You Get

In the nursing home, you are entitled to:

- Bed and board in a semi-private room limited to four patients (tho a doctor may order a private room "for medical reasons").
- Nursing care.
- Physical, occupational and speech therapy.
- Services of medical social workers.
- Drugs and appliances usually furnished to patients.

This is the sixth of 14 articles which will give our readers a complete run-down on the benefits of the Medicare program.

- Services of interns and residents attached to hospitals that have a working agreement with the nursing home.

Definitions

All nursing homes won't be covered. In fact, most facilities now called nursing homes won't qualify unless they raise their standards or change their method of operation.

Actually, the law says you may go to an "extended-care facility" — not a plain "nursing home." Thus, institutions which offer only "custodial care" (such as old folks' homes) are excluded.

Under the law, the "facility" must be "primarily engaged" in providing "skilled nursing care and related services" or "rehabilitation services." This could be a nursing home, or a hospital wing, or a special section of an old folks' home.

(Christian Science nursing homes are excluded. On the other hand, Christian Science sanitoriums may give up to 120 dayas of care per stay whereas the limit on regular hospital care is 90 days.)

The Rules

Rules governing nursing home services must be drawn with the help of a professional medical group including at least one physician and one registered nurse. And a physician, registered nurse or medical staff must be responsible for carrying them out.

At least one registered nurse must be employed full time (tho not around the clock). And adequate nursing service (which may include practical nurses) must be provided at all times.

Every patient in the nursing home must be under a physician's supervision, and a doctor must always be "available" for emergency care. The home also must keep proper records on all patients and have "appropriate" rules for dispensing drugs.

Generally, the home must be licensed or approved by the state. It also must have a written agreement, governing patient transfers, with at least one hospital that has signed up for the Medicare program (altho a state may ask that this requirement be waived "in the public interest" if a home tried "in good faith" to negotiate such a "transfer agreement" but couldn't get a hospital to go along).

Above all, the nursing home must have a "utilization review plan" under which a physician-controlled committee must make sure patients aren't admitted needlessly, kept in longer than they should be or given unnecessary treatment.

(NEXT—Medicare benefits available in the patients own home.)

MEDICARE—SOCIAL SECURITY

Help When Patient Is Home

This is the seventh of 14 articles which will give our readers a complete run - down on the benefits of the Medicare program.

By JOHN TROAN

MEDICARE will deliver some health benefits right to a patient's home. These "home health services" become available July 1, 1966:

- Part-time or intermittent nursing care provided by or under supervision of a registered nurse. (But services of a private-duty nurse won't be covered.)
- Physical, occupational and speech therapy.
- Services of medical social workers.
- Part-time or intermittent services of a "home health aide," such as a nurse's aide. (But services of so-called homemakers, who handle cooking or housekeeping chores, won't be covered.)
- Medical supplies other than drugs (such as dressings and splints).
- Use of medical appliances (such as wheelchairs and crutches).
- Services of interns and residents connected with a hospital which is affiliated with an agency authorized to provide "home health" benefits.

Unnecessaries

Excluded will be any services not deemed to be both reasonable and necessary.

For example, if the homebound patient doesn't really need to rent a special hospital bed, Social Security won't pay the tab. The same will apply to such things as massages and heat treatments — if they are of real value in the patient's treatment, the government will pay; otherwise, no.

Under some circumstances, a patient will be able to obtain "home health services" outside his home. For instance, if he needs hydrotherapy the agency handling his case may send him to a hospital, nursing home or rehabilitation center for the treatment — because the equipment is too bulky to take to the patient's home.

But in such event he'll have to provide his own transportation. And he won't be able to stay overnight at the treatment center.

How to Qualify

To qualify for "home health services" under the basic Social Security Medicare plan, the patient first must be hospitalized at least three days.

He then may go to a nursing home or his own home. Within 14 days after the patient returns to his home, a "plan" outlining the services he is to get must be "established" by a physician.

The doctor must certify such services are required because the patient is confined to his home. He also must certify the patient needs "skilled nursing care on an intermittent basis," or needs physical or speech therapy for a condition which was being treated in the hospital or nursing home. The other home benefits then would be available, too, if needed.

Checkups

The patient must remain under the care of a physician. And from time to time, as specified by government regulations, the doctor must review the treatment plan to gear it to the patient's progress.

A patient may receive up to 100 health "visits" after he returns home. Each service will count as one visit. For instance, if a nurse and therapist both see the patient the same day at his home, it will count as two visits.

Likewise, if a medical social worker interviews him at a hospital while the patient is getting hydrotherapy, the single trip to the treatment center will count as two visits.

Termination

The benefits end one year after the patient's discharge from a hospital or nursing home. However, if a patient is rehospitalized after being home 60 days, it will be regarded as a new "spell of illness" — and he then will be eligible for 100 more visits upon returning home.

The "home health services" must be supplied by or thru a "home health agency." This may be a public agency or a private non-profit organization "primarily engaged in providing skilled nursing services and other therapeutic services." (But an agency whose main aim is to serve mental patients is excluded.)

The agency must be governed by policies established by a professional group that includes at least one physician and one registered nurse. And the services must be supervised by a doctor or registered nurse.

Also, the agency must keep proper patient records. And, where applicable, be licensed or aproved by the state.

Profit-making organizations offering such services (there is none now) may join the program if they get a state license and meet Federal standards that will be set up for them.

(NEXT: Additional benefits provided by supplemental health insurance.)

Phone Answers

The Social Security Administration has set up phone service for area residents to ansaer questions about the new Social Security Amendments.

The phone number for the service, which starts August 10, is RE 7-1850. Calls will be answered from 8:45 a. m. to 5 p. m. All persons desiring information about the service should call the RE 7-1850 number, rather than their Social Security office.

Enrollment for Medicare Begins in Week

Enrollment for the voluntary medical insurance portion of the new Medicare program will begin next week, officials said today.

The Social Security Administration will begin the massive enrollment process by mailing information kits and sign-up cards to persons over 65 who are already on the Social Security benefit rolls.

About 14 million such persons will receive the cards between mid-August and early December.

MEDICARE—SOCIAL SECURITY

Extra Benefits You Can Buy

This is the eighth of 14 articles which will give our readers a complete run-down on the benefits of the Medicare program..

By JOHN TROAN

BESIDES the basic health benefits provided by Social Security, persons past 65 will be able to buy supplemental insurance thru the Government to help with other medical bills. Such insurance, effective July 1, 1966, will cover.

Doctor Bills — House calls by physicians, office visits, and services rendered in a hospital, nursing home or other institution.

However, routine physicals won't be covered. Neither will vaccine shots, nor exams for eyeglasses or hearing aids. (But diagnosis and treatment of eye and ear ailments will be included.)

Plastic surgery will be excluded if done purely for cosmetic reasons. But if it's "required for the prompt repair of accidental injury," or to fix an impaired limb or other malformed part of the body, the surgery will be covered.

Dental Care — Services of dentists for jaw or other facial-bone surgery required by accident or disease (but not ordinary dental treatment).

Psychiatric Care — If a patient is treated outside a hospital for a "mental psychoneurotic or personality disorder," the insurance will cover half of the bill — up to a total of $250 a year.

Home Visits — Up to 100 visits a year to a patient's home by part-time nurses, nurse's aides, medical social workers, and physical, occupational and speech therapists.

Under the basic Social Security Medicare plan, such visits will be covered only if the patient is hospitalized first. The supplemental insurance will provide such care even if the patient hasn't had prior hospital treatment. Or it can be used to get 100 visits in addition to the 100 offered by the basic Medicare program.

To obtain such benefits, the home care must be spelled out in a plan drawn by the patient's doctor. He also must certify that the patient is confined to his home and needs either "skilled nursing care" or physical therapy or speech therapy (in which event, the other home benefits also will be available).

¶ Other Services

Other Medical Services include:

- Diagnostic tests, including Xray and laboratory tests, performed in a legally approved lab or in one operated by a physician or hospital.
- Radiation therapy (treatment with Xrays, radium or radioactive isotopes).
- Surgical dressings, splints, casts and other "devices" used
- Rental of "durable" medical equipment (including iron lungs, oxygen tents, hospital beds and wheelchairs).
- Ambulance service to the nearest hospital if ordinary transportation would endanger the patient.
- Artificial limbs, artificial eyes, and braces (but not orthopedic shoes).
- Other prostheses (such as an artificial heart valve or synthetic artery) designed to replace part or all of an internal organ. (But no false teeth, hearing aids or eye-glasses.)

¶ Deductible Features

In any case you will have to pay for the first $50 worth of such "supplemental" services which you get each year. You'll also have to pay 20 per cent (one-fifth) of the balance.

Not counted toward your "$50 deductible": Anything you pay for drugs, for inpatient hospital or nursing home care, and for any dental care except dental surgery required by an accident.

The monthly premium for supplemental insurance (which may be raised every two years) will start at $6 a person. Of this, the Federal Government will pay half. If you're on relief and will be 65 before Jan. 1, 1968, your state may pay the other half. Otherwise, you must put up the $3 (or have it taken out of your Social Security, Railroad Retirement or Civil Service check).

If you fail to buy the insurance during the first enrollment period, the premium will go up 10 per cent for each year you delay. (To illustrate: If you'll be 65 before Jan. 1, your first enrollment period ends March 31, 1966. Should you fail to sign up by then, you won't get another chance until October 1967 — at which time your share of the monthly premium would be $3.30 instead of $3.)

NEXT: Free health benefits for needy aged.

MEDICARE—SOCIAL SECURITY

Washington Star Daily News Aug. 12, 1965

Health Benefits for the Needy

This is the ninth of 14 articles which will give our readers a complete run-down on the benefits of the Medicare program.

By JOHN TROAN

THE health benefits provided by the new Social Security Medicare law have been likened to a three layered cake.

The basic layer is what people call "Medicare." With funds collected form Social Security taxes, it offers certain hospital, nursing-home and other health benefits to persons 65 and older.

Layer No. 2 is the supplemental health-insurance program which povides additional benefits, including coverage of regular doctor bills, on an optional basis to persons past 65 who agree to split the $6-a-month premium with Uncle Sam.

The third layer offers free health benefits to the needy and the near-needy. It embraces what is now known as the Kerr-Mills program of "medical assistance for the aged" as well as health benefits available to regular recipients of public assistance (welfare).

This free care is financed jointly by the U. S. Treasury and the states. In some cases, counties and local communities also chip in money.

¶ Assistance

All states provide health benefits for recipients of "old age assistance," a form of relief available to genuinely needy persons past 65. In addition, all but six states — Alaska, Georgia, Mississippi, Missouri, Ohio and Texas — have put into effect so-called Kerr-Mills programs to care for the "medically indigent." These are persons past 65 who aren't poor enough to rate regular welfare checks yet can't afford to pay their sick bills.

In effect, the Kerr-Mills programs amount to "medical relief." They are administered by state, county and city welfare agencies, and they have nothing to do with Social Security as such.

Programs for the "medically indigent" vary from state to state. All provide some hospital care. Some also cover certain doctor bills, some drugs, some care in a nursing home and even such things as eyeglasses and false teeth.

Phone Answers

The Social Security Administration has set up phone service for area residents to answer questions about the new Social Security Amendments.

The phone number for the service, which starts August 10, is RE 7-1850. Calls will be answered from 8:45 a. m. to 5 p. m. All persons desiring information about the service should call the RE 7-1850 number, rather than their Social Security office.

¶ Who's Eligible

Eligibility rules also differ. For instance in some counties of Maryland an elderly person with an income exceeding $1080 a year couldn't qualify but in Louisiana he might have an annual income as hign as $3000 and still get "medical assistance."

The ceiling on assets also varies. So does the definition of assets. Example: Massachusetts disregards an elderly person's life insurance policy in figuring his assets but most states calculate the cash surrender value. California discounts any auto needed for transportation "regardless of market value" but Idaho specifies a "popular-priced car" and Hawaii sets a flat $400 limit. Iowa exempts "tools or equipment necessary for pursuit of an occupation," and Colorado discounts $200 worth of "working animals."

¶ Assets

States still may set their own rules concerning assets. But Congress now has jiggled the law to encourage states to drop fixed income ceilings and to conside, in determining a persons's need, only income "actually available'.' (Thus, a state wouldn't count nonexistent income a woman is supposed to be getting from a runaway husband or reluctant relative.)

Nor would a grown son or daughter be required to pay for an elderly parent's health care, as some states now demand. However, if you draw "medical assistance" a state still could place a calim against your property — so as to get its money back after you and your spouse die, and all your children grow up.

(At least 18 states and the District have such a "recovery" provision.)

¶ Under 65

Effective next Jan. 1, the same health benefits offered to "medically indigent" persons past 65 may be extended by a state to certain other individuals under 65 who would ordinarily qualify for the welfare rolls except for the fact that, when they aren't sick, their incomes or assets exceed the specified ceilings. This includes children under 21 and some of their parents; the blind; and persons who are totally and permanently disabled.

And by Jan 1 1970 minimum standards will be applied to all such welfare-type, free-care programs. Every state which implements such a program will have to offer some hospital benefits , some nursing-home care, some laboratory and X-ray services and some coverage of doctor bills. Beyond this, any state may add almost any "extras" it wishes — and can afford.

Becasue these programs vary so much, and will be in a state of flux for some time to come, the best way to find out if YOU qualify for any such benefits is to check with your nearest public assistance (welfare) office. Your hospital or county medical society also may be of help.

NEXT: Cash Retirement Benefits.

MEDICARE—SOCIAL SECURITY

Washington Daily News Aug. 13, 1965

How to Figure How Much You'll Get

This is the 10th of 14 articles which will give our readers a complete run-down on the benefits of the Medicare progam.

By JOHN TROAN

HOW much will I get when I retire?"

That question is often uppermost in the minds of millions of Americans who are working their way toward a Social Security pension.

The answer depends on your "average earnings" — how much you make on jobs covered by Social Security, averaged over a certain number of years.

You may average out your earnings from 1937 on (that's when the Social Security law took effect) or from 1951 on.

When you apply for your retirement benefit, the Social Security office helps determine which method gives you the better break. In most cases, averaging earnings from 1951 on results in higher benefits — because pay levels in recent years have been higher.

Limits

In figuring your average, you may count only up to:

- $3000 a year earned from 1937 thru 1950.
- $3600 a year from 1951 thru 1954.
- $4200 a year from 1955 thru 1958.
- $4800 a year from 1959 thru 1965.

(Because that's all that has been taxed for Social Security purposes.)

Starting with 1966, you may count the first $6600 you earn each year.

You must count a certain number of years to figure your "average earnings." The number depends on when you were born, and whether you are a man or woman. The minimum is 5 years; the maximum, 38. (The accompanying table shows exactly how many YOU must count.)

Your retirement benefit is based on your highest earning years. But if you haven't worked the number required for this purpose, some "zero earning" years must be included in calculating your average earnings.

An Example

For example, take a man born in 1906. As explained in a previous article, he needs 20 "quarters of coverage" to qualify for SOME retirement benefit. That's five years. But in figuring HOW MUCH he is to get, he must average out his earnings over 15 years.

Thus if he works only 5 years under Social Security, he must include 10 years of "zero earnings" to calculate his average. This pushes the average earnings down — and reduces his monthly benefit.

Social Security headquarters in Baltimore keeps a lifetime record of your earnings. You can find out how much is credited to your Social Security account, and how many "quarters of coverage" you have earned, by filling out a post card form available at any Social Security office.

High and Low

The smallest retirement benefit a worker may draw at age 65 is now $44 a month. This is if yearly earnings under Social Security average $804 or less.

The maximum monthly benefit at age 65 is $135.90 — for a worker with average yearly earnings of $4800. This will climb steadily until the year 2000 at which time some workers will qualify for the top retirement benefit of $168.

You may claim your retirement benefit at age 62. But in that case you get only 80 per cent of what you'd draw at age 65. If you wait until you're 63, you get 86 2/3 per cent. If you start collecting at age 64, you get 93 1/3 per cent.

In short, the sooner you begin drawing your benefit the less you get per month. That's because you'll be getting it for a longer time.

When you draw a retirement benefit, your wife and children also may qualify.

Your wife must be at least 62. Or she must be caring for an unmarried child under 18 or a child incapable of self-support due to a disability incurred before age 18.

Such children also are eligible for monthly checks — plus any child under 22 who is still in school. (Coverage for such students is retroactive to Jan. 1, 1965.)

The wife gets one-half of the husband's "primary insurance benefit" — what he'd be entitled to at age 65. (But her payment is reduced, up to 25 per cent, if she claims her benefit before reaching 65 herself.) Each child also is entitled to one-half of the worker's basic benefit.

There is a ceiling, however, on what one family can draw. This now ranges from $66 to $309.20 a month, depending on the worker's average yearly earnings. The family maximum will rise in some cases to $368 in 1967.

A special provision, effective next Sept. 1, pertains to retired workers reaching 72 before 1969. Regardless of average earnings, such a person may draw a flat $35 monthly benefit if he worked a specified number of months — in some cases, as few as nine — under Social Security at any time since Jan. 1, 1937. And his wife may collect an extra $17.50 a month if she reaches 72 before 1969.

NEXT: You don't have to quit working to draw retirement benefits.

Monthly Retirement Benefits

Here are examples showing about how much you'll draw in monthly retirement benefits at age 65, based on your average yearly earnings under Social Security:

Average Yearly Earnings	Retired Worker	Average Yearly Earnings
$ 804 or less	$ 44.00	$ 66.00
$1,200	63.20	94.80
$1,800	78.20	117.30
$2,080 (x)	83.50	125.30
$2,400	89.90	134.90
$3,000	101.70	152.60
$3,600	112.40	168.60
$4,200	124.20	186.30
4,800	135.90	203.90
$6,600 (y)	168.00	252.00

(x)—Current average of all retired workers receiving benefits.

(y)—Generally, this won't become possible until the year 2000 for retired women workers and 2003 for retired men.

Years to Count

Here is a table listing the number of years that must be counted in figuring a worker's average earnings—on which all Social Security cash benefits are based.

Year Worker Was Born	Years Counted Man	Years Counted Woman	Year Worker Was Born	Years Counted Man	Years Counted Woman
1896 or earlier	5	5	1913	22	19
1897	6	5	1914	23	20
1898	7	5	1915	24	21
1899	8	5	1916	25	22
1900	9	6	1917	26	23
1901	10	7	1918	27	24
1902	11	8	1919	28	25
1903	12	9	1920	29	26
1904	13	10	1921	30	27
1905	14	11	1922	31	28
1906	15	12	1923	32	29
1907	16	13	1924	33	30
1908	17	14	1925	34	31
1909	18	15	1926	35	32
1910	19	16	1927	36	33
1911	20	17	1928	37	34
1912	21	18	1929 or later	38	35

Effective Sept. 1, 1965, this table need not apply to a retired worker reaching 72 before 1969. Such a person may draw a flat $35-a-month retirement benefit simply if he has three to five "quarters of coverage"—nine to 15 months of work—credited to his Social Security account.

MEDICARE—SOCIAL SECURITY

You Can Have an Income—and Still Draw efits

This is the 11th of 14 articles which will give our readers a complete run-down on the benefits of the Medicare program.

By JOHN TROAN

YOU don't have to quit working to draw a Social Security retirement benefit.

Starting with 1966, you'll be able to collect your full benefit as long as you don't earn more than $1500 a year (as compared to $1200 now). Even if you earn more, you may be eligible for some Social Security checks.

And no matter how much you make in one year, you'll be entitled — effective 1966 — to your regular Social Security check for any month in which you don't earn more than $125 (compared to $100 now).

If you are self-employed, the same rules apply. However, you can't get a check for any month in which you perform "substantial services" even if your net earnings (profits) for that month fail to exceed the limit.

There is no hard-and-fast definition of "substantial services." Generally, it means devoting more than 45 hours to your business during one month.

The ceiling on earnings is lifted the month you reach age 72. Then, you forfeit no Social Security benefits regardless of how much you earn.

What Counts

In figuring your earnings, you count only such things as wages, salaries, commissions, and what you net from self-employment.

You do NOT count investment income (such as stock dividends), interest on bank deposits, rents you collect, private pensions, endowments on insurance policies, veterans' benefits, gifts, inheritances, capital gains, or royalties collected after age 65 from copyrights or patents you obtained before 65.

However, rental income is counted if you are a real estate dealer or if you rent out your own farm under an agreement permitting you to "participate materially" in "production or management of production." And dividends are counted if you deal in securities.

A wife's earnings do not affect a retired worker's benefits. But they are counted against her Social Security benefit if she is drawing one along with her husband.

On the other hand, earnings of a retired worker may count against any benefits his dependents are drawing — as well as against his own.

The ceiling on earnings applies also to widows and children getting Social Security checks. But a widow's earnings don't count against her children's benefits — and her children's earnings don't count against her benefit.

During 1965, you may earn up to $1200 without losing any Social Security benefits. If you make more, $1 is taken out of your total year's benefit for each additional $2 earned. After you earn $1700, a dollar is substracted for every additional dollar of earnings.

Effective 1966, this will be eased. You may earn up to $2700 a year — instead of just $1700 — before the dollar-for-dollar rule sets in.

Thus, from 1966 on: You may earn up to $1500 without losing any benefits. After that, $1 is taken out of your annual benefit for every $2 earned. And after you make $2700 in a year, a dollar is substracted for every additional dollar of earnings.

This means a person under 72 who is drawing a Social Security retirement benefit and continues to be employed regularly could earn $2556 to $5811 a year before losing all his benefits.

over the year. In general, you may — effective 1966 — draw some Social Security payment if your monthly benefit (or family benefit) is at least $50 and your earnings for the year don't equal 12 times the benefit amount plus $2100.

* * *

(NEXT—Disability benefits).

HOW EARNINGS AFFECT SOCIAL SECURITY

(Effective 1966)

Here is a table showing how much you can collect in Social Security benefits even if you continue working. First, look at the column on the left for the amount nearest to the monthly benefit which you are getting or which your family is drawing on your Social Security account. Then look under the figure closest to your estimated earnings for the year to get a rough idea of how much Social Security you may still draw.

MONTHLY BENEFIT	BENEFITS FOR YEAR IF EARNINGS TOTAL $0-$1500	$2100	$2700	$3300	$3900
$ 44	$ 528	$ 228	$ 0	$ 0	$ 0
50	600	300	0	0	0
60	720	420	120	0	0
70	840	540	240	0	0
80	960	660	360	0	0
90	1080	780	480	0	0
100	1200	900	600	0	0
110	1320	1020	720	120	0
120	1440	1140	840	240	0
130	1560	1260	960	360	0
140	1680	1380	1080	480	0
150	1800	1500	1200	600	0
160	1920	1620	1320	720	120
170	2040	1740	1440	840	240
180	2160	1860	1560	960	360
190	2280	1980	1680	1080	480
200	2400	2100	1800	1200	600
210	2520	2220	1920	1320	720
220	2640	2340	2040	1440	840
230	2760	2460	2160	1560	960
240	2880	2580	2280	1680	1080
250	3000	2700	2400	1800	1200
260	3120	2820	2520	1920	1320
270	3240	2940	2640	2040	1440
300	3600	3300	3000	2400	1800

NOTE: Regardless of how much you make, you may still draw your regular check for any month in which your earnings don't exceed $125 or, if you are self-employed, for any month in which you don't perform "substantial services."

Medicare—Social Security

Disabled—But Not Helpless

This is the 12th of 14 articles which will give our readers a complete run-down on the benefits of the Medicare program.

By JOHN TROAN

YOU needn't be a helpless invalid to qualify for a Social Security disability benefit.

However, you have to be so disabled that you can't "engage in any substantial gainful activity." In other words, it must be established that because of your physical or mental condition you are unable to do ANY kind of work for a living.

In the past, such benefits were issued only if it was shown the disability was expected to last indefinitely or to result in death. But this has been changed, effective next Sept. 1.

Now the law says — if you have a disability which (1) has lasted at least 12 months or (2) is expected to last that long or (3) is expected to result in death, you may start collecting such a benefit.

Provided, of course, you have worked long enough under Social Security to be eligible. Generally, you must have worked under Social Security at least 5 of the 10 years just before you became disabled.

¶ The Form

When you apply for a disability benefit, the Social Security office gives you a special medical form to be filled out by your doctor and by hospitals and other institutions where you have been treated.

On this form they tell what has been found to be wrong with you, how severe your condition is, what medical tests have revealed, what treatments you have received and to what degree you are unable to do such things as move about, handle objects, hear, speak, understand or reason.

All this — plus information about your age, education, training, skills and work experience — is sent to an agency specified by your state. There, a team of doctors and others experienced in this field decide whether you are "disabled" within the definition of the Social Security law.

¶ First Check

If your application is o.k.'d, your benefit may start with the seventh full month of disability, and your first check would arrive the following month.

If you resume working despite your disability, you may keep drawing your benefit during a "trial work period" that can last as long as nine months. Once it is determined you are no longer disabled, you may get a benefit for three more months.

Suppose you then became disabled again? Well, you wouldn't have to put in another waiting period if (1) the new disability arises within five years after the previous one ended and (2) your new disability is expected to last at least a year or to result in death.

¶ The Blind

A special provision covers the blind. If you are totally blind (within the meaning of the Social Security law) but can still work, you may "freeze" your Social Security record. In this way, the years you earn little or nothing won't count against you — so the future benefits you draw wont be reduced.

Under Social Security, a person is regarded as blind if (1) his vision rates no better than 5-200 with glasses of (2) he has such gun-barrel vision that his "visual field is limited to five degrees in the better eye even with glasses.

The new law also makes it easier for blind persons to collect disability benefits. This applies to persons blinded before age 31 and to jobless blind individuals 55 or older.

¶ How Much

The size of the disability benefit depends on the workers average earnings under Social Security. It is equal to what the worker otherwise would draw upon retiring at age 65 — even tho the disability benefit is payable to a worker at any age.

The wife of a disabled worker also qualified for a benefit if she is at least 62, or if she has in her care a child under 18 or a child who became disabled before 18.

Such youngsters also are eligible for benefits. So is any child of a disabled worker who is under 22 and still in school.

Each such child gets one-half of the workers benefit amount. The wife alos draws one-half. But her benefit is reduced slightly if she applies for it before age 65 — unless she has a "disabled child or a child under 18 in her care.

However, no family may now receive more than $309.20 a month.

All of the valuable information contained in this series, PLUS additional details and charts are available in a new 80-page book for permanent reference. To order, use the coupon below.

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MEDICARE—SOCIAL SECURITY

What Does a Widow Get?

This is the 13th of 14 articles designed to give our readers a complete run-down on the benefits of the Medicare and Social Security programs.

By JOHN TROAN

CONGRESS has now made it possible for widows to draw monthly Social Security benefits as early as age 60.

Effective next Sept. 1, a woman no longer need wait until she is 62 to collect such checks. However, the size of the check is reduced if she applies for her widow's benefit before 62.

Normally, the widow of a worker who was insured under Social Security is entitled to 82½ per cent of her husband's primary benefit — what he would have received if he had lived to retire at age 65.

But she can get that much only if she waits until she is 62 to apply. If she chooses to start collecting at age 61, she gets only 77 per cent; at age 60, only 71½ per cent.

Actually, a widow may draw Social Security benefits even before she is 60 — provided she has an unmarried child under 18 or one who was disabled before

amounts to a mother's rather than a widow's benefit — stops when her youngest child reaches 18. And she then can't resume collecting Social Security checks until she herself becomes 60 (and isn't married at the time).

¶ Eligibility Rule

There's also a difference in the eligibility rules. A widow with a disabled child or one under 18 may collect survivors' benefits if the worker was either "currently" or "fully" insured under Social Security. But if she has no such children she can collect benefits only if he was "fully" insured.

To be fully insured, a person must work under Social Security for periods ranging up to 10 years — depending on his year of birth. To be currently insured, he must work only 1½ of the three years preceding death.

Whether the worker was fully or currently insured, each of his surviving children is entitled to 75 per cent of his primary benefit. This pertains to any child under 18; any child under 22 who is still a full-time student; and any child of any age who is incapable of self-support due to physical or mental disability incurred before age 18.

The "student benefit" is new, and it is retroactive to Jan. 1, 1965. But unless she is at least 60, the widowed mother of such a student cannot collect an extra benefit for herself — as she can if she has a disabled child or a youngster under 18.

¶ Family Limit

In any event, there is a limit on how much one family can draw each month. This now ranges from $66 to $309.20, depending on the deceased worker's average earnings under Social Security. The ceiling will go up to $368 in 1967.

When a worker dies, his parents also may collect survivors' benefits. To qualify, a parent must be at least 62 and must have received at least half of his financial support from the worker. Also, the worker must have been fully insured at time of death.

The monthly payment to one dependent parent equals 82½ per cent of the worker's

Sometimes a widower qualifies. To do so, he must be at least 62 and must have depended on his wife for at least half of his financial support. Also, she must have been both fully and currently insured under Social Security. The payment to a dependent widower is 82½ per cent of the wife's primary benefit.

Also available when a worker dies is a lump-sum death benefit. It is equal to three times the worker's primary monthly benefit, up to a maximum of $255.

This is paid to the widow or widower, provided the spouse was living with the worker at time of death or paid the burial expenses. Otherwise, the lump-sum benefit goes to the person who paid for the funeral.

NEXT: Who is taxed how much for Social Security benefits.

WIDOW'S CASH BENEFITS

This table shows how much a worker's widow may draw in monthly survivors' benefits, depending on her husband's average yearly earnings under Social Security.

The examples are for (1) a widow aged 62 who has no disabled children or youngsters under 18, and (2) a widow under 60 who has one such child. The family maximum is also indicated.

Annual Yearly Earnings	Age 62 (No Child)	Under 60 (One Child)	Family Maximum
$804 or less	$ 44.00	$ 66.00	$ 66.00
$1,200	52.20	94.80	94.80
$1,800	64.60	117.40	120.00
$2,400	74.20	135.00	161.60
$3,000	83.90	152.60	202.40
$3,600	92.80	168.60	240.00
$4,200	102.50	186.40	280.80
$4,800	112.20	204.00	309.20
$6,600*	138.60*	252.00*	368.00*

*—Not possible until 1967, and then only in rare cases.

Medicare Racket Hit

Racketeers posing as representatives of the Social Security administration are defrauding elderly Americans by pretending to sign them up for medicare coverage, it was disclosed today.

Federal authorities said they had received complaints about the racket from New York and Texas. They believe medicare con men may be at work in other states as well.

Here is how the racket works:

The crook shows up at the home of an elderly person and introduces himself as a Social Security field agent. He says he's there to explain the medicare program.

After giving the intended victim a certain amount of authentic information about the new law, and perhaps showing him an official brochure (readily available at any Social Security office), the glib visitor says he will be glad to take care of the enrollment paperwork.

He baits the hook by sying that persons over 65 ccan obtain a special discount on medicare insurance premiums by signing up early and paying in advance. In fact, he's ready to collect the advance premiums then and there.

If he succeeds in obtaining money with this story, he simply pockets it and disappears.

MEDICARE—SOCIAL SECURITY

Washington Daily News Aug. 19, 1965

What It Costs Everybody

This is the last of 14 articles designed to give our readers a complete run-down on the benefits of the Medicare and Social Security programs.

By JOHN TROAN

As Social Security benefits increase, so does the tax that makes them possible.

When the program started in 1937, the Social Security tax for workers was one per cent on the first $3000 earned. By 1965, it had risen to 3 5-8 per cent on the first $4800.

Effective Jan. 1, 1966, it will be 4 1-5 per cent on the first $6600 a year. And the tax is scheduled to go up, step by step, six more times before it crests in 1987 at almost 5 2-3 per cent on the first $6600 a year.

This is the tax rate for ordinary wage earners. In each case, it is matched by the employer.

¶ Self-Employed

For the self-employed, the tax rate for 1966 is set at 6 3-20 per cent on the first $6600 of net earnings (compared to 5 2-5 per cent on the first $4800 in 1965).

The rate for the self-employed will rise in six additional stages to a peak in 1987 of 7 4-5 per cent on the first $6600 of net earnings.

Thus the maximum Social Security tax for an ordinary worker will rise from $174 in 1965 and $277.20 in 1966 to $372.90 in 1987. For the self-employed, the maximum will go up from $259.20 in 1965 and $405.90 in 1966 to $514.80 in 1987.

¶ Medicare Bite

The Medicare portion of the Social Security tax will range from a little over one-third of one per cent in 1966 to four-fifths of one per cent in 1987.

This means the most any individual will have to pay for Medicare in 1966 will be $23.10 (an average of about $1.93 a month). In 1987, the maximum "Medicare tax" will be $52.80 (which comes to $4.40 a month).

This is to pay for the basic health benefits — hospital care, nursing-home care and certain types of care rendered in a patient's own home. The supplemental benefits, which are optional for persons past 65, will cost an individual $3 a month in the beginning.

Medicare Tax

This is the most any worker can be taxed in any year for the health benefits (Medicare) provided thru Social Security:

1966	$23.10
1967-72	33.00
1973-75	36.30
1976-79	39.60
1980-86	46.20
1987 on	52.80

A worker's contribution is matched by his employer. The self-employed will be taxed at the same rate for Medicare purposes even tho there is no matching contribution in their case.

The amounts above are included in the total Social Security tax.

¶ Hold-Outs

Practically everybody who works is covered by Social Security. The last of the big "holdouts" — self-employed physicians — will pay Social Security taxes for the first time (on this year's earnings) when they file their 1965 income tax returns next year. Physicians who work for someone else (such as "company doctors") have been under Social Security since 1937.

Effective Jan. 1, 1966, medical and dental interns also come under Social Security.

¶ Farmers

Starting with 1966, the rules governing earnings of self-employed farmers are changed. The new rules for such farmers read like this:

If you gross $2400 or less in a year, you may report — for Social Security purposes — either your net earnings (profit) or two-thirds of your gross (over-all income). If both figures are under $400, however, you can't report anything — because you're excluded from coverage.

If you gross over $2400 and net $1600 or more, you must report your actual profit. If you gross over $2400 and net less than $1600, you may report $1600 or your actual net (provided it's at least $400).

The higher the amount you report, the higher your Social Security tax. And the higher the benefits.

¶ Tips

Congress also has extended the Social Security tax to tips, effective next Jan. 1.

If a worker collects at least $20 in tips during a month while working for a particular employer, he will have to report the amount to his boss.

The employer then will take out of the worker's next pay the Social Security tax that's due on these tips and send it to the government.

The boss won't have to match the tax on tips — tho he must continue matching the employe's Social Security tax as far as the worker's regular wages are concerned.

What You Pay for Social Security

Here is how much a worker must pay in Social Security taxes (in each case, the amount is matched by the employer):

Year	Tax For Cash Benefits	Tax For Medicare	Total Tax Rate	Wages Taxed	Maximum Tax
1965	3.625%	——	3.625%	$4800	$174.00
1966	3.85	0.35%	4.2	6600	277.20
1967-68	3.9	0.5	4.4	6600	290.40
1969-72	4.4	0.5	4.9	6600	323.40
1973-75	4.85	0.55	5.4	6600	356.40
1976-79	4.85	0.6	5.45	6600	359.70
1980-86	4.85	0.7	5.55	6600	366.30
1987 on	4.85	0.8	5.65	6600	372.90
SELF-EMPLOYED					
(No Matching Contribution from Employer)					
1965	5.4	——	5.4	4800	259.20
1966	5.8	0.35	6.15	6600	405.90
1967-68	5.9	0.5	6.4	6600	422.40
1969-72	6.6	0.5	7.1	6600	468.60
1973-75	7.0	0.55	7.55	6600	498.30
1976-79	7.0	0.6	7.6	6600	501.60
1980-86	7.0	0.7	7.7	6600	508.20
1987 on	7.0	0.8	7.8	6600	514.80

EDITORIAL AND NEWS REACTION TO THE BEGINNING OF MEDICARE JULY 6, 1966



NEW ENGLAND AND MIDDLE ATLANTIC STATES

Maine

New Hampshire

Vermont

Massachusetts

Rhode Island

Connecticut

New York

Pennsylvania

New Jersey

Maryland

Delaware

Virginia

West Virginia

Washington, D.C.

Bangor, Maine

The Bangor Daily News

FRIDAY, JULY 1, 1966

A Costly Rubber Stamp Job

While attention centers today upon the inauguration of Medicare as a help for the nation's elderly, there is belated concern in Congress over a broader but less-publicized health measure that would provide aid for the "medically needy" of all ages. It is Title 19 of the Social Security amendments approved by Congress last year and is known as Medicaid.

Like Medicare, its socialistic implications are clear. And by admission of federal health officials it is going to cost more than four times the original estimates.

The Department of Health, Education and Welfare placed a price tag of $230 million on the bill when it was before Congress. Now they concede it will top $1 billion next year. This will only be the start, not the end. Costs would rise substantially annually for several years to come.

Title 19 offers to provide assistance for a wide range of health services ranging from 50 to 83 per cent, depending upon the per capita income of the applying state. Seven states and Puerto Rico have already fallen in line for federal funds, 25 more are preparing to do so and, of course, all states and territories will eventually adopt the program. Why wouldn't they, when Uncle Sam is being so generous?

A very unfunny joker in the legislation permits states to decide who is medically indigent. This was too much for New York politicians to resist. They passed a measure that deems the "medically needy" to be any family in the state having an income of $6,000 or less, after taxes. It is now asking the federal government to come up with $250 millions in Medicaid as a starter, more than the total estimate for the entire program fixed by HEW.

As Democratic Congressman Wilbur D. Mills of Arkansas observes in a hindsight opinion: "If a limitation isn't put on this program, Title 19 will be used as the back door for putting into effect socialized medical care for the entire population."

Credit for bringing the cost of Title 19 to light goes to Republican Senator John Williams of Delaware, chief Senate watchdog over money since the retirement of Democratic Senator Harry F. Byrd of Virginia. But where, oh where, were other members of Congress, Republicans as well as Democrats, when Title 19 came up for discussion?

Blaming the HEW for giving an estimate far below reality is no excuse. Bureaucratic planners are notorious for soft-peddling cost when they are undertaking to sell a new program. Congress should have done some research of its own.

Its members are elected to serve the people, not the bureaucrats or the Great Society or any other special interest groups bent upon dreamy reforms and the reaping of votes.

Instead, Congress shirked its responsibility and dutifully rubber-stamped a measure that in the end probably will outdo Medicare as a socialistic and costly program.

Huntington, W. Va

The Herald-Dispatch — Friday, July 1, 1966

Editorials:

Not The Doctor's Best Friend

THE AMERICAN Medical Association — which fought Medicare bitterly but ineptly for many years — continues to be the worst enemy of doctors in the field of public relations.

Meeting in Chicago Wednesday, the AMA's House of Delegates adopted a resolution that recommended direct billing of patients by every member of the organization — thus ignoring the machinery through which individuals insured under the Medicare program would be relieved of the necessity of paying bills in full out of their own pockets before submitting them to the government for repayment.

The recommendation for direct billing would affect patients who are over 65 and who have elected to take the voluntary part of the government's program at a cost of $3 per month.

UNDER THE terms of the voluntary insurance package, the patient must pay the first $50 of the doctor's charges. After the first $50 is deducted from the bill, the patient is responsible for 20 per cent of the balance, with the government paying 80 per cent.

The individual doctor has the choice of billing the patient direct or of submitting the whole bill to the "intermediary" in the area (this may be Blue Cross, Blue Shield or some independent insurance company selected by the Department of Health, Education and Welfare).

IF THE doctor elects to "assign" the bill to the intermediary, the patient has to pay only the first $50 plus 20 per cent of the balance. But if the doctor holds firmly to his "direct billing" procedure, the patient has to put up the money for the entire bill before he can collect his insurance.

There is a further disadvantage to the patient in direct billing. It will be up to the intermediary to determine if the bill is "reasonable." Thus if the patient pays the doctor direct and submits the receipted bill to the intermediary, he may not be reimbursed for the full 80 per cent (less the first $50) which the government has agreed to pay. For the intermediary may rule that some of the charges are unreasonable.

THE ACTION of the AMA's House of Delegates was interpreted as the group's unreconciled determination to continue fighting the Medicare plan by any means at its command.

To the extent that this determination is fostered by the fear that Medicare is only the opening wedge to completely Socialized medicine, it is shared by millions of Americans. But the AMA should have learned from sad experience that mere opposition to an idea is not enough. It has to have an idea of its own to solve the problems in which it is deeply involved.

It was standard AMA procedure to bring out a new program for relieving elderly patients of costly medical and hospital bills every time Medicare was being debated. The programs became increasingly liberal and at the end of the debate might have represented a better solution of the problem than the one Congress finally adopted.

Not all doctors, by any means, will follow the AMA recommendations on direct billing. Experience probably will persuade many doctors that they will be better off with 80 per cent of a sure thing than 100 per cent of something doubtful.

But in the meantime, the profession as a whole may get further public abuse for its avariciousness and its resort to a type of noncooperation that neither wins friends nor influences voters.

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READING, JUNE 30, 1966

The big question: will it work?

Medicare will go into effect Friday. It is now the law of the land, so there's not much use in prolonging the debate about whether it's a good thing for the nation or a bad thing.

The big question now is: How is it going to work? Any program, no matter how desirable it may be, isn't going to do much good for the people it is designed to help if it doesn't work out in practice.

A large part of the success of the Medicare program hinges, we believe, on the attitude of the doctors. As far as hospitals go, Berks County appears to be ready to roll. Four hospitals in the Reading area, with a total of 1,338 beds, are certified as eligible to participate in the Medicare program.

About doctors, here and in other parts of the country, we are not so sure. A news article in Tuesday's Times, with a Chicago dateline, quoted the chairman of the board of trustees of the American Medical Assn. as saying: "We trust that the physicians and the public will place the blame for such deficiencies (in the Medicare program) squarely where they belong—on the federal government."

It is questionable whether users of the voluntary program under Medicare, which covers doctor bills, will be satisfied to place the blame on Uncle Sam when they run into a type of doctor whose attitude clearly indicates that he wants as little to do with Medicare as possible.

The two-pronged payment plan for taking care of doctor bills is a convenient out for the doctor, it seems to us, and at the same time gives the patient the hard end of the deal.

Under the voluntary program, coverage of doctor's bills and some other medical expenses for persons 65 and more, costs $3 a month per person. It has been reported that 9 out of 10 of those in that age range have enrolled.

Payments under this voluntary plan do not begin until after the patient has incurred expenses of at least $50 for services provided July 1 or later.

Now comes the catch. There will be two ways to claim payment for doctor bills. The doctor can accept an "assignment," which means he'll apply for payment himself, asking for the allowable 80 per cent of a "reasonable charge." That method relieves the patient of the necessary paperwork, and makes him responsible for only the remaining 20 per cent of the "reasonable charge."

Patients aren't apt to quarrel about the above method of collecting bills. And any doctor who chooses to use that method isn't likely to be accused of trying to hamstring the program or of making it tough for Medicare patients.

Doctors won't have to use this method, however. There is another, which makes it much easier for them, but not for the patient. That is the provision which enables a doctor to make the patient do the collecting of what is due him AFTER he has paid the doctor. And all the patient can collect is 80 per cent of what the government says is a "reasonable charge." If the patient has to pay the doctor more than a "reasonable charge," that's just too bad.

Elderly persons who are enrolled in this voluntary program are going to have to wait until they start using the program to find out just how effective it is in reducing the cost of seeing a doctor.

Ecstasy Amid the Agony

Medicare's First Days

AMID the agonies of his Viet Nam decisions and explanations, President Johnson broke off ecstatically to welcome the launching of Medicare, the law promising 19 million Americans 65 and older financial help in meeting medical costs.

Announcing that more than 92 percent of the nation's hospital beds were in hospitals that had complied with the law's provisions, including accepting patients of all races, the President said preparations had been more extensive than for any other peaceful undertaking in the nation's history.

The program, he said, was not only a blessing for older Americans. It was a test for all Americans, a test of their willingness to work together. He had, he said, no doubt about the outcome. "I believe," he declared, "July 1, 1966 marks a new day of freedom for our people."

• • •

ON ITS EVE, the 238-member House of Delegates of the American Medical Association wound up its five-day annual meeting in Chicago in a rebellious mood about Medicare.

It recommended to the association's 214,000 members that instead of submitting 80 percent of their fees to the Government and 20 percent to patients, they adopt the alternative of submitting the entire bill to a patient and leaving him or her to find out and obtain whatever reimbursement the Government will allow.

The Nation

Under the "direct billing" procedure, doctors can charge whatever fee they consider proper. Under the other "assignment" method they must accept what the Government considers reasonable.

Delegates approved this means of protecting the doctor-patient relationship and avoiding any semblance of government direction in the face of warnings from the platform that any attempt to thwart the will of Congress would lead only to stricter legislation.

They also adopted — whatever lawsuits against the AMA may result — a decision which would deem a physician unethical if he took the place of another doctor dismissed from a hospital position for refusing to allow the hospital to act as his billing agent.

• • •

AS IT WAS, Medicare got under way with little commotion or friction on the appointed day—and no sign of the half-expected rush of new patients, no doubt in some measure because of the Fourth of July weekend ahead. Some 160,000 oldsters already in hospitals became Medicare patients.

Hospitals in Mississippi—scene last week of the triumphantly completed civil rights march across the state to Jackson, the capital, despite white opposition and Negro division over "black rule" slogans — remained the biggest holdout for segregation, thus depriving them under the 1964 Civil Rights Act of federal aid such as that provided under Medicare. In that state, the White House said, only 42 percent of its hospital beds were in hospitals that had dropped racial barriers.

★

Our Views On The News

The Easton Express, Easton, Pa. 7/1/66

Medicare!!

An historic program in social welfare — no one will be able to tell for a long time whether it is bane or boon — has become a reality. Beginning today citizens over 65 are entitled to liberal hospital-medical benefits under social security.

In principle this is good. The elderly indigent too long have been denied health and medicine services available only to those with ample means. One might quarrel with the methods of funding and administering this program, but not with the idea that the elderly poor without means are entitled to adequate treatment for their aches and pains.

The potentially difficult problem now is one of facilities. Do we have enough hospital beds, enough nurses, enough equipment, doctors and technical personnel to meet the demand which can be created by creation of these new benefits for nearly 20 million Americans?

Here, in the Lehigh Valley, hospitals and doctors have no idea how much the burden on the institutions and practitioners is going to increase. The region already is troubled deeply by a shortage of nurses and technical personnel, and any substantial claim by the elderly on hospitalization benefits could create a full-blown crisis in bed space.

The American Medical Association convention in Chicago this week showed that the physicians will be a long time accepting Medicare as a happy fact. They are determined to alter some of its policies. They have asked, for example, that doctors be permitted to bill elderly patients directly instead of dealing with Medicare bureaucrats. The less doctors have to do with federal government the better they like it.

From the ranks of the medical men is stemming the chief current criticism against the Medicare program — the complaint that the law was enacted without first considering the extra personnel and facilities which will be needed to handle the additional load.

One cannot say that Medicare came about in a big hurry. It began kicking around in Congress when Harry Truman was President and was thwarted until increasing Democratic-liberal control of the legislative processes and the White House made passage possible.

Sponsors of the law were aware that the shortages existed. But they were not willing to go along with further delay while government and private resources were being marshalled to expand the schools of medicine and nursing and technical education, and to enlarge hospital and nursing home facilities. Opponents of the law nevertheless bear a share of the onus for the cart being ahead of the horse.

Medicare now is a fact of life; both government and private resources are charged with the responsibility to make it work. The test that begins today soon should determine the degree of expansion needed here in medical facilities, services and personnel. Once this determination is made we'll have our work cut out for us.

Paper Transcript — Telegram

Place Holyoke, Mass

Date 7-2-66

Holyoke Daily Transcript. Holyoke Telegram

EDITORIAL PAGE – JULY 2, 1966 – PAGE 4

A need fulfilled

Medicare has arrived. In a way it is unbelievable that the long-standing monolith of opposition to it lost its political foothold and socialized medicine for the elderly came through so quickly. We use the term deliberately. It is time to get used to it. Whatever Medicare is, its hospital care provisions and the supplementary provisions for doctor's bills promise a kind of security that Americans have never had before.

It is undoubtedly true that a great many people do not understand just how much is promised (it is less than what many with some kinds of insurance are getting) and it is certainly true that the full promise will not be delivered immediately or ever perfectly. What Medicare does do immediately is remove a shadow of fear from the lives of most elderly people and many approaching the age of 65.

It is the universal coverage of Medicare that enhances its security. In considering how successful the vast new program will be in aiding the ill, it is important not to overlook what it does economically and psychologically for the healthy. To a lonely person of limited finances, it is valuable that Medicare is there.

And to countless families where care of elderly relatives is a heavy burden, Medicare offers a measure of economic freedom, better opportunities for the education of children and so on.

The hospitals are not instantly flooded with elderly applicants for attention. It is inconceivable, however, that the pressure will not grow and present very serious problems. We do not really know how many people there are who have actually been denied needed hospital and medical care for lack of funds. To us it has seemed that wild statements about masses of the elderly waiting for such care once Medicare starts are a shocking admission that the community and the nation have in truth been ruthlessly negligent toward the elderly. So we shall watch the increase with special critical interest.

The program will demand more efficient use of all medical facilities and personnel, less pampering of the not very ill, strict screening to keep services from being squandered on those who don't need them. Administration of Medicare will be a tough test for everyone in the health field.

And we do not, alas, have much confidence in the ability of the federal government to facilitate the operation of Medicare. The program is fairly complicated. The question of billing is already a controversial one. The paperwork involved will be a cross for everyone. Many patients will expect much more than they are going to get. Probably many have no idea of what hospitalization involves and what it expects of them.

But like any program designed to meet a long accumulation of unmet needs, Medicare is bound to be bumpy for a long time. It is bound to reveal shortages in hospital and nursing home facilities, shortages in doctors and nurses, shortcomings in the standards of medical services. We have to keep in mind that Medicare's whole "raison d'etre" is a national need. The need is there. The old people are there, more of them all the time, representing a heavy percentage of our low-income population. At last an important measure of security is being offered to them and one more wellspring of despair is being removed from American life.

The Boston Globe

12 FRIDAY, JULY 1, 1966

A New Revolution

The United States begins today a new American Revolution, but one that is peaceful and in line with its democratic traditions.

For today the Medicare Law takes almost full effect. Whatever its imperfections and the probable need for later changes, it amounts to nothing less than a declaration of independence for the elderly.

Some 20 million of them become eligible for Medicare's basic health plan, providing among other things for up to 90 days of hospital care for each spell of illness. Almost the same number become eligible for supplementary medical care, which pays for 80 percent of the cost of other medical services including those of doctors, after a $50 annual deduction.

The last great social revolution of this nature occurred in 1935, in the pit of the Great Depression, when President Franklin D. Roosevelt pushed through a compliant Congress the Social Security Law. It set up a system of social insurance in which people contributed during their working years toward the cost of their eventual unemployment and retirement.

The Medicare Law sets up, under the same system, a way in which people contribute during their working years toward the cost of their health needs in their later years. This, as in retirement benefits, is largely an earned benefit.

As under the Social Security Act of 31 years ago, the benefits accrue to both the pauper and the coupon-clipper. But as a Washington official has said, it doesn't cost much to take care of the rich—there are so few of them; and as Abraham Lincoln said, the Lord must have loved the poor people—He made so many of them.

Medicare has become law despite fierce opposition for years from the American Medical Assn. Only a year ago, just before the law was passed, the doctors were debating whether to declare a total boycott of Medicare.

But many of them, too, were forward-looking. Even last year, the New York Medical Society urged the extension of Medicare to all Americans, regardless of age, and were joined in this proposal by delegations of doctors from California, Michigan and Indiana.

This may, indeed, be the next big social change in America. Bismarck's Germany began it in the 19th century. Britain has long had socialized medicine "from the cradle to the grave," as a result of the Beveridge Report issued during the late Winston Churchill's regime.

That document had all the effect of a brick thrown through the window of a London club. It woke up the Tories, and the Labor government made socialized medicine the law.

Such great social changes inevitably come about despite an opposition that is at first formidable but later dwindles. So it seems with the A.M.A. Its House of Delegates often seems to be paraphrasing the words of H.R.H. Prince George in 1895.

That royal prince, a perfect Col Blimp, bade farewell as commander-in-chief of Queen Victoria's troops that year by saying: "Gentlemen, there have been great changes in my time—great changes. But I can say this. Every change has been made at the right time—and the right time is when you cannot help it!"

In this spirit, the American Medical Assn. this week passed a resolution urging all doctors to bill all Medicare patients directly, and thus disregard the government machinery. Already Dr. John Knowles, the general director of the Massachusetts General Hospital, has rightly criticized the action.

It may be doubted, in any event, that much will come of it. Doctors do have the right, under the law, to bill patients directly, but they will still have to fill out the government form. And they are likely to find from experience that they will be paid for their services far more quickly and with less irritation all around if they use the other method.



What is important, despite such skirmishes on the side, is that even the opponents of Medicare are coming into the 20th century, whether their arrival is graceful or, to use the late Adlai Stevenson's phrase, whether they are dragged into it kicking and screaming.

The fact remains that a new social revolution is beginning. It means very much to the elderly, and will in time mean as much to everyone.

It is also bound to bring higher costs to the hospitals, and the public must expect it. The politicians who have campaigned, and rightly, for higher quality medical care, and the public which has in effect voted for it, all must understand that such programs cost money and are just as important as the nation's defense system.

They have to do with the defense of the nation's health. That is the meaning of today's revolution.

The Berkshire Eagle
Pittsfield, Mass.
July 1, 1966

Editorials

Medicare Is the Beginning

Like any great social innovation, the official inauguration of the Medicare program today is taking place in an atmosphere that is permeated not only with high hopes but also with some uncertainty and controversy.

The uncertainty arises from fears that a huge increase in demand for medical services may overstrain inadequate hospital and nursing home facilities in many areas of the nation. The controversy arises from the rear-guard action of American Medical Association diehards who are holding out for the right to disregard the Medicare administrative machinery by continuing to bill their elderly patients directly for services rendered.

But these are only minor distractions in the launching of the greatest advance of its type since the original Social Security program was enacted 31 years ago. They are trifling problems when measured against the establishment at long last of the principle that our elderly citizens should be freed from the curse of calamitous medical costs in the years when their vulnerability, both physically and economically, is the greatest.

Indeed it is safe to predict that a few years from now the question that will be asked is not whether Medicare was a wise innovation but, rather, why it took so long to come about. Already it seems strange to recall that only seven or eight years ago the advocates of such a program were looked upon as radicals or, at best, impractical dreamers.

And it is also safe to predict that the principle which has now been established is going to be expanded steadily in the years ahead. Eventually, it is certain, the provision of medical services, in and out of the hospital, and for persons in all age brackets, is going to become accepted as an economic obligation of society, rather than the individual. The question is not whether "cradle to grave" Medicare will come about, but when.

Like it or not, this trend will also be accompanied by increasing governmental regulation of medical services as more and more tax money is pumped into this area of the national life. It seems certain, for example, that the day is not far off when the federal government will use its power of the purse to eliminate the ridiculous waste and duplication that is taking place in hundreds of communities like Pittsfield because of the unwillingness of privately operated hospitals to merge their facilities and administrative control in the interests of greater efficiency. Washington can and will enforce such common-sense mergers by the simple expedient of denying federal subsidies for construction or expansion to hospitals which persist in going it alone.

Inevitably these developments will be accompanied by intense controversy. But as in the case of Medicare, the controversy will delay rather than prevent progress toward goals which make sense and which are supported by the great majority of thoughtful Americans.

FALL RIVER
Herald News

903 POCASSET STREET FALL RIVER, MASSACHUSETTS

EDITOR
Edward J. Delaney

Cornelius F. Kelly — Founder
1874-1938

GENERAL MANAGER
Dennis A. Toomey

Medicare Begins

As the Medicare program gets underway, there is bound to be some confusion about its administration. Any program so vast in its implications cannot function initially without hitches and snags. They must be expected, and they should be borne with good humor by the public. The government and the medical profession are doing their best to put Medicare into action. Given time and a little good will on the part of everyone, they will doubtless succeed. But at the outset, before all the difficulties are ironed out, some adjustments are bound to be required.

Perhaps the most obvious area in which operational changes will be needed is in the use of available hospital space. Clearly everyone who requires hospital care will have to be kept there as long as their condition warrants it . But in cases where hospitalization has been optional, the option may not always continue to exist.

Medicare should make it possible for elderly persons to get the assistance they need without the financial strain they have been under in the past. This is a major step forward for the country, but it is undeniable that the step involves an extremely complicated process of adjustment for our physicians and our hospital staffs. We must not expect Medicare to work perfectly overnight. Nothing so complicated ever does. The benefits Medicare will bring are apparent; we must be prepared to put up with some initial inconvenience to procure them.

Springfield, Mass.

THE SPRINGFIELD UNION

EDITORIAL PAGE

24 JULY 1, 1966

Medicare's Opening Day

Medicare begins today, offering hospital insurance to some 19 million Americans. The views on how it will work out are almost as numerous. Rarely, if ever, has the start of a new federal program found so many so unsure of what to expect.

One view, from Dr. John H. Knowles, general director of Massachusetts General Hospital in Boston: "It's going to look like the rush on Sutter's Mine. It's going to look like California did in the 1800s. There's going to be a line stretching from here down to LBJ's office."

Another view makes a slightly different reference to gold hidden away in the hills of Medicare's future. John Estabrook, director of Nebraska Methodist Hospital at Omaha, doubts that Congress realized the impact of its Medicare measure, "particularly what it will cost. They're in for a big surprise when the bills start rolling in."

A survey of hospital administrators by The National Observer found some more concerned than others, some even confident. But there is no question that many, many older persons who can be helped by modern medicine will seek that help now for the first time, because of the government-run insurance program.

A lot will be disappointed at first. Less urgent cases will have to wait where hospitals and staffs already are crowded. Until there is a clearer picture of demand, hospitals may decide to hold off expanding plant and personnel. Next Jan. 1, nursing-home coverage for hospital dischargees begins, probably permitting shorter hospital stays and thus faster turnover. But the over-all increase in paying customers may permit a gradual, healthy improvement and enlargement of medical facilities.

Most of the 19 million Medicare participants also have signed up for the voluntary coverage on doctor bills. This system also will be slow in shaking down. Doctors, under new AMA action, are urged to bill patients directly rather than fill out insurance forms to collect their fees from the government-designated carriers. Where this is done, patients will have to collect their insurance benefits themselves. There may be complications at first, perhaps some unpaid bills. But in the doctor-patient relationship, private insurance like Blue Cross-Blue Shield has worked out. So will Medicare

For the opening days of confusion, the peppery New York Daily News has advice to would-be in-patients: "If you're just a bunion-or-hangnail type of case, stay out of the hospital until this Medicare thing shakes down." And AMA's president, Dr. Charles L. Hudson, speaks soothingly to the doctors: "The changes we do find will be scarcely more drastic than those (both scientific and political) we've seen in the past."

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Nothing Is Free

As the government and the medical profession seek to discharge their duties to older people under the medicare law, everyone should be reminded again and again that there is no such thing as a "free" service. Nothing in this world is free and nothing new has been created under medicare. By law, the taxpayers are paying some of the medical bills of a selected group of people. As time goes on, the law may be revised to include the care of other age groups. Medicare may eventually be extended until it becomes a national health service such as was adopted in Britain nearly 18 years ago.

The British plan of government medical care which was to provide free service to all is threatened with a disastrous breakdown. A British Medical Association reports that, "Unless vast new sums of money are made available—from some source or another—the present concept of a hospital service must be abandoned....Half of the nation's hospitals are more than 80 years old, and only two new general hospitals have been built since 1939. The British Medical Association report concludes: 'If the public wishes to have an unrestricted health service, it must be prepared to pay for it...'"

The medical profession in the United States is going to do everything possible to facilitate the operation of medicare. It will do its utmost to preserve the all-important, doctor-patient relationship that is so vital to the high medical standards to which we have become accustomed. It is the obligation of the people, all of us, to remember that medicare does not mean "free" medical care. The more that is demanded in the way of service from hospitals and doctors, the more it is going to cost unless we wish to end up with a bankrupt medical system as Great Britain appears to have done.

HARTFORD COURANT 7/1/66

D-Day for Medicare

With computers poised and on the ready mark, the hundreds of insurance companies, and other organizations like Blue Cross and Blue Shield, face today with considerable confidence. Today's the day that Medicare goes into effect and 19 million persons over 65 become eligible for hospital or nursing home care. Of that group 17.3 million have also signed up for the optional part of Medicare covering medical bills. As Hartford has reason to know, the preparation for Medicare has been careful. New machines have been purchased and additional help hired as the process of tooling up has gone on.

In addition to the function of paying hospital bills, the intermediary agencies will have the job of policing the law. They must report periodically on how effectively hospitals are using their resources to serve patients, and how well they are pinpointing costs on which to base charges. Most good hospitals already have excellent accounting systems. But the intermediary agencies have been stepping in to help the others to get sound record-keeping systems. Only 25 per cent of the hospitals had cost analysis procedures.

In addition to the regular Medicare procedures, many of the Blue Cross agencies have formulated new policies that cover the gaps in medical care not covered by Medicare. Connecticut Medical Service is also designing such a policy for those over 65, supplementing Medicare to cover the entire medical bill after the original minimum of $40 has been passed. It is reported that this supplementary service is being snapped up by the great majority of elderly persons who thereby widen their coverage.

It would be a miracle if there were not at least mild chaos at the outset. Nobody knows, for example, how heavy the new load will be on local hospital facilities. It is safe to say however that there will be needed proliferation of nursing homes and that many hospitals will have to expand their facilities to care for the increase in patients.

Friday marks a historic occasion. It is the first giant step taken by the Federal Government to provide security for the elderly since the original Social Security Act was passed 30 years ago.

New AMA Head Has Some Sound Advice

Hfd Courant 7/3/66

The new head of the American Medical Association Dr. Charles L. Hudson, issued a refresingly frank statement on the eve of Medicare's beginning. He sought to allay the fears of physicians who have become aroused by the members of AMA's policy making board, which has been unalterably opposed to Medicare. He urged on physicians "a sound policy of self-examination." He said he was convinced that with the advent of the government's health program for the aged, "we are not stepping off the brink into the bottomles pit of professional destruction and despair.

Dr. Hudson is correct in saying that the members of the profession should not waste their collective professional energy to belabor the past. Medicare is here, he said, and while its operation will be uneven, good and bad, and sometimes vexatious, the medical profesion should learn to live with it.

There is little doubt that physicians in general will be irked by the clerical work, but many of them will bill their patients directly as they have every right to do. But Medicare is a reality, not a prospect, and the AMA, having fought its battle and lost should, as every good doctor advises his recuperating patient, learn to adjust to the new environment.

The medical profession, despite Dr. Kildare and other hero images, has been creating an unfortunate picture of itself as a group of reactionaries. Doctors by nature are conservative. The practice of medicine is an art as well as a science, and anything that disturbs the doctor patient relationship is bad. But doctors do not live in a vacuum. They are important parts of a changing society. And the public image of the self-sacrificing, ready at any hour doctor has disappeared. Now the public too often has a picture of a well-heeled individual who drives a big car and who opposes all social legislation. Sometimes, as recent magazine articles point out, they have a financial interest in a drug company or a pill-making concern.

All stereotypes are false, as is this one. But at the same time the new AMA president is wise in urging a course of moderation on members of that organization lest they deepen the image that already too generally exists. That the advice is needed is shown by the resolution adopted by the House of Delegates urging doctors to bill patients directly, thus ignoring the machinery of Medicare.

THE HARTFORD, CONN. TIMES 7/1/66

Social Milestone

Today we are passing a milestone stone marking an historic point in the social progress of the nation—the start of Medicare.

An enormous amount of research, study and detailed preparation has preceded the launching of this program. It will relieve the health anxieties of the nation's older citizens as well as ease their nagging financial burdens.

Early fears that the initial impact might overwhelm our hospitals have now been largely dissipated. Most medical experts across the country are not disturbed or fearful that hospitals will be swamped.

Hartford's four general hospitals face the new program with quiet confidence. They are fully prepared to discharge their responsibilities in the same full measure as always.

Medicare, a program of vast scope, will have its share of faults, kinks and abuses. Time and experience will eliminate them and bring needed assistance to millions.

". . Always fight for progress and reform, never tolerate injustice or corruption, fight demagogues of all parties, never belong to any party . . . always remain devoted to the public welfare, never be satisfied with merely printing news, always be drastically independent, never be afraid to attack wrong, whether by predatory plutocracy or predatory poverty."—Joseph Pulitzer

Editorial Opinion

AMA Show Its Contrariety

For an organization that is so devoutly opposed to socialized medicine, the American Medical Association seems to be doing more than any other to bring it about.

The action is not deliberate, of course, and perhaps most of the AMA members don't even realize what's happening. But whether intended or not, the result is the same: Step by step, the AMA is trampling down its defenses against socialized medicine.

The latest incident in what can be called a progression of blunders was the vote taken by the AMA's House of Delegates urging the nation's doctors to make their patients collect their own benefits under Medicare, rather than send bills to government-designated insurance carriers.

While this would not cheapen the value of Medicare or frustrate its operation, it may have the effect, in many cases, of inconveniencing and sometimes embarrassing the patient. What it means is that the patient would have to pay the doctor directly and then wait for a refund through application to Medicare.

It's not hard to imagine the difficulty which will be caused elderly persons who can expect problems enough with the intricacies of Medicare.

But that, sadly enough, appears to be the whole purpose and motivation behind the AMA's newly voted resolution. The members of this medical trade association, unreconciled as they are to Medicare, want to make the plan as troublesome as possible for its beneficiaries; thereby to diminish its popularity.

It's strictly a spite deal, with the AMA showing characteristic cussedness.

But if the doctors who sway the formal opinions of the AMA were able to take a more sensitive reading of the public pulse, they would know that Medicare, like Social Security, is here to stay, and nothing they can do will abolish or change it.

Indeed, they should know that a government program of medical care for the elderly is something this country should have been enjoying long ago. The present turmoil and confusion surrounding Medicare is simply the price of prolonged neglect.

The doctors, through their trade association, exercise the fear, of course, that Medicare is an "opening wedge" for universal socialized medicine. This, plus the fact that they resent the encumberance from any extra paper work, is the main basis of their anti-Medicare activity. But if the doctors band together in self-interest to oppose what the people want, need and deserve, they'll be hard put to muster public sympathy for their cause when and if the real push for socialized medicine comes.

By declaring an attitude of non-cooperation in the matter of Medicare billings, the AMA has increased the threat of socialized medicine. This is because the action further dims the humanitarian image of the doctor and tends to emphasize his mercenary interests instead. As the complexion changes, respect wanes —and the medical profession can't afford much more such loss if it expects to have any friends in the ultimate fight against socialized medicine.

PULITZER PRIZE
The Evening Bulletin
12 WEDNESDAY, JUNE 29, 1966 B

The Medicare Challenge

Medical care for the aged under Social Security, known as Medicare, which becomes effective Friday, will surely test the resources of hospitals and their personnel. But to what extent remains anyone's guess. Some administrators fear the very worst—a mass wave of help-seeking oldsters overloading medical, nursing and hospital facilities. Others, including government officials, are inclined to a more optimistic view—a view generally supported by caseload experiences in states operating local programs similiar to Medicare.

This is a time, nevertheless, to make an extra effort toward cooperation on this complex and still confused program. The 19 million Americans eligible to participate in one or both parts of Medicare might try to achieve a further understanding of what it is all about, what it offers and what it does not offer. The medical and allied professions should mark their preparations with their traditional mixture of compassion and common sense. Both will be needed if Medicare is to be kept in good health, medically and fiscally.

New Haven Journal-Courier June 28

State Is Poised For Medicare

By LEE GRABAR
Journal-Courier Staff Reporter

HARTFORD — Starting Friday, the weight of heavy medical expenses incurred by elderly people is going to be taken off a lot of burdened shoulders—both young and old—by good old Uncle Sam.

For Friday is the day that the country's health insurance program for persons 65 and over—which we all know as Medicare—goes into effect.

As of that day, the federal government will be picking up a good piece of the tab (albeit through higher Social Security payments by you, me and our employers) for an aged person's hospital stay that up to now was being paid for by a loyal son or daughter or by the person himself—if paid at all.

There is no question that it is a red-letter day and the Social Security Administration, which has charge of Medicare, seems to be as skittish about the launching as a bride on the eve of her wedding.

To accentuate a "state of readiness" for the coming of Medicare, the federal agency scheduled simultaneous news conferences throughout the country Monday, including one here in Hartford, at which the various groups concerned—hospitals, medical societies, public health agencies — reported on how ready they were.

What it all amounted to is that the medical and health industry, along with the federal government, was facing one big unknown in how medicare was going to work out.

Social Security officials stationed in the state conceded that until some experience is had, there is no predicting what is going to happen when the program takes effect.

A high degree of interest in the program by Connecticut's elderly population is clearly shown in the near-total enrollment of the eligibles under the voluntary part of Medicare covering medical expenses.

This so-called Part B of the plan, which requires a $3-a-month payment from the beneficiary, has drawn a 96 per cent enrollment from the 276,000 persons now in the 65 and over group.

Further, it was reported unofficially that one of the hospitals in New Haven has a rela-

See MEDICARE Page 15

Utica Observer-Dispatch

Member of The Gannett Group and The Associated Press

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HERMAN E. MOECKER, Publisher

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Published every afternoon and Sunday (holidays excepted) by the Utica Observer-Dispatch, Inc., 221-223 Oriskany Plaza, Utica, N. Y., 13503. Paul Miller, Utica, N. Y., president; Herman E. Moecker, Utica, N. Y., vice president and secretary, and Cyril Williams, Utica, N. Y., treasurer.

Protest on Double Medicare Payment

A Utica man has detected what he considers a charge for U. S. Medicare insurance for a month in which Social Security eligibles haven't been covered by it.

John Soltys, 1002 Miller Street, wrote both the Supreme Court and the Department of Health, Education and Welfare in Washington — and the replies he received are non-committal to say the most for them. The Commissioner for Social Security, Robert M. Ball, signed a letter saying "we are giving your letter our attention and will be in touch with you as soon as possible." Marshal T. Perry Lippitt said the Supreme Court "is without jurisdiction."

Mr. Soltys refers to the deduction of $3 from Social Security checks for June to pay for Medicare. Since Medicare coverage starts July 1, the Utican believes this taxation without medical attention, and that the deduction should have been postponed to the July check.

The $3 is a small amount, but to an individual living entirely on Social Security it may mean no tobacco or no bus fare for a month. Over the nation, it amounts to millions of dollars the government takes from June checks for July coverage.

The Utican seems to have a complaint, even if the plan is to collect Medicare premiums in advance. Should people on Social Security be assessed in advance, since the Social Security office can always take the fee from the current month's payment?

Established 1882

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The absolute independence and integrity of a member of the Gannett Group of newspapers must never be in doubt—FRANK GANNETT

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THOUGHT FOR TODAY

This is the first day of July, and we have completed the writing of a document that I believe will make an impression on history and will have a part in deciding the course of this land and this people.—**John Adams in a letter to Mrs. Adams, July 1, 1776.**

Method of Doctor Payment Chief Issue As Medicare Plan Begins

As the nation's Medicare program goes into effect today, the hot issue is how those over 65 will pay their doctor and obtain their benefits.

The House of Delegates of the American Medical Association, meeting in Chicago this week, approved a resolution that recommended direct billing by the doctor of the elderly patient enrolled in the Medicare program.

This is the traditional way, of course—a bill for services mailed by the doctor to the patient's home. Many doctors have favored it because they believe it maintains the doctor-patient relationship.

Doctors also like it because it allows them to charge the fee they desire and feel is necessary. It frees them of some Medicare paperwork. It allows them to remain more independent of the Medicare program which many in the medical profession accept reluctantly.

* * *

THE ALTERNATIVE to direct billing is called the "assignment method." This means that the patient signs a form that indicates he is turning over his Medicare benefits to his doctor. The doctor completes the form, reporting on diagnosis and treatment, and sends it to an insurance company—which is authorized by the government to pay benefits. The carrier mails the doctor a check, based on a "reasonable fee schedule," for the treatment given.

* * *

THOUGH distasteful to many doctors, this "assignment" method is easier for the over-65 patient. He merely signs a paper in the doctor's office. Under direct billing, he pays the doctor, gets a receipt, and files this with a special form with the carrier. The carrier then mails the patient a check for his benefits. He will collect, however, only within the limits of the carrier's "reasonable fee schedule."

* * *

THE PAYMENT problem is more simple when the over-65 Medicare patient goes to a hospital. Medicare will help to pay for up to 90 days of hospital care for one spell of sickness. The patient pays the hospital the first $40 of his bill and everything over $10 a day after 60 days.

The remainder of the bill—the insured portion—is sent by the hospital to a carrier for reimbursement. Utica Blue Cross has been selected as the carrier under the hospital section of the Medicare program by all 32 general hospitals in 15 upstate New York counties between the Canadian and Pennsylvania borders.

* * *

INEVITABLY, confusion will exist as Medicare starts. Although the Social Security Administration has been talking about it for months and all of those enrolled received handbooks, many will want questions answered. Medicare does not cover everything. There are deductibles in both hospital and medical coverage. But it will help the elderly meet the cost of sickness, one of the deep concerns facing many men and women at a time in their lives when their income is down and health problems are up.

Democrat and Chronicle

PAUL MILLER, Publisher ALLEN H. NEUHARTH, General Manager C. E.

JOHN C. QUINN, Director of News NORRIS W. VAGG, Managing Editor AL F. P

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TELEPHONE: 232 5300

Medicare Calls For Patience

Medicare begins today, and for nearly 100,000 persons over 65 in the Rochester area it means a better break on health costs.

No longer will some of our elderly be forced to expend savings, sell their homes and end up on welfare when they are stricken with costly illnesses.

Medicare brings them a new and justifiable independence.

This newspaper has supported Medicare substantially in its present form. We hope it works effectively.

We are mindful, though, that the program is administratively complex, involving literally hills of paper work for the government, hospitals, physicians and health insurance carriers.

It would be naive to expect that there will not be confusion and errors for a while.

For this reason, the Medicare patient will have to be patient in the face of early mistakes in claims and procedures.

Until these wrinkles are removed, Medicare patients ought not jump the gun and demand hearings, to which they are entitled if they think claims have not been handled properly. Such hearings would only complicate things in the beginning weeks.

As Medicare moves along, we hope that the cooperative planning efforts here will maintain a high quality of care for older persons and at the same time guard against possible abuses in unnecessary use of hospitals and healthcare resources.

Medicare is bound to increase the patient load, coming at a time when there are already serious manpower shortages, and abuses of this kind would harm everyone.

Paper New York Times
Place Chula N/E

New York Times
July 1, 1966

Date 7/1/66

EDITORIAL - NEW YORK TIMES

Medicare's Beginning

The beginning of Medicare ushers in a new way of life for millions of Americans. Those over 65 and those in need now have the precious security of knowing that their medical bills will no longer be a ruinous or calamitous burden. This assurance provides a measure of independence and dignity that for older citizens is in many respects as important as the services that will be available to them.

Indeed, many may find that in its initial stages Medicare offers more promise than performance. The United States has lagged behind other industrialized countries in providing medical care for the elderly. The price of this neglect is likely to be a soaring demand for treatment that could strain the nation's resources of trained personnel and professional facilities. So for a time at least the qualtiy and quantity of medical care for some may not be as good or as thorough as it should—and must—be.

There has been no lack of warnings about the shortages of doctors and nurses and the inadequacy of hospitals. The trying experience of Britain after the introduction of her national health service is an object lesson. But the warnings have been largely ignored, with the result that demand for medical services may race ahead far faster than the supply of medical resources, particularly in rural areas.

The strain can be partially relieved in the short run by cutting down on superfluous use of hospitals and nursing-home facilities. But in the long run, the solution lies in more medical schools, more hospitals and a big expansion in "extended care facilities"—nursing homes that can serve as halfway houses between hospital and home and that provide treatment at home, thus keeping patients out of hospitals. The cost of training and maintaining professionals and of constructing adequate facilities will be high, but it is a cost that must be met.

But as Medicare gets under way the danger is that the strains on it will generate pressures for unsound change. They will come from those who will be disappointed because they have been led to expect too much as well as from those who will see failure in every shortcoming. Changes will come in time, but they should be made on the basis of Medicare's own experience. This great new experiment must be given ample time to get over its growing pains.

Syracuse Post Standard
7/1/66

Medicare for All?

SYRACUSE POST STANDARD 7/1/66

State Medicine May Take Over

AS FEDERAL MEDICARE goes into effect today for 19 million Americans 65 years of age and older—

As Medicaid looms for another 78 million who could be classed as "medically indigent" by the 50 states—

And as 8 million persons already on relief are automatically eligible for medical benefits under state and local programs matched by federal funds—

The question inevitably arises:

How close is the United States to total state medicine, with all medical, dental, hospital and health expenses paid out of tax funds?

★

THE UNITED STATES NEWS & WORLD REPORT poses that question in this week's issue, in a broad analysis of past, present and potential costs of state medicine.

Before Medicare (before today), health programs of all kinds have been costing the taxpayers $11 billion a year.

From now on, with Medicare added, including broader aid to the "medically indigent" of all ages (such as the New York open-end, no-limit Medicaid law), the magazine estimates taxpayer-financed programs will cost $16 billion a year. (This seems conservative in view of the insurance actuaries' estimate that the New York Medicaid alone may cost up to $1.8 billion the first year.)

If Medicare covered everybody of all ages, total tax fund outlays through government agencies would reach $48 billion a year, it is figured.

And Syracusans yesterday witnessed a "welfare march" intended to persuade more citizens to apply for welfare benefits, with the ultimate purpose of swamping the public treasury so that Congress would be forced to grant a "minimum annual wage" for not working!

★

OF THE $16 BILLION a year that the new Medicare program will cost, $2.4 billion will be provided by a Social Security payroll tax, $550 million by medical-insurance premiums paid at $3 a month to the Federal Government by persons over 65 (State Medicaid requires NO contribution by beneficiaries), and the rest will be paid out of federal, state and local treasuries, U.S. News notes.

"All of this is expected to be just the beginning," says the magazine.

"The U.S., it appears, is well on the way toward a system of tax-supported medicine for everyone . . .

"Once Medicare gets into full swing and care for the medically indigent is made more liberal, the burden of paying for health service will fall chiefly on the working and earning group of the population. This group already is helping pay for Medicare itself through an increase in Social Security taxes.

"In addition, these 'middle millions' — people not old enough to qualify for Medicare and not poor enough to be classed as medically indigent — must pay family hospital and medical bills, often without the help of group hospitalization or medical insurance . . .

"How long can this situation continue? How long before political demands will become irresistible in favor of Medicare for all?

"The answer given is: Maybe not so long."

★

GETTING AWAY from the long range threat of total national and state bankruptcy to yesterday's Medicaid vote-jockeying in Albany:

In offering to allow a vote to be taken in the Assembly on Medicaid amendments, Speaker Anthony J. Travia was obviously merely trying to buy enough Upstate support to jam through the New York City tax program.

Even if all the amendments approved by the Senate were passed by the Assembly, they would not materially affect the basic operation or excessive potential cost of the Medicaid program.

The Democratic leadership now regards Medicaid as a two-edged weapon by which they will win votes in New York City and which will cut deeply into a Rockefeller plurality Upstate. They are not about to grant any significant concessions.

★ ★ ★

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As Medicare Begins

July 1, 1966, may well be a date that coming generations of Americans will have to commit to memory as a significant milestone in the history of their country. With the establishment of Medicare, the nation is firmly committed to the principle that all its older citizens must be given the medical attention they need. The commitment, of course, is not so abrupt a departure from the past as many feel. Over the past two decades in particular we have been moving toward it along a variety of paths. The long tradition of charity work among doctors themselves, the banding together of subscribers to hospital and medical insurance plans with the encouragement and financial support of employers, the Federal and state programs for the poor and the medically indigent, the free services extended by hospitals—all these have been different attempts to ameliorate and spread the tremendous burden which sickness in old age imposes. To some extent Medicare is a consolidation and rationalization of these existing programs. But it will also fill large gaps, extend what is already being done and establish a new basis on which the older citizen will have a clearly defined right to the care he needs.

The cost will be high. Most employed workers have been paying a part of it in the form of heavier Social Security taxes since the new rates went into effect the first of the year, in effect storing up credits against their retirement period. Doctors will bear much of the burden in being forced to abandon some of their cherished traditions of private practice. Beneficiaries who subscribe to the voluntary medical portion of the plan will continue to make monthly payments. Hospitals and nursing homes will face new problems as they brace for an influx of patients in undetermined numbers. The ordinary taxpayer will foot the bills for those persons who are not covered by Social Security. Few will be getting something for nothing.

What the complications will be, no one can yet tell. A prodigious campaign of explanation has produced widespread discussion of Medicare's details in Government pamphlets, in newspapers and periodicals as well as on television and radio, in lectures and informal discussions. Most of those eligible should by now have a reasonable idea of the benefits available—and of the limitations on those benefits which will frequently require some contribution by the patient. The task now is to make this vast new program work, to find out what new facilities and personnel are needed, what administrative and statutory changes must be made. That all this will be done—sometimes well, sometimes poorly—no one can doubt. For the commitment has been made and while there may be modifications there will be no turning back from the principle of a national program to insure that the aged of the country, all of them, get the medical treatment they need.

The News American
BALTIMORE MARYLAND

The Award-Winning Newspaper:
Winner of the 1965 Albert Lasker Medical Journalism Award and the 1965 American Medical Association Award for distinguished reporting in the medical field.

The only newspaper in Maryland with all the great news and photo services: Associated Press, United Press International, AP Wirephoto, UPI Telephoto, Hearst Headline Service, Chicago Daily News Wire Service.

Maryland's Most Widely Read Daily
Established in 1773 as The Maryland Journal and Baltimore Advertiser

6A ★ Saturday, July 2, 1966

Medicare

MEDICARE, which became effective yesterday, will deeply affect the lives and happiness of millions of older Americans and their families.

Few issues in domestic politics aroused such controversy as Medicare during its tortuous path through the Congress. The lines for and against it, moreover, still exist both inside and outside the medical profession.

Similar uproar, some of us remember, accompanied the first Social Security legislation, of which Medicare is now an extension. But it all calmed down, and those first laws became an accepted and important part of American life.

Now Medicare is the law of the land, too. And it can be confidently expressed that the overwhelming majority of persons, again inside and outside the medical profession, will abide by it and take full advantage of it, and will not try to circumvent this law in any way. All efforts, instead, should be directed toward helping Medicare achieve its end — that of easing the financial burden of being ill.

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6A ★ Saturday, July 2, 1966

Court Demand

REP. CARLTON R. SICKLES has taken a decisive step toward streamlining Federal Court machinery in Maryland by introducing legislation authorizing the court to sit in Hyattsville.

If approved, the measure could significantly speed federal justice throughout the central part of the state by relieving the judicial burden now on the court in Baltimore. The proposed branch would syphon from the docket here the majority of cases involving residents of Montgomery and Prince Georges counties, which account for 27 percent of the state's population.

The court's other branches—in Cumberland in the west and in Denton on the Eastern Shore—are unable to accommodate conveniently Maryland residents of the Washington suburbs.

In addition to its obvious immediate advantages, Sickles' proposal would become progressively more beneficial to the state's' legal complex due to the rapid growth foreseen for the Washington suburbs in both Montgomery and Prince Georges counties.

The News American hopes the Judicial Council, composed of Court of Appeals judges in the Fourth Circuit, gives the measure its undivided endorsement to grease its passage through Congress. If so, it would be a case of the judiciary reinforcing statutory law by invoking a business law—the law of supply and demand.

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'Our Wards Are Full – You Wouldn't Mind A Private Room, Temporarily?'

EDITORIAL—TIMES-HERALD
NEWPORT NEWS, VIRGINIA, FRIDAY, JULY 1, 1966

Medicare: Fraud Or Hoax?

Today is opening day for medicare, and officials are facing the impact of this new phase of socialism in a mixed mood of confidence and apprehension. As the bureaucrats brace for a flood of applications for medical treatment they have nothing to fall back on, no experience nor data, and the air is filled with unresolved problems and unexpected controversies.

Congress is complaining that unforeseen costs have escalated the cost of medicare far beyond even the most extreme of the original estimates. There are manpower shortages in every area of the immensely complicated proposal.

As written into law and effective beginning today; medicare includes a system of basic hospital insurance financed on top of the social security cut taken from pay envelopes; there is a voluntary supplementary plan for doctor bills paid for by contributions from the patients; and, finally, an extension of the previous Kerr-Mills program for the elderly to cover most needy people.

How has the nation prepared for this new service of the welfare state? Today, the advance planning for medicare is in pretty much of a shambles, because a number of controversial issues have not been firmly resolved, even after continuing debate and discussion.

Only yesterday the American Medical Association's Council on Medical Services, meeting in Chicago, worked away at the problem of 250,000 illegitimate births every year, attempting to relate medical needs to community health agencies involved in medicare.

President Johnson called on the nation's doctors not to drive a hard bargain by demanding direct, immediate reimbursement" from indigent patients. Mr. Johnson said it was up to the individual doctor how he will bill payment under the massive health plan.

As Congress strove to include every possible elderly voter under the protection of medicare, it even added maternity benefits to the plan. The eventuality of a woman of 60 or over becoming a mother belongs in the annals of science rather than in the records of medicare.

Furthermore, certain guidelines for repayment of hospital costs have not yet been clearly charted. The Senate Finance Committee has estimated that additional payments to hospitals to cover depreciation and to provide them with a profit will add $110 million a year to the cost. And that base cost itself has never been identified!

Another source of confusion as the bill becomes law today has to do with extension of the existing Kerr-Mills Act. Optimistic officials of the Health, Education and Welfare Department, apparently troubled by their own credibility gap, stated before the Senate Finance Committee that extending Kerr-Mills medical provisions would cost $238 million if every state took part. In actuality, it has been determined that the added cost would amount to $217 million for New York alone, and seven other states have claimed $262 million in extra federal money for this part of the medicare program. Thus, with only 8 states involved, the added cost is twice the original estimate for 50 states! It is a concrete example of the devious manner in which the medicare program was 'sold' to the Congress.

The problem of segregation in the Deep South will reduce available facilities, for many hospitals are refusing to integrate despite federal threats to bar them from the medicare program and to cut off all further federal aid. One fourth of the hospital beds in the state of Mississippi may be used for medicare patients, for instance. In Mobile, Alabama, only 30 out of 3,940 hospital beds have been approved. On the Virginia Peninsula, Riverside, Mary Immaculate and Whittaker hospitals have escaped the threat of federal exclusion from the program by accepting HEW's regulations and guidelines. Others on the Peninsula are still being processed. As medicare begins, three points are clear:

First, there has been a tragic failure to prepare for extended medical care facilities. There is an acute shortage of trained personnel (Note Sylvia Porter's column today).

Second, some of the people will not get all of the health care they want.

Third, medicare's cost—a nebulous figure kept that way until it passed the Congress, has escalated astronomically now that hospital authorities are looking into the specific items listed among its provisions.

Our view has been that the program, as it was built in Congress, would become an outright fraud and a political hoax in practice. Let's say we will keep our fingers crossed to see what happens—but we won't count on somebody to care for our cramped fingers until something does happen.

Front Page - New Britain Herald
New Britain, Conn

Front page - New Britain Herald 7-1-66

Medicare in Effect

Hospitals Here Absorb Persons Already Patients

By ANTHONY G. GREY

Medicare health insurance which became effective today for 13,000 people 65 or over in the New Britain area was just another day in the area hospitals.

The major impact of Medicare on New Britain General Hospital will probably be felt in its outpatient facilities.

Waiting List Already

No great influx of elderly persons seeking admission is anticipated. Should large numbers apply, however, only emergency cases could be admitted promptly, for the time being, reports Dr. Bliss B. Clark, executive director of NBGH. A waiting list for the hospital's available medical and surgical beds already exists.

Necessary paper work will increase considerably because of the number and complexity of Medicare forms.

This, in capsule form is Dr. Clark's opinion of the effect the advent of Medicare will have on the city's only short - term general hospital.

Dr. Clark said he believes

(See Page 2, Col. 6)

City Doctors Plan to Bill Individually

An informal survey indicated today that New Britain physicians will decide on an individual basis how they will submit their billing for Medicare patients.

The New Britain Medical Society reported it has not discussed the question and had no further statement to make other than the billing will be decided on an individual basis.

This means that the physicians could bill their Medicare patients directly and have nothing to do with forms that provide for doctor payments by government - designated insurance firms.

The physicians could follow the American Medical Assn. policy on a strictly voluntary basis by having their elderly patients get reimbursed under the federal health care program, and in other cases follow the Medicare procedure in billing.

The society may discuss the billing question at a future meeting, after complete reports are received from the American Medical Assn. on its convention in Chicago this week.

The AMA House of Delegates urged the nation's physicians to bill all their Medicare patients directly and are planning radio and TV time to explain to the public its Medicare policies.

—HOSPITALS HERE

(Continued)

there will be a notable rise in the number of persons 65 or over who will use the hospital's diagnostic services as out patients.

His judgement, he said, is based on the fact that health insurance plans, up to now, pay only minimal amounts for X-ray examinations, laboratory test and other diagnostic service obtained in the outpatient department of the hospital. Medicare pays most of these costs

Many Have Blue Cross

Moreover, a majority of elderly persons in the area also subscribe to Blue Cross 65 and CMS 65 which pay almost all outpatient and inpatient costs not covered by Medicare.

Last year, 6,000 of the 52,000 visits to NBGH outpatient facilities were made by persons 65 or over. It is estimated that visits by the elderly will increase initially about 30 per cent under Medicare.

Dr. Clark believes there is a pool of elderly patients with chronic diseases waiting for the start of Medicare before seeking hospital help. The number of such persons in New Britain, he indicated, is probably smaller than in other parts of the country.

He pointed out that an average of 30 per cent of the 274 medical and surgical beds at NBGH were occupied by persons 65 or over during a recent six-month survey period.

Emergency Cases Get Priority

Persons seeking hospitalization at NBGH for chronic diseases of the elderly, such as varicose veins, hypertension, hernias, hemorrhoids and arthritis, will have to be added to a waiting list. The waiting period is now from four to six weeks.

"Of course, emergency cases, regardless of age, will receive top priority, just as always," he said.

Admitting and billing procedures under Medicare will be much more involved and time consuming, due to the number, length and complexity of the forms which must be completed and processed.

(continued)

NBGH has added the equivalent of two and onet half full-time people to its payroll to handle what it expects will be a sharply increased load of paper work.

Reminder to Patient

Persons covered by Medicare must remember to bring their health insurance card when checking into a hospital for either inpatient or outpatient care.

The advice comes from Raymond P. Roden, chief admitting officer at NBGH. The card lists the patient's health insurance claim number which the hospital must have in order to process the Medicare forms, he said.

The hospital reported that 82 patients, including eight who were admitted yesterday, are now Medicare patients. No new Medicare patients were admitted before forenoon today.

At New Britain Memorial Hospital, 52 patients are beneficiaries of Medicare where the insurance care became effective today .The hospital is in the same category as general hospitals. Persons 65 and over may enter the hospital directly upoin certification of a physician under the new health plan.

Medicare regulations covering convalescent hospitals and rest homes take effect Jan. 1, 1967.

For the next 90 days, Medicare patients at New Britain Memorial Hospital will receive the following benefits: For the first 60 days they will pay $40 and the government will pay the rest of the bill. For the following 30 days, the patients will be charged $30 a day and the rest will be paid by Medicare.

Under the new law, effective Jan. 1, 1967, patients will be entitled to additional benefits for 100 days during which the government will pay for all charges for the first 20 days and all charges over $5 a day for the next 80 days.

THE TIMES UNION

GENE ROBB, Publisher
JOHN J. LEARY, Managing Editor
ALBANY, N. Y., SAT., JULY 2, 1966

Editorials

Medicare Day

Medicare went into effect yesterday. It will deeply affect the lives and happiness of millions of older Americans and their families.

Few issues in domestic politics aroused such controversy as Medicare during its tortuous path through the Congress. The lines for and against it, moreover, still exist, both inside and outside the medical profession.

Similar uproar, some of us remember, accompanied the first Social Security legislation, of which Medicare is now an extension. But it all calmed down, and those first laws became an accepted and important part of American life.

Your Medicare is the law of the land, too. And it can be confidently expressed that the overwhelming majority of persons, again inside and outside the medical profession, will abide by it and take full advantage of it, and will not try to circumvent this law in any way. All efforts, instead, should be directed toward helping Medicare achieve its end—that of easing the financial burden of being ill.

Medicare Points Up Critical Shortage of Nurses in Hospitals Throughout the Nation

By NATALIE JAFFE

Medicare recipients who expect more thorough nursing care to accompany their change in status from charity to private patients are in for a disappointment.

There is no relief in sight for the chronic shortage of nurses.

In many of the nation's 7,000 hospitals—particularly in the South and Southwest—there is only one registered nurse to supervise hundreds of patients. Most of the work is done by nurses' aides and attendants.

In states such as Arkansas—where there are only 121 nurses for every 100,000 persons—it is unlikely that there will be a trained nurse in the hospital at night. Only an attendant will be on hand to check respiration and blood pressure and to watch for signs that a shot of digitalis or insulin is needed.

Even in New York State, where there are 388 registered nurses for every 100,000 persons, there are hospitals in Putnam and Jefferson Counties that the Social Security Administration has certified as acceptable only with reservations. And in the municipal hospitals of New York City, one registered nurse often has the responsibility for hundreds of patients at night.

Nationwide, 20 per cent of the nursing positions in general hospitals are vacant. To fill the gap, many hospitals use nurses' aides who are "inadequately trained," according to the United States Surgeon General's Consultant Group on Nursing.

"This pragmatic solution to the problem of shortages has produced an alarming dilution of the quality of service," the group's report in 1963 declared. "In some hospitals the use of auxiliary workers has reached such extreme proportions that nursing aides give as much as 80 per cent of the direct nursing services."

Between 1950 and 1962, the report said, the proportion of direct care given by professional nurses dropped from about 40 per cent to 30 per cent, and was still dropping at the time of the report.

Today, there are 621,000 professional nurses practicing in hospitals, clinics, doctors' offices and patients' homes. About two-thirds of the nurses are in hospitals. Nearly one-quarter work part-time. About 25,000 abandon the profession each year.

Registered nurses have two or more years of training in a hospital school of nursing, a junior college or a university-related hospital program. Licensed practical nurses take a one-year course. Both receive their licenses only after passing state board examinations.

Militancy Found an Aid

Most hospital administrators around the nation who were interviewed last week seemed resigned to the continuing shortage. Several, however, predicted that the combined pressure of high public expectations and the new militance of nursing associations would have some effect on improving salaries and, therefore, attracting more young men and women to the profession.

"Medicare will, of course, be a real support to the nurses in their collective efforts to improve economic conditions," was the comment of Mrs. Judith Whitaker, executive director of the American Nurses Association, which represents the nation's 621,000 practicing registered nurses.

It was the association's New York branch that won a substantial salary increase in May from the city's municipal hospital system. The base pay went from $5,150 annually to an immediate $6,050, to be raised to $6,400 next January.

The New York victory has already resounded from Boston to Los Angeles, and the national association last month, for the first time, established a salary goal for beginning registered nurses—$6,500 a year. Today's average is $4,700, less than that of classroom teachers, secretaries and factory workers.

Increases Are Sought

Last week, the licensed practical nurses—of whom there are 275,000 nationwide—began their own campaign. Those working in New York's city hospitals demanded an increase comparable to that of the registered nurses.

In California, the Los Angeles County General Hospital is preparing to increase its nurses' salaries "as a direct result of the New York developments," according to the assistant administrator, John O'Connor.

"The whole point of the Medicare legislation," he said, "is to bring the public hospital standard up to the level of the others. If we don't pay the nurses more, we'll never make it," Mr. O'Connor declared.

He would like to add 180 more registered nurses immediately to the staff of 720 that now care for 3,000 patients.

In Boston, what the head of Massachusetts General Hospital calls "the rippling effect from the New York nurses" has already had an impact. New York hospitals are advertising in Boston newspapers "and about 40 nurses have left Boston already" according to the hospital's general director, Dr. John H. Knowles. None of them have left Massachusetts General, he said.

"The first thing I did when I got this job five years ago," Dr. Knowles said, "was to put the head of nursing on the medical policy board of the hospital. Overnight, the word went out that we consider nursing a profession in this hospital and we got about 70 nurses. Now, we're only about 5 per cent short."

The hospital, with 1,060 beds, has 450 registered nurses and 200 licensed practical nurses, in addition to aides and attendants.

"Boston hospitals now pay nurses about $96 a week, compared to the $125 that New York got," Dr. Knowles said. "If we try to hold them at the lower level, all the hospitals will be unionized and they ought to be."

However, he continued, if nurses' salaries are raised, the same would have to be done for hospital dieticians, social workers, pharmacists, medical record librarians and all the personnel whose salaries use up three-quarters of a hospital's operating budget.

"At that point," he said, "the hospital's costs will go up from 10 to 20 per cent and the administrator will have to be ready to explain why that's absolutely necessary."

The definition of "better care," as far as nursing coverage goes, is specific in Medicare's conditions of participation. They require a hospital to have a registered nurse on duty "at all times," and enough of them to be "immediately available to give bedside care when needed."

Arthur E. Hess, director of the Medicare program in the Social Security Administration, said several hundred hospitals who had applied for certification could not meet the minimum nursing standards. These hospitals have ben given certification with a time limit, he said, and will be checked again in nine months or a year by state health agencies.

As for nursing homes, less than 5,000 are expected to qualify as "extended-care facilities" where patients will be eligible for Medicare benefits starting next January. The inability of the 20,000 other nursing homes to qualify, according to a spokesman for the American Hospital Association, is that they are primarily custodial and lack many medical facilities as well as nurses.

"Medicare requires professional nurses to be directors of nursing homes, but where will they get them?" an association spokesman asked. "Very few schools are teaching geriatrics. They don't have either facilities or faculty."

Nurses are especially bitter about the skimpiness of Federal concern with nursing education. In 1964, the National Defense Education Act made money available for 1,000 nursing scholarships a year.

The New York Times.

NEW YORK, SUNDAY, JULY 3, 1966.

MEDICARE LINKED TO FEE INCREASES

Doctors Deny a Connection but U. S. Aides Cite Big Rise in Recent Months

By DAVID R. JONES
Special to The New York Times

WASHINGTON, July 2 — There is evidence that some doctors around the country are raising their fees because of the start of the Medicare program. But the men who advise doctors on business matters assert that this is true only in a minority of cases.

However, a survey among doctors and their financial advisers this week in several key cities confirmed recent Government statistics indicating that doctors' fees have been rising in the first five month of this year roughly twice as fast as in previous months.

The reasons for the sharper increases are difficult to pinpoint. Most medical business advisers put the blame on mounting costs. But there is a suspicion among some Government experts that the arrival of Medicare is spurring the rise, and some medical business consultants agree.

Sensitive Question

The impact of Medicare upon medical costs is a sensitive question fraught with political implications. Doctors generally believe the program will raise and push up fees. But liberal forces are on the lookout for fee gouging under the law, which would lead them to call for Federal fee controls that doctors fear.

The Medicare program, which took effect yesterday, is designed to help those aged 65 and above to defray the rising cost of medical care. The law provides for Federal payments for 80 per cent of most annual doctors' bills, except for the first $50 in costs, and also pays most hospital bills.

The law, passed last year over strong opposition from the medical profession, specifies that the Government will reimburse doctors' "reasonable charges" for Medicare patients.

What is "reasonable" is determined by insurance companies, who must base their finding on the "customary charges" made by the doctors for such services and the "prevailing charges" in the locality.

Medical financial experts surveyed this week said the arrival of Medicare had prompted a widespread re-examination of fee structures.

Most of these experts said they had advised their doctor clients to make such studies to be sure their "customary charges" cited under Medicare were in line with costs and the fees levied elsewhere in the community.

The majority of financial advisers agreed with Lewis A. Miller, executive editor of Medical Economics, a trade publication, who said that recent talks with perhaps 500 medical people had convinced him there was no widespread Medicare-inspired fee boosting.

"Generally speaking, doctors are not changing their fees because Medicare came in," he said. "Some are, but I would guess it's a rather small minority."

Some advisers, however, indicated the increases were more widespread. William D. Huntington, northern division manager of Professional Management Midwest in Minneapolis, said Medicare "has been a very definite factor" in influencing higher fees "pretty much across the board" in his region. And a New York consultant, insisting upon anonymity, said "very few" of his clients had raised fees due to Medicare but that he thought many doctors had done so.

"We have found more concern about fee schedules in the past six months than I've seen in 15 years," Mr. Huntington said. "The doctors wish to have their fee schedules up to date at this time above all other times," he added, and there has been "more effective raising of fees" since the end of 1965 than "in many years."

John C. Post, president of Professional Business Management in Washington, said that with the start of Medicare, "doctors have paid much more attention to fees in the past few months than in the past several years. I don't mean they are unnecessarily raising them, but they are taking a hard look at items."

"Where they might be charging $5 for office fees for the past few years, they are raising it to $7," Mr. Post said. These fee revisions are resulting, he explained, because "they're putting themselves on record now as to the fees they reasonably expect" and "if they are careless or indifferent enough to put out a 1955 cost in 1966, they're going to be out of luck."

Some doctors who recently had raised fees seemed to think it advisable to do so before Medicare authorities began a careful watch on all fee revisions, several advisers suggested, because increases after the law took effect could set up howls of protest.

A large number of those doctors who have been increasing fees appeared to be motivated by elminating what they considered to be "substandard" charges that were below the prevailing level in the community.

Some advisers said these doctors had been encouraged to bring their fees "in line" by other doctors who feared the low rates would reduce the community average and cut their allowances from Medicare.

Fee Study on Coast

Richard V. Bibbero, president of Medical Management Control in San Francisco, said that his company recommended to its 400 clients that "anybody that was below the area" average should raise fees. "We had everybody look at all fees in March," he said, and the company "had people who were low shaped up" before California's own state Medicare bill took effect.

Dr. Eugene G. McCarthy, associate professor of administrative medicine at the Columbia University School of Public Health in New York, said that this development was typical with a Medicare-type program. He said it normally resulted in a narrowwer range of fees at the higher end of the scale.

Some Government authorities, including experts within the Social Security administration that is administering Mdicare, suspect the new program is prompting more fee increases than the doctors will admit. But they are remaining silent because they concede there is no solid evidence.

"It is our opinion they are raising the fees because Medicare," one Government price expert said privately, "but we can't say anything about it without some hint from our field staff."

Harry J. Becker, economist for the New York Academy of Medicine, a nonprofit research group, said it was "human nature" for doctors to raise fees at a time like this and "there's nothing to indicate human nature's not working."

Dr. Philip R. Lee, Assistant Secretary of Health and Scientific Affairs, said it was his "hunch" that doctors generally had not raised fees because of Medicare. "We are certainly concerned about the rising cost of medical care," he said. "But we don't have any substantial evidence to indicate this was done in anticipation of Medicare."

Most of those who think doctors have raised fees in anticipation of Medicare base much of their suspicion on the recent rapid rise in medical care costs. The costs of medical care for several years have been rising faster than most prices, but since the end of 1965 the increase has sharply accelerated.

Doctor fees rose by about 1.9 per cent in the first half of 1965 and by 1.8 per cent in the last half of the year, according to the Bureau of Labor Statistics. But the increase in the first three months this year was also 1.8 per cent.

This means the costs in the first quarter rose twice as fast as in 1965. Arnold Chase, assistant commissioner for prices, said indications are that the rate of increase was at least maintained in April and May.

Price authorities point out, however, that the overall cost of living has climbed sharply in recent months.

The Consumer Price Index rose by 2 per cent in the 12 months through December against 1.3 per cent the year before, and in the year through May it gained 2.7 per cent. Medical care services, which include doctor and hospital charges, rose by 4.4 per cent in the year through May.

The cost of medical care has risen by 25.3 per cent since the 1957-59 period. It has been outpaced only by the cost of automobile insurance, domestic help and local transit fares. Doctor fees have risen by 25.5 per cent, and the biggest increase in the entire economy has been the 60.8 per cent rise in daily hospital service charges.

The New York Times.

THE NEW YORK TIMES, SUNDAY, JULY 3, 1966.

Medicare

Toward Welfare State?

In January, 1935, Franklin Delano Roosevelt proposed to Congress his "Second New Deal"—a package going beyond the urgent needs of Depression relief to provide "security against the major hazards and vicissitudes of life." A major plank in the program was a new concept for social security through a Federally insured pension program (and there was also a start toward unemployment insurance).

Thus began a 30-year trend toward greater Federal responsibility for the citizen's welfare. Last week with the advent of Medicare to help pay the increasing cost of illness for the elderly —the biggest single enlargement of the Government's welfare role since 1936—the United States moved a step closer to the condition that has been called the welfare state.

In the three decades between Social Security and Medicare, these have been some of the major steps in the enlarged Government welfare role:

In 1937, the Housing Act initiated a Federal program to subsidize low-rent housing. Urban renewal and community development began with the Housing Acts of 1949 and 1954.

In 1938, the Fair Labor Standards Act set the first national minimum wage at 25 cents an hour.

In 1958, the National Defense Education Act provided loans for college students and funds to improve scientific education.

In 1960, the Kerr-Mills Bill allocated money for state programs of medical assistance for the needy aged.

In 1964, the Economic Opportunity Act launched the war on poverty.

And throughout these years, there has been a steady expansion of state relief and welfare programs, most of them with supplementary Federal funds.

The Medicare program has been a controversial measure for 10 years. But this time the specter of socialism was raised mainly by the more conservative elements in the medical profession as Medicare went through both Houses of Congress by large majorities. And there was little floor debate even on Title XIX which sets up separate programs—such as New York's much-celebrated Medicaid —providing for an enormous expansion of Federally-aided state payments of all medical bills for most members of needy families.

How It Works

"An auspicious start," declared U.S. Surgeon General William H. Stewart as Medicare officially went into operation last Friday—July 1. From around the country, hospitals—which had earlier feared they would be swamped with elderly patients—reported: "No rush." "Everything normal." "No problems." "Going smoothly."

At the same time, there was some concern over what seemed to be a lack of clear understanding of just what Medicare is—and is not —and how it affects those who are involved: the 19-million Americans over 65 who are automatically eligible for hospital benefits; the 17-million of these older citizens who have signed up for the voluntary program of medical coverage; the nation's 290,000 doctors; and the more than 7,100 hospitals around the country, 94 per cent of which are participating.

As the program is now set up, every American on reaching his 65th birthday automatically becomes eligible at no charge for Part A of Medicare—Part A insurance pays for all but the first $40 of ordinary hospital costs for a 60-day hospital stay, and all but $10 a day for the next 30 days. It is financed by a new 0.35 per cent Social Security tax which went into effect this year.

To be included in Part B—medical insurance—with a special designation on the red, white and blue Medicare card, the older citizen must agree to pay $3 a month (deducted from his Social Security check). The medical insurance covers 80 per cent of a doctor's "reasonable" fee beyond the first $50, regardless of where the treatment takes place. But it covers only genuine illness and not such things as check-ups.

Embattled Doctors

"Medicare will succeed," declared President Johnson on the eve of the program's start, "if doctors treat their patients with fairness and compassion as they have in the past." But just what is the fair and compassionate way to treat elderly patients covered by Medicare—particularly as regards collecting fees—was debated with considerable heat last week at the annual convention in Chicago of the American Medical Association's 238-member policy-making house of delegates. While the complexion of the house of delegates ranges from ultra-conservative to moderate, the body as a whole is believed to be more conservative than the rank-and-file members of the medical profession.

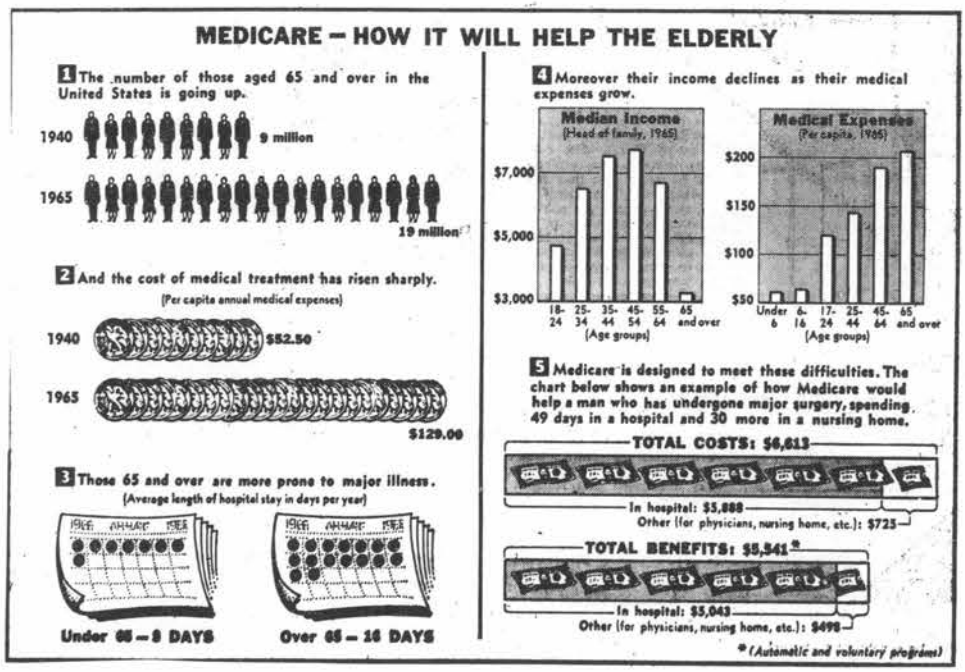
Under Medicare, doctors have a choice of two ways of collecting fees for patient care. They can bill the Medicare administration directly and be reimbursed on the basis of what Medicare considers a reasonable fee. Or they can bill the patient, and leave it up to him to collect from Medicare.

Moderates at the A.M.A. convention saw some merit in both billing methods, depending on circumstances. But conservatives demanded that all patients be billed directly.

Moreover the delegates selected by acclamation as president-elect —to take office a year from now —Dr. Milford O. Rouse of Dallas, an ultra-conservative politically and professionally and an outspoken opponent of Medicare.

At a news conference after his election, Dr. Rouse said that he would refuse to bill Medicare, and instead would bill his patients directly. If the patients "don't want to cooperate," he said, "I'll just tell them to go down the hall." Resolutions that came out of the convention tended to back the Rouse hard-line — although not without some confusing qualifications.

But around the country, particularly in poor neighborhoods, a lot of doctors are likely to find an increasing part of their practice covered both by patients under Medicare and by those—a much larger group potentially—who come under the Federal-state programs to give free medical aid to the needy. Many of the doctors may make more money than they ever have before by cooperating with the government agencies. And thus many many simply refuse to follow the lead of the A.M.A.



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Sedation for Disturbed Doctors

To nervous, paranoid doctors who had forecast a day of national calamity, we trust the news of what happened on the first day of Medicare will provide quick sedation.

According to the Associated Press, the nation's medical facilities had "easily absorbed" the initial impact of the new programs and, in many Southern cities, thousands of hospital areas were desegregated without incident.

There was no panic, no "rush," no upheaval of any significance.

The beginning was described as auspcious by U. S. Surgeon General Stewart This does not mean there will be no problems; New York City has recently received dramatic reminders of the wretched inadequacy of some of our hospital facilities. But that disease long preceded Medicare.

The central fact is that an historic new era in aid to the afflicted aged has begun without turmoil or disarray. Relax. Dr. AMA.

New York Times
July 3, 1966

MEDICARE — HOW IT WILL HELP THE ELDERLY

1 The number of those aged 65 and over in the United States is going up.



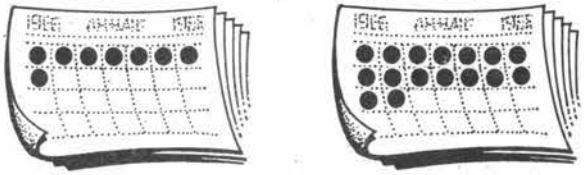
2 And the cost of medical treatment has risen sharply.

(Per capita annual medical expenses)



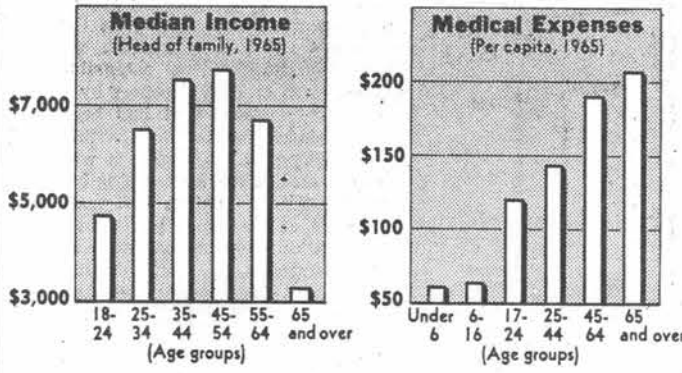
3 Those 65 and over are more prone to major illness.

(Average length of hospital stay in days per year)

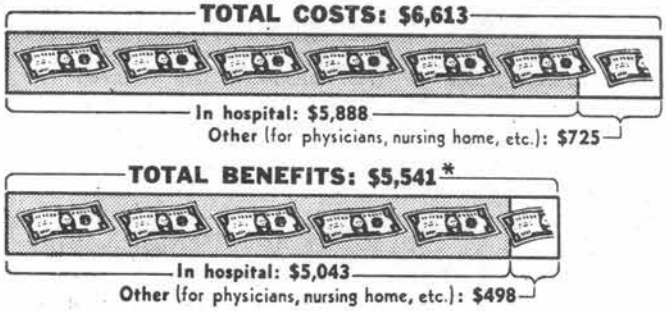


Under 65 — 8 DAYS **Over 65 — 16 DAYS**

4 Moreover their income declines as their medical expenses grow.



5 Medicare is designed to meet these difficulties. The chart below shows an example of how Medicare would help a man who has undergone major surgery, spending 49 days in a hospital and 30 more in a nursing home.



*(Automatic and voluntary programs)

The New York Times.

NEW YORK, SATURDAY, JULY 2, 1966.

Medicare Is Off to Smooth Start; No Overcrowding Is Reported

By HAROLD M. SCHMECK Jr.
Special to The New York Times

BALTIMORE, July 1—The Medicare program, affecting Americans over 65, got off to a smooth start today.

Some 160,000 patients already in hospitals from Guam to the East Coast and Puerto Rico automatically became Medicare patients eligible to have part of their hospital bill paid by the Government. Others were admitted during the day.

The program is the most sweeping extension of Social Security in 30 years.

As Medicare went into operation 94 per cent of all the nation's general hospitals were in compliance with the laws covering hospital standards and civil rights rules against discrimination. These hospitals contain 95.9 per cent of all hospital beds suitable for Medicare patients, Dr. William H. Stewart, surgeon general of the United States Public Health Service, said today.

He and Robert M. Ball, commissioner of Social Security, appeared at a news conference this afternoon at the Social Security headquarters here.

"We find that the program has started off very smoothly," said Mr. Ball. "There just is not any crowding or difficulty that can be attributed to Medicare."

The first list of Medicare hospital patients was received here shortly after 10 A.M. in a two-minute transmission over the agency's nationwide telecommunications network as the task of keeping the records of Medicare eligibility began.

The first data came from Blue Cross Association headquarters in Chicago. Heading the list of 150 names was Mrs. Lillian Grace Avery, 68 years old, of Naperville, Ill., a patient at Edward Hospital there since June 26. She was admitted for minor surgery.

Nine hours before Medicare went into effect in the continental United States six hospitalized eligible patients on Guam became the first to be covered. Their names and data have not yet been received at Social Security headquarters here.

In the continental United States the first new Medicare patient may have been Eugene Schneider, 65, an embroidery worker from West New York, N. J. He turned up at Polyclinic Hospital in New York at 12:01 A.M. today for eye treatment.

In addition to putting most of the nation's elderly hospital

Continued on Page 7, Column 1

patients on an insured basis, Medicare also had the effect of desegregating thousands of hospital beds in the South. Only Mississippi and Louisiana still have substantial percentages of their general hospitals ineligible for Medicare on civil rights grounds, Dr. Stewart said today.

The number of noncomplying hospitals has been dwindling for weeks under the pressure of the impending act.

"We hope—and have every confidence—that within a short time all hospitals will be in compliance," Dr. Stewart said.

6,600 Hospitals Apply

In Mississippi, only 23.6 per cent of hospitals are in compliance, Dr. Stewart said. The latest figure for Louisiana was 67.6 per cent.

As of noon today 6,600 hospitals had applied for participation and had been found to meet quality standards. But 327 of these have not been cleared on civil rights grounds, Mr. Ball said. An additional 100 hospitals that probably could have met quality standards did not choose to apply, often because of the requirements against discrimination, he said.

"The fact that some hundreds of hospitals in reply to Medicare requirements have now changed their practices and policies is particularly heartening," Dr. Stewart commented.

He said a referral center for emergency cases had been set up in his office at the National Institutes of Health in Bethesda, Md., to help make sure maximum service is available during the opening weeks of Medicare.

Advice for Doctors

This center will be a clearing house to advise doctors and patients who cannot find hospital space and are faced with a serious medical emergency. The center, with telephones to be manned 24 hours a day for the time being, will first advise the persons faced with the emergency that the patient can be taken to a hospital not eligible for Medicare if no eligible hospital is available. The name of the nearest one will be supplied.

If the patient is unable to get in he will be referred to the nearest available Federal Hospital. Dr. Stewart said the information can be obtained through the local Social Security or Public Health Service office, or, if necessary, by calling the center in Bethesda directly.

Virtually all Americans 65 and older are eligible to have part of their hospital bills paid under Medicare. More than 17 million have signed up for the voluntary program that covers part of their doctor bills too.

Alien residents of the United States covered by Social Security are also covered by Medicare. In addition those aliens not covered by Social Security, but who have been admitted for permanent residence and have lived in this country for five years or more, are also eligible.



The New York Times (by Meyer Liebowitz)

EARLY ARRIVALS: First to check in at Mount Sinai Hospital under Medicare program were Mrs. Pauline Kaufman and Joseph Lindenberg. Miss Betty Kearney, admissions clerk, signs them in. They are two of 21 patients who sought admission under new plan.

Few Seek Hospital Aid Here as Medicare Starts

By MARTIN TOLCHIN

An unexpectedly light turnout of elderly patients surprised hospital administrators here yesterday, when Medicare went into effect.

The small showing was attributed to both the balmy weather and the holiday weekend, which some prospective patients and their physicians apparently planned to enjoy outside the hospitals.

"No one wants to go to the hospital for the weekend unless it's an emergency," Dr. E. Hugh Luckey, president of the New York Hospital-Cornell Medical Center, said. The 1,225-bed institution admitted only two new patients covered by Medicare.

Only five Medicare patients were admitted to the 1,600-bed Columbia Presbyterian Medical Center; two were admitted to St. Vincent's Hospital, which has 1,000 beds; three were admitted to the 650-bed University Hospital, and one patient was admitted to Manhattan Eye, Ear and Throat Hospital, which has 170 beds and specializes in surgery to remove cataracts of the elderly.

Mt. Sinai Admits 21

However, 21 Medicare patients were admitted to the 1,200-bed Mt. Sinai Hospital, which had conducted a vigorous neighborhood campaign informing older persons that they would be welcome at the institution. The number of overall admissions at Mt. Sinai was normal for the day.

Few new elderly patients registered in hospital clinics throughout the city. At Mt. Sinai Hospital, only one new elderly patient attended a clinic. At Columbia Presbyterian Medical Center, eight new elderly patients visited the clinics, including several who were healthy. A spokesman for the institution explained:

"Some patients thought you had to register at hospitals if you wanted to be treated if you got sick later."

Admissions Postponed

Most of the new inpatients had postponed their admissions to be covered by Medicare. Mrs. Carolyn Marshall, an 80-year-old widow, estimated that she had saved $600 in hospital and doctor bills by postponing elective surgery for 10 days.

"I've never been sick in all these years," said Mrs. Marshall, a short, spunky woman with piercing blue eyes who arrived at the hospital wearing a colorful print dress and a brown feathered hat.

"I hope we'll make you better," Sister Margaret Marcedes, the admitting clerk, said. "Do you still have Blue Cross?"

"Yes," Mrs. Marshall replied.

"Will you be able to pay the first $40 [not covered by Medicare]?"

"Yes," Mrs. Marshall said.

Sister Margaret assigned the patient a two-bed room, placed a plastic identification bracelet around her wrist, and said: "God bless you."

Meanwhile, hospital administrators sought to transfer to the Medicare rolls those patients over 65—approximately 20 per cent of the hospital population. This was characterized as an "administrative furor" by a spokesman for Montefiore, where 283 patients over 65 are being transferred to Medicare rolls.

The first patient admitted to a local hospital was Eugene Schneider, 65, of West New York, N. J. At 12:01 A.M., he was admitted as an emergency patient to Polyclinic Hospital. Mr. Schneider suffered a detached retina, and is scheduled to undergo surgery this weekend. He was the hospital's only patient 65 or older who was admitted yesterday.

The Low Level of Admissions Is Attributed in Part to Holiday Weekend

The low admission rate of elderly persons to hospitals drew a sharp comment yesterday from Zalmen J. Lichtenstein, director of the Senior Citizens Golden Ring Council. The council organized a 19-block march of 125 persons — aged 65 to 90 — to Mt. Sinai from their headquarters yesterday without a single dropout.

New Staffs on Job

"We came here to give the lie to all these people who fought against Medicare," he said, "saying just wait and see how the old people flood the hospitals. Those liars got their lesson today."

Hospital administrators said that they were far less concerned with Medicare than with the fact that yesterday was the first day for a new staff of interns and residents. The staff appointments in hospitals across the nation traditionally begin July 1.

The News American
BALTIMORE MARYLAND

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Winner of the 1965 Albert Lasker Medical Journalism Award and the 1965 American Medical Association Award for distinguished reporting in the medical field.

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4C ★ Friday, July 1, 1966

RABBI SAMUEL ROSENBLATT

Medicare's Next Giant Step

The Medicare bill passed by Congress last year against the determined opposition of the majority of the organized members of the medical profession in our country went into effect today.


ROSENBLATT

At a nominal cost, deductible from Social Security payments, it provides for hospital and medical services to millions of the elderly members of our population who find themselves unable, at an age when their earning capacity has dwindled, to meet the mounting costs of hospitalization and medical treatment for which they have greater need as they grow older.

Whatever advantages private insurance agencies, like Blue Cross and Blue Shield, may offer—and they are considerable—only a minority of our citizens over 65 are covered by them.

MEDICARE, on the other hand, extends such benefits to everybody, including the indigent who could not afford to pay the premiums for health insurance, and the improvident who out of sheer lack of foresight, failed, when they were in a position to do so, to take such precautions against the inevitable debilities of old age.

Yes, as formulated by its authors and sponsors and spelled out in the Medicare Handbook, issued by the Department of Health, Education and Welfare under the imprimature of Robert M. Ball, commissioner of Social Security, Medicare is unquestionably one of the most marvellous bits of social legislation in the history of the human race.

It is the finest answer any government could give to such prayers as, "Do not forsake us at time of our old age. When our strength fails us, do not cast us off."

HOWEVER, as in the case of other laws on the statute-books, all the good intentions of the Medicare bill would be meaningless unless they are implemented. And in order that its provisions may be carried out, there is need not only of a sufficient number of hospital beds, clinics, and dispensaries. There are required also physicians and psychiatrists for diagnosis, surgeons to perform the necessary operations, and nurses to care for the patients and administer the prescribed therapies.

Unfortunately, long before Medicare was even thought of, there was a shortage in many sections of our country, especially in the rural areas, of competent medical practitioners.

As for trained nurses, they have, even in our large cities, become so hard to obtain that there are public health institutions that are run most inefficiently for want of adequate personnel. Only God knows how many lives that could be saved are lost because of lack of attention at a moment when a timely hypodermic might have made the difference between life and death.

Under such conditions, the prospects of success for Medicare are none too bright. What a wonderful opportunity for the opponents of Medicare to laugh up their sleeves and say, "We told you so!"

HOWEVER, no one whose heart is truly wrung by the plight of the aged — and their proportion is increasing — who are unable to get relief from their aches and pains, would take such an attitude. Rather would he bend every effort to have the situation remedied by providing facilities for increasing the number of physicians graduated annually by our medical schools and by making the nursing profession more attractive then it is now as the means of a livelihood.

It would be a tremendous pity, indeed, if, after the visions of physical comfort conjured up by Medicare for those who were blessed by the Master of Fate with length of years, these hopes were to be blasted by nothing more than failure to secure the personnel necessary to make this vision a reality.

The News American
BALTIMORE MARYLAND

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Court Demand

REP. CARLTON R. SICKLES has taken a decisive step toward streamlining Federal Court machinery in Maryland by introducing legislation authorizing the court to sit in Hyattsville.

If approved, the measure could significantly speed federal justice throughout the central part of the state by relieving the judicial burden now on the court in Baltimore. The proposed branch would syphon from the docket here the majority of cases involving residents of Montgomery and Prince Georges counties, which account for 27 percent of the state's population.

The court's other branches—in Cumberland in the west and in Denton on the Eastern Shore—are unable to accommodate conveniently Maryland residents of the Washington suburbs.

In addition to its obvious immediate advantages, Sickles' proposal would become progressively more beneficial to the state's' legal complex due to the rapid growth foreseen for the Washington suburbs in both Montgomery and Prince Georges counties.

The News American hopes the Judicial Council, composed of Court of Appeals judges in the Fourth Circuit, gives the measure its undivided endorsement to grease its passage through Congress. If so, it would be a case of the judiciary reinforcing statutory law by invoking a business law—the law of supply and demand.

Medicare

~~MEDICARE~~, which became effective yesterday, will deeply affect the lives and happiness of millions of older Americans and their families.

Few issues in domestic politics aroused such controversy as Medicare during its tortuous path through the Congress. The lines for and against it, moreover, still exist both inside and outside the medical profession.

Similar uproar, some of us remember, accompanied the first Social Security legislation, of which Medicare is now an extension. But it all calmed down, and those first laws became an accepted and important part of American life.

Now Medicare is the law of the land, too. And it can be confidently expressed that the overwhelming majority of persons, again inside and outside the medical profession, will abide by it and take full advantage of it, and will not try to circumvent this law in any way. All efforts, instead, should be directed toward helping Medicare achieve its end — that of easing the financial burden of being ill.

DAILY TIMES - SALISBURY, MD.
July 1, 1966

81 Patients In PGH Eligible For Medicare

Eighty-one patients in Peninsula General Hospital, Salisbury, automatically became eligible for Medicare assistance payments at the stroke of midnight.

Forrest C. Thompson, administrator for the hospital, said the hospital population last night was 325, not counting new - born. Mr. Thompson said one fourth of the patient load at Peninsula General for the past several years has been patients over 65.

Continued From Page One

PATIENTS

These 81 patients who qualify for the new government program will all have to be discharged on paper as regular hospital patients, and readmitted as Medicare patients. Their coverage on various of forms of aid, such as Blue Cross, state aid, and commercial insurance, will have to be changed to Medicare, and the hospital administration will have to collect from these patients the $40 required from each under the new system as the initial payment to the hospital.

THE EVENING SUN

BALTIMORE, SATURDAY, JULY 2, 1966

No Ailments, She Requests Medicare

Dallas, July 2 (AP)—Cautiously the woman stepped into Parkland Hospital's emergency room yesterday and handed a nurse her Medicare card.

"Where are you hurting?" asked the nurse.

"No place—I just thought I was supposed to report out here today," replied the visitor.

The nurse suggested she come back later, but only in case of illness.

Medicare Fails To Cause Rush Of Applicants

[By the Associated Press]

Down the corridors of Miami's Jackson Memorial Hospital figures in white passed each other with a cheerful greeting: "Happy Medicare!"

For the nation's hospitals yesterday was indeed Happy Medicare—the first day of the Social Security hospital program for persons 65 years and older had gone smoother than anyone had dared hope.

Still, there were problems: mountains of paper work, missing forms, bewildered patients, lost Medicare cards, and one woman who got mad and swung her purse at a hospital worker.

Quiet By Midafternoon

By midafternoon in the usually frantic emergency room at Jackson Memorial interns sat with their feet propped on a table.

"It's the quietest day we've had," said Dr. James Connaughton, who joined the Miami hospital last month after graduation from the University of Indiana.

The situation was virtually the same in hospital after hospital across the United States. Fear expressed by some that medical facilities would be swamped by elderly people evaporated as the day wore on like any other before a Fourth of July holiday.

Seattle Hospital Admits None

Northwest Hospital in Seattle, the first in the nation to be certified for Medicare, admitted not a single Medicare patient. Six elderly patients already in the hospital, however, were automatically switched over to Medicare at its start, 12.01 A.M. yesterday.

"Heaven help us when Tuesday comes," said Alfred E. Riley,

[Continued, Page 3, Column 1]

business manager of St. Elizabeth's Hospital in Chicago. Riley said he looks for a big inflow of patients then because of the people who wanted to be home for the holiday or delayed entry because so many doctors would be away for the weekend.

At 9 A.M. on the first day Anna Winston, 71, of New York city, showed up in the emergency room at mammoth Mount Sinai Hospital complaining of "aches and pains." Within an hour she became one of the hospital's nineteen first-day Medicare admissions.

Opinion Of Program

"I knew I'd wind up in the hospital because I was very sick," Mrs. Winston said. "I should have been here a month ago, but I couldn't get into this or any other place."

Asked her opinion of the new program, she said:

"I feel very strong about Medicare. This is a very, very rich country—why shouldn't we have it? And why shouldn't it work?"

The biggest problem faced by the hospitals is the increased load of paper work. Mount Sinai added 41 clerks just to handle all the new forms and extra bookkeeping. Other hospitals are also taking on new help.

No Sleep In 3 Days

At St. Joseph's Infirmary in Atlanta, business manager David Messinger recalled that he had spent twenty years in the Air Force as a medical budget officer. He shuffled the forms piled high on his desk and said, "I'm right back home again. I haven't had much sleep in three days. I can't sleep any more, trying to figure out what to do about Medicare."

Most frightening to him is the requirement for itemized billing for laboratory tests. There are 223 lab tests listed by the hospital, and special billing forms are required—and at least two sets must be filled out for Medicare.

By the end of the first day at Massachusetts General, the hospital had 941 patients, of whom 260 were over 65 years. During the day the hospital admitted 67 new patients, 18 of them under Medicare. Eight of the Medicare patients entered the hospital after 5 P.M.

"Hectic Night"

"The newness of it all gave us a hectic night," said John Stella, night admitting officer.

Most frightening to him is the requirement for itemized billing for laboratory tests. There are 223 lab tests listed by the hospital, and special billing forms are required—and at least two sets must be filled out for Medicare.

An information desk was set up on the main floor at Detroit's Henry Ford Hospital, where more than 200 elderly persons came with questions about the program.

One elderly woman insisted a girl behind the counter was wrong when she explained that Medicare doesn't cover all expenses. "You're trying to line your pockets with my Medicare money," the woman shouted, and swung her purse at the girl.

Stomps Out

The girl ducked and the blow glanced off her hairdo. She retreated into a nearby office and the woman stomped out.

"They're generally surprised to learn that everything isn't paid for," said Miss Thelma Cogswell, clinics admitting officer at Massachusetts General Hospital in Boston.

Paper Virginian - Tennessean

Place Bristol, Va.

Date 7/1/66

Bristol Doctors May Leave Bookwork To Patients

Medicare Paperwork Battle Begins Today

Doctors and medical facilities in the Twin City are "ready" for the advent of the federal government's Medicare program today.

The program of old age medical security for our country's 19 million older Americans is predicted to have a smooth start here and across the land.

Woodrow Fanning, Bristol Memorial Hospital Administrator, said he "doesn't expect a big rush of elderly patients."

However, if there is a rush, "we are ready," he said.

Doctors in Bristol express few fears for the initiation of the program.

Originally they said, there were fears of hospital facilities being swamped by elderly patients as soon as the "free" program began.

Kenneth Williamson, Washington Director of the American Hospital Association, said the idea "was plain silly."

"There will be some abuse to the program," said Bristol Doctor Bernard Grigsby, "and there will be some problems arising later."

★ See Related Story On Page 16 ★

But, he added, the program will not be too difficult to put into operation.

Another Bristol doctor pointed out that the senior citizens still have to pay the first $50 of medical expenses.

"That," he said, "will hinder any large-scale abuse of the program."

One of the biggest complaints expressed by area doctors is the amount of the paper work necessary to carry out the program.

Doctors have two choices concerning how to administer the financial end of the program.

By handling the paper work themselves, they insure that they will get their money as soon as it can be approved.

This involves precise records and accounts of illnesses to be prepared and presented to the insurance firms which are administering the program for the federal government.

To eliminate this bookwork, doctors say, they could leave the responsibility to the patients.

The patients would have to keep the records and then submit them to the insurance firms and be reimbursed or get the money to pay their bills.

The American Medical Association's policy-making house of delegates staged a floor rebellion at Chicago Wednesday and strongly urged the nation's doctors to bill all their Medicare patients directly.

Under the newly spelled out AMA policy, doctors will leave it up to their elderly patients to collect health insurance benefits from Medicare.

Representatives of 200,000 doctors, shouting approval of resolutions which study committees had recommended be killed, called on physicians to have nothing to do with forms that provide for payments to doctors by government-designated insurance firms.

The AMA advisory committee on Medicare simultaneously reported it was "disturbed" at the submission of a new government regulation just six days before the advent of the Social Security-financed program of medical care for the aged.



"Well, Doc, I see you've got your office all set for the Medicare program!"

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HEALTH, EDUCATION, AND WELFARE
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MEDICARE 'A GODSEND TO MANY'

Mrs. Ann M. McCaffrey of Hampton, left, was one of 76 patients already in three Newport News hospitals who became eligible for medicare coverage when the program became effective Friday. Although she was admitted to Mary Immaculate a month earlier, she had arrived with her card in her wallet, ready to make the transfer at the earliest moment. Scanning the card is Sister Marie Ignace, in charge of the admitting office, who changed the registrations for 19 patients and admitted two more under the program.

HOSPITALS ENROLL THOSE ALREADY UNDER CARE

No Rush For Medicare Services

By JEAN HOLT

There was no indication of a rush on the part of elderly Peninsulars to take advantage of the Social Security Administration's medicare provisions when the program became operative Friday.

As the hands of clocks crawled past midnight into the early moments of July 1 the three general hospitals in Newport News had a combined total of 76 patients who were immediately eligible for medicare.

As Friday afternoon waned the number had risen to 81.

At Riverside Hospital, where only one medicare patient had been admitted through the day, associate administrator John N. Simpson predicted: "We won't feel the impact until after the Fourth of July holiday."

"Things have been very quiet," was the comment of Dr. E. Stanley Grannum, administrator at Whittaker Memorial where one medicare patient arrived in the morning and another in the afternoon.

"I know some people have been waiting for this," said Sister Edwinalda, administrator at Mary Immaculate, "but there has been no rush. I imagine some are deferring coming in until after the weekend."

As she spoke the day had brought one patient who qualified for medicare, but almost immediately the phone rang in the admitting office, to be answered by Sister Marie Ignace whose part of the conversation consisted mainly of the phrase "yes, certainly."

As she cradled the receiver she said, "That was a doctor asking if we had accommodation for an 83 - year - old male medicare patient. He'll be here shortly."

Eligible patients in Riverside when the program became effective numbered 46. There were 11 in the same category in Whittaker Memorial and 19 in Mary Immaculate.

One of those already in the latter hospital was Mrs. Ann M. McCaffrey of 204 East Taylor Ave. in Hampton, a retired postal clerk who gave her age as "72 in October" but whose merry manner and obvious zest for living belied the years.

Even though she was in traction with movement severely restricted to allow a ruptured spinal disc an opportunity to mend, Mrs. McCaffrey was cheerful — and enthusiastic about medicare.

"I'm still a little confused

See No Rush, Page 10, Col. 5

Daily Press
Newport News,
Va.
July 2, 1966

• No Rush

Continued From Page Three

about the plan's relationship to my United Postal Insurance," she said, "but think its wonderful — especially for those old people who had nothing and no insurance at all. For many people, medicare is a godsend."

She said she had signed up quite early, as soon as she received a form indicating she was eligible for medicare despite the insurance she had obtained as a postal worker. She was one of those who did not debate about obtaining the supplementary medical insurance which broadens the coverage.

Retired Clerk

A resident of Hampton for the past 38 years, Mrs. McCaffrey was a clerk in the Hampton Post Office for 20 years, retiring in March, 1963.

She was admitted to Mary Immaculate a month before medicare went into effect and, on one occasion, talked her doctor into allowing her to go home—but was back next day.

"This time," she laughed, "I'm going to follow my doctor's advice. I'm not sure how long I'll be here, but it will be until my doctor says I'm well enough to go home."

She described herself as a woman interested in a multitude of things — "still active in club work, just out of office" — who retired from the presidencies of both the Phoebus Womans Club and the Peninsula Deanery of the Council of Catholic Women not long ago.

"Whenever she's in the hospital and not strictly confined to bed," commented Sister Rosamnud, business manager, "we're apt to find her in the office, working away as a volunteer."

More Office Help

Sister Rosamund foresaw one change medicare was apt to bring in the very near future in the hospital's operation. She predicted it would be necessary to obtain more office help to handle the increased work admittance and billing procedures will entail.

"But," said Sister Edwinalda, "we're happy with the plan. Its good for the senior citizens. For some it will mean they will have the help and care they needed but couldn't afford otherwise."

SATURDAY EVENING
JULY 2, 1966

WILKES-BARRE
TIMES LEADER
THE EVENING NEWS

JOHN A. HOURIGAN, JR., Vice President-Secretary
JOHN J. McSWEENEY, Editor

WEEKLY FOUNDED 1810
DAILY FOUNDED 1879

SATURDAY, JULY 2, 1966

HARRISON H. SMITH, President
JOSEPH T. MURPHY, Managing Editor

Medicare Adds To July's Milestones

July is an important month in American life. Our country was born on Independence Day. The Wyoming Massacre occurred in July. The decisive battle of the Civil War was fought at Gettysburg. The month lists memorable dates in other conflicts. For business and government, it inaugurates another fiscal year. And it has other significance.

Now Medicare is added to the list. This is a milestone also in American life, although similar programs are in effect elsewhere in the world, notably Britain and Sweden.

It is not surprising there should be some confusion and uncertainty because it is as complicated as it is revolutionary. It will require a lot of effort to make it work, so let us have no abuses. It will be difficult enough to apply even with the best of intentions.

The Pittsburgh Press

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. . . And A Member of the Family

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Doctors' Medicare Bills

IT already is apparent, at the American Medical Assn. (AMA) convention in Chicago, that many of the doctors hope to shed some of the paperwork involved in Medicare by billing patients directly.

This would mean the patient would have to fork over the whole of the bill and then seek reimbursement from Medicare.

For patients who really are poor, this could work a genuine hardship. If the doctor's fee was of any size, full payment by the patient, even if prompt reimbursement were promised, might be impossible.

Under the law, the doctors have a choice. For instance, on a $300 fee (usual for a major operation) the patient in any event would have to pay the first $50 plus 20 per cent of the balance, or a total of $100. Digging up the whole $300 might be rough.

In his swansong as retiring president of the AMA, Dr. James Z. Appel told the delegates their first concern, as always, must be with the patient, regardless of what they think about Medicare. He said any other policy would "invite hostility" from most people—and so it would.

Extra paperwork, admittedly, would be burdensome to a busy doctor. But it also is burdensome to the patient, especially the elderly of scanty resources.

Patients who can afford to pay a total fee and wait for reimbursement from the Government properly could be asked to do this; but the doctors will be making a great mistake if they insist on such a system for those who can't readily manage it.

Paper PHILA. INQUIRER (DAILY)

Place PHILA. PA

Date 7-1-66

Medicare and the Patient

Arrival of the July 1 opening date for the Federal health insurance program, popularly known as Medicare, is marked by a mixture of hope and anxiety.

Much has been said about problems confronting the hospitals, doctors, the nurses, the nursing homes and the vast army of administrative personnel who will operate the health insurance system.

They have serious problems, no doubt about it. But how about the patients—the men and women of 65 or over who are to be the beneficiaries of Medicare? The more elderly among them are likely to be confused about such things as $40 and $50 deductible clauses and the computing of 80 percent of the post-deductible portion of doctor bills to be paid by the Government.

Let's face up to it: Medicare is not a simple program, Government claims to the contrary notwithstanding. It is an extremely complex program. Patients eligible for benefits are going to need all the help they can get.

Where is the help to come from? Who is to advise them? Often it will be children or other relatives. Frequently it will need to be representatives of welfare organizations or civic groups. In almost every case, though, a prime responsibility for providing help and counsel will rest with the physician.

It is the physician who will send the patient to a hospital or nursing home. It is the physician who will prescribe nursing care or other medical services. It is the physician who will set his fees and determine the method of billing. In all of these instances the patient is going to be dependent upon the doctor to explain who pays what bill and who fills out what form.

The medical profession is dedicated to the proposition that physician-patient relationships are a sacred trust to be protected and preserved. Never before have these relationships assumed so enormous importance for the patient. We urge every doctor to give compassionate attention to the problems of Medicare as they apply specifically to the patient and the patient's point of view.

Medicare's First Day

HOSPITALS throughout the United States, and there are thousands of them catering to the sick and injured, today, July 1, enter upon a new career, one that the federal government has fretted and fumed about for several years past, and so today the aged folks, those over 65, become patients under Medicare.

Beginning today, all persons over 65 are entitled annually to 100 free visits at home by nurses, physical therapists and other health care workers. Another hundred visits will be available to the more than 17 million aged who bought supplementary medical coverage at $3 monthly for husband and wife each, this sum being deducted from Social Security checks due after this month.

The Medicare system is expected to move into operation without too much trouble. Hospital, home health care and many benefits begin July 1 but after six months the real worry is expected. Whether crowded hospitals or nursing homes can handle the expected load is problematical and won't be ascertained until Jan. 1. Patients, to get medical care, must first spend three days in a hospital and this is cause for concern.

As the government and the medical profession seek to discharge their duties to older people under the Medicare law, everyone should be reminded again and again that there is no such thing as a "free" service. Nothing in this world is free and nothing new has been created under Medicare. By law, the taxpayers are paying some of the medical bills of a selected group of people. As time goes on, the law may be revised to include the care of other age groups. Medicare may eventually be extended until it becomes a national health service.

The medical profession in the United States is going to do everything possible to facilitate the operation of Medicare. It will do its utmost to preserve the all-important, doctor-patient relationship that is so vital to the high medical standards to which we have become accustomed. It is the obligation of the people, all of us, to remember that Medicare does not mean "free" medical care. The more that is demanded in the way of service from hospitals and doctors, the more it is going to cost.

Pittsburgh Press Editorial
Pittsburgh, Pennsylvania
July 3, 1966

'WOULD AN ASPIRIN MAKE IT GO AWAY?'



Not Good Business

Whatever else we may think of our physicians these days, we can't accuse them of being very good businessmen. At least not if we are to judge the profession by the action of its House of Delegates at a convention of the American Medical Assn. the other day out in Chicago.

Rebelling against a committee recommendation, delegates voted to instruct all AMA members to bill patients directly under the government's new Medicare program that went into effect on Friday. The AMA group recommended that doctors should not cope with government forms and the like in order to collect their fees.

The procedure would work this way, as we understand it: A man or woman over 65 falls ill and secures treatment from a physician that is covered by the government's new medical insurance. The doctor sends his bill; the patient pays the bill and, then, the patient is supposed to seek reimbursement in whole or in part from the government. That's the way doctors figure it will work and nothing could sound simpler, but we suspect that the AMA delegates should have sought the advice of those of the members of their profession who specialize in human behavior.

The way it appears to us, what is likely to happen may be something like this: The doctor sends his bill and, then, he waits until the patient secures the money from the government before the bill is paid. That's an optimistic appraisal, too. We can foresee even less favorable results.

Let's take, for example, the case of an elderly patient who runs up a doctor bill of maybe $500. Perhaps he never saw that much money in one lump in all his life. So the doctor sends his bill to the patient, the patient passes the bill along to the government and, in due time, he r e c e i v e s in his own name, not in the name of the doctor, a check for $500. Great will be the temptation, indeed, to spend the $500 for other purposes instead of paying the doctor. Of course, the doctor can sue. But even a doctor should know the wisdom of that old proverb: "You can't get blood out of a turnip."

Reading, Pa
Eagle

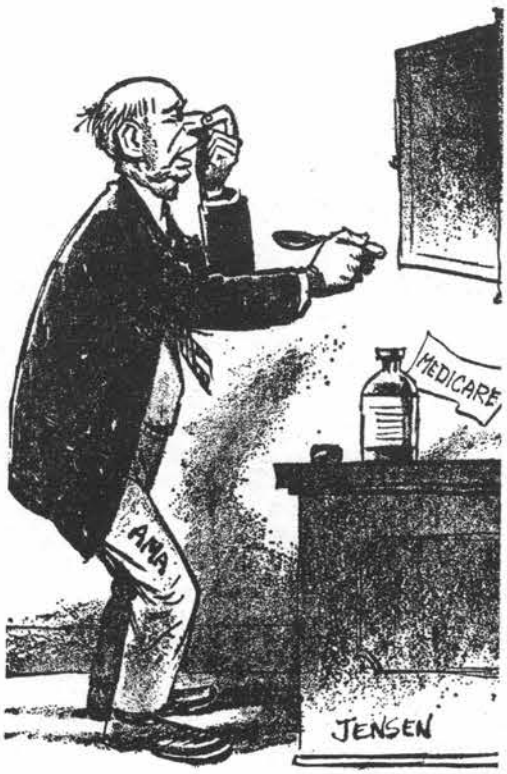
Pittsburgh Press Editorial
Pittsburgh, Pennsylvania
July 1, 1966

Come Again, Richard?

RICHARD M. NIXON says, "When I get sick I want a doctor who is working for me, not the Federal government."

This is major political news: Apparently Richard has given up any hope of becoming President—a job in which one fringe benefit is being cared for by Government medics.

DOWN THE HATCH



—From The Chicago Daily News

PHILA. INQUIRER
PHILA, N/E
JULY 3, 1966

Red Tape for Patients

AMA Shifts the Load In Medicare Billing

By Gary Brooten
Of The Inquirer Staff

CHICAGO.

THE meeting of American Medical Association policy-makers here last week was partly an exercise in hopeless frustration. Tempers flared and debate niggled, to the point that an exasperated California doctor took the floor and exploded, "There's been a hell's hatful of I-dotting and T-crossing, and gentlemen, if we can't do better we should go home."

Yet the haggling over words and phrases was a logical outgrowth of the dilemma faced by the AMA house of delegates.

It was not that "the psychophysiologic effects" of a lack of air conditioning in many hotel rooms here — a factor called to the house's attention by one perspiring delegate — had unsettled the nerves of too many delegates.

It was not even that the delegates shared the worry of a few that any opportunity lost to heckle the enemies of "free medicine" would be interpreted by the newspapers as a softening AMA backbone.

The real shadow over the session was Medicare — the law that doctors, in retiring AMA president James Z. Appel's words, thought "unnecessary, unwarranted and not in the public good," and the law that delegates knew would take effect for 19 million older Americans and 300,000 doctors on Friday, no matter what action they took before adjourning Thursday.

Shift Red Tape

Unable to alter the basic fact, the doctors lashed out at every available target — including, at times, the AMA leaders who have restrained their sometimes unruly organization in an effort to protect its 200,000 physician-members from the hazards of possible Federal antitrust action.

Militants in the house and physicians testifying at open hearings vented most—though not all — of their unhappiness with Medicare on a single issue: The method by which payment is to be collected under Medicare Part B, the voluntary $3-a-month "doctor bill" supplement to Medicare's basic hospital plan.

After acceding to AMA trustees' pleas for the necessary moderating phrases, the delegates got tough and made it crystal clear that they felt it would be best if doctors shifted the red tape of Part B onto its elderly beneficiaries.

This is possible under a provision of the Medicare law permitting the physician to bill his patients directly under Part B, leaving it up to them to collect their benefits from the Government's Medicare intermediary.

delegates curtly rejected a portion of a committee report which would have placed them in the position, in effect, of reminding themselves that their previous strictures against interference in the doctor-patient relationship applied to the AMA house of delegates as well as to the Federal Government.

Stress 6 Points

What they did do was this:

—They urged "direct billing" as the method of choice (a physician phrase for method to be used in the usual case) for collecting fees under Medicare Part B.

—They affirmed a doctrine of "individual responsibility which rejected the notion that anyone but their patients was responsibile for payment of their fees.

—They qualified these statements by stating that it is ethical for a doctor to agree to exceptions. In other words, if a patient wants the doctor to collect his fee directly from a third party, even the Medicare intermediary, and if the doctor is willing, it's OK.

—They instructed AMA leaders, and urged local and State medical societies, to work for laws and regulations that would permit "direct billing" under welfare medical programs, especially those under so-called Title 19 of the 1965 Medicare act.

—They reasserted their belief that hospital specialists in pathology, radiology, physical medicine and anesthesiology also should bill their patients directly, though nearly all have been reimbursed from hospital bills in the past.

—They made it "unethical" for such a specialist to step in after a hospital dismisses a colleague who wants to bill patients directly.

Chink in Guard

This last measure could be a chink in the AMA's guard against a risk of antitrust action, since a matter of ethics has legal consequences for doctors in practice. The measure was opposed by AMA leaders on grounds it might expose the AMA to such action.

Almost certainly, it will weaken hospitals' bargaining position with these specialists. Almost certainly, it will bring to many patients double bills for X rays, laboratory tests, and other hospital services supervised by the specialists—one bill from the hospital, another from the doctor.

This proliferation of paper work applies to all patients in hospitals. In the case of Medicare Part B, it is conceivable — on the basis of action here last week — that many of them will have to pay their own bills under Medicare who did not have to do so previously under private insurance plans.

Warning Issued

The other aspect of the "direct billing" controversy was not even touched by the house, although it was the subject of a warning by Dr. Appel in his retirement address.

This aspect is that under direct billing — as opposed to the alternative "assignment" method of billing Medicare for 80 percent and the patient for 20 percent — the physician retains complete freedom to set any fee he chooses.

Thus many finacially better-off Medicare Part B patients could end up paying a much higher fee for doctors' care than they expected, since they will be able to collect only 80 percent of what the intermediary determines is a "reasonable" fee.

Dr. Appel warned the doctors directly not to raise their fees suddenly as Medicare goes into effect. Dr. Hudson, in a press conference, noted that doctors could "bring the house down" on themselves if they do charge more.

How many doctors will crawl through this loophole and continue their traditional "soak the rich" fee policies remains to be seen. If many do, it will profoundly influence the political climate when Congress comes back into session after the 1966 elections.

22 F
The Evening Bulletin
PHILADELPHIA
Friday, July 1, 1966

Johnson Sees Medicare as U. S. Blessing

Washington, July 1— (AP)— The Medicare program providing hospital insurance for all 19 million of the nation's senior citizens went into effect today, hailed by President Johnson as "a blessing for older Americans."

Swinging into operation with the program was an optional doctor-bill insurance plan for which 17.3 million elected to pay $3 a month.

The two programs were brought into being at 12.01 A.M. in one of the biggest operations in medical history.

Doctors and patients reserved any prognosis, but the President was optimistic. In a statement here, he called it "a test of our willingness to work together."

By Public Health Service count, 6,714 institutions— or 91 percent of all the country's 7,374 general hospitals with roughly 93 percent of the beds—opened their doors for the insured care of any American aged 65 or over.

Exceptions In South

The nonparticipating hospitals were mainly in the South. Most were barred from Medicare payments by their failure to comply with the no-racial-discrimination provisions of the Civil Rights Act.

To make extra sure that no one dies for want of access to a participating hospital, the Government ruled last night that federal hospitals—veterans; military and others—may be used for critically ill Medicare patients in emergencies.

Previously it had been announced that any other nonparticipating hospital could be used—private or public, with Medicare picking up the bill—if a bed in a participating hospital could not be found to avert the threat of death "or serious impairment" of the health.

U. S. Officials Happy

Despite the serious gaps in participation — only 25 percent of Mississipi hospitals were in the pool—administration aides were jubilant over the generally high participation nationwide.

"We've done far better in the South than we had dared to hope a month or two ago," one Public Health Service official said.

"And more hospitals will be desegregating when they begin to feel the pressure from unhappy local residents, both white and black," he added.

Twenty-three states entered Medicare with 100 percent participation by their qualified hospitals, and some others came close to that.

Johnson Sees 'Ifs'

In his statement last night, the President said he had no doubt of the success of the twin Medicare programs if these three things happen:

"—If hospitals accept their responsibility under the law not to discriminat against any patient because of race."

"—If doctors treat their patients with fairness and compassion. I feel sure that most doctors do not plan to drive hard bargains with needy patients."

—"If old patients cooperate in scheduling treatment and do not demand unnecessary hospital and medical services . . ."



UPI Telephoto

MEDICARE identification card for 19 million Americans over the age of 65 is red, white and blue.

Private Hospitals Joining Medicare

New York, July 1—(AP)— The Federation of American Hospitals, which represents private, profit-making hospitals, announced today its 114 members hospitals throughout the nation will join the Medicare program.

I. Leon Goodman, executive director of the organization, said member hospitals agreed to sign participating contracts after receiving federal assurance that a formula could be worked out for reimbursement.

Last week, in a letter to Secretary of Health, Education and Welfare John W. Gardner, Goodman said the members were reluctant to join Medicare because present regulations "did not recognize the need of proprietary hospitals for allowances to meet capital costs."

He concluded: "I have no doubt for the future. I believe that July 1, 1966, marks a new day of freedom for our people."

Swamping Forecast

The Government has poohpoohed forecasts that a tide of elderly patients will swamp the hospitals.

Hospital administrators generally agree that there will be some difficult local situations but that they can handle the expected average increase of not more than 5 percent in the patient load.

This judgment was reinforced as each recent day brought scores of new hospitals into compliance. Officials expect that many more will meet both the medical care standards and the civil rights test during July.

Two Medicare Benefits

Medicare provides two types of coverage.

One is the basic hospitalization program.

This is free to almost all persons over 65.

It provides up to 60 days of hospital care, with the patient paying the first $40. It also provides an additional 30 days at a cost to the patient of $10 a day.

It also calls for outpatient diagnostic services by hospitals; the patient pays the first $20. After that, Medicare pays 80 percent of the bills. In addition, it provides for health services in the patient's home after discharge from a hospital. Medicare pays the full cost up to 100 visits per year.

Then there is the second type coverage.

This is optional. It costs $3 a month per person. It is designed to help pay doctor bills.

Under it, the patient pays the first $50 of doctor bills per year. Beyond that, Medicare will pay 80 percent of any doctor bill determined to be a "reasonable charge."

What is reasonable?

Local insurance carriers designated to handle Medicare claims for the Social Security Administration will decide this. If a doctor charges more, the patient must pay the difference.

This plan also covers 80 percent of the cost of X-rays, radiation therapy, surgical dressings, splints, casts, dressings, braces, artificial arms, legs, eyes, use of iron lungs, oxygen tents, emergency ambulance services.

Medicare Patient Admitted at 12.01 AM

Bridgeport, Conn., July 1 — (UPI) — At 12.01 A. M. today, 83-year-old Rudolph Beers of Bridgeport made history.

Admitted to Bridgeport Hospital, Beers became the first senior citizen in Connecticut, and possibly the first person in the nation, to enter a hospital under Medicare coverage. He is being treated for a surgical condition which became aggravated last night. He was admitted 60 seconds after the comprehensive federal health program went into effect.

Baltimore, Md.

No First-Day Rush Encountered

Medicare Hospital Jam Fails to Envelop State

With all 66 hospitals in Maryland declared officially approved for the Medicare program, the expected first-day rush failed to develop as the new health plan for the aged went into effect.

The main roadblock which confronted hospital workers was the re-registration of persons already hospitalized. To transfer them to Medicare status required using unfamiliar forms, and in some instances these had failed to arrive in time.

The U. S. Public Health service said all Maryland hospitals were in compliance with civil rights standards required for participation in the Medicare program.

Basically, Negroes must be admitted, rooms must not be segregated, staff privileges must be available to qualified Negroes, and they must be accepted in training programs.

The last four Maryland hospitals to be certified were Calvert County Hospital; Greater Baltimore Medical Center, Towson; Provident Hospital and Baltimore County Hospital, Randallstown.

Most Baltimore hospitals reported no increase in outpatient loads, and the converting existing patients to Medicare was going smoothly. A sample was Lutheran Hospital's conversion record of 23 patients plus three new admissions.

Sinai Hospital reported its usual daily run of 300 to 350 in its outpatient clinic. Johns Hopkins Hospital, whose clinics are the busiest in the city, had paperwork troubles which finally were solved.

Manchester, N.H.
June 30, 1966

Program Effective Tomorrow

16,000 from Area On Medicare List

(Page 1)

By M. EILEEN BESAKIRSKIS

Nearly 16,000 elderly citizens have enrolled in Medicare in the Greater Manchester area, according to the latest estimate made by the Social Security Office for the Manchester district. The program goes into effect tomorrow.

All have signed for Part A of the federal plan which covers services in a hospital and extended care facility. But only 92 per cent or 14,700 elderly have enrolled in Part B, the medical insurance plan which pays for 80 per cent of a physician's services, up to 100 home health nurse visits and other medical and health services.

John M. Sargent, district

MEDICARE Page 16

MEDICARE (Page 16)

(Continued from Page One)

manager for the Social Security Office of Manchester, gave two reasons for the lower enrollment in the medical insurance plan.

"One reason for the lower enrollment may be due to the direct premium payment of $3 a month that is required under part B," Sargent explained. "Another reason is that a great number of these elderly citizens have some medical coverage from other sources."

The 34 hospitals throughout the State of New Hampshire have appointed Blue Cross to be the administrator of Medicare.

"When a person over 65 covered by Medicare goes into the hospital," Sargent said, "his hospital bill is sent directly to Blue Cross. The local Blue Cross agency then deals with the main headquarters of Social Security in Baltimore, Maryland."

There is one exception to Blue Cross as the intermediary for New Hampshire elderly. All railroad workers eligible for Medicare will have their medical insurance handled by the Travelers Insurance Co. and not through Blue Shield.

What happens to the elderly citizen who already has medical insurance with a private company and goes into the hospital under Medicare?

Supplement Coverage

"This is between the individual and his insurance company," Sargent stated. "Most private insurance companies have tailored their medical plans effective July 1 which will probably supplement Medicar coverage."

For instance, the Medicare hospital insurance will cover up to 60 days in hospital expenses except the first $40, but the private medical insurance of an aged person may cover expenses after the 60 days and pay for the first $40, depending on the medical plan.

beneficiaries under Medicare in any way possible.

Since last September the Manchester Social Security Office hired six temporary employes for Medicare enrollments and three permanent employes also were hired to alleviate the extra duties brought by Medicare.

According to Sargent, the office staff worked on many holidays, evenings and on Saturday mornings since last September to meet the Medicare enrollment deadline. But this Saturday morning the Social Security Office at 50 Bridge St. will be closed.

The district manager is optimistic "with not only the job oir people have done in enrollcitizens but also with the cooperation we have been getting from hospitals and doctors."

Sargent added: "The key to the success of Medicare lies in this willingness to work together."

ıe role of the Manchester [redacted] security office before was to enroll elderly people over 65 in Medicare and to certify people eligible for this coverage.

"Before Jan. 1, 1968, people who have reached 65 years of age and never worked under social security, will still be eligible for Medicare under a special clause in the act," Sargent said. "But after 1967 to qualify for Medicare, a person must have worked under the Social Security system."

The Social Security Office will switch in emphasis after July 1. The federal office's new role will be to collect the monthly $3 premium payment on medical insurance and to assist the

THE WEATHER
Fair–Mild
(Details on Back Page)

MANCHESTER

NEW HAMPSHIRE

"There is nothing so powerful as truth"
—DANIEL WEBSTER

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MANCHESTER (N. H.) UNION LEADER — Friday, July 1, 1966

Medicare Rush Expected

UNION LEADER CITY EDITION

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Next Week

None Admitted So Far At Any Hospitals Here

By M. EILEEN BESAKIRSKIS

Manchester hospitals experienced no sudden admissions increase as Medicare went into effect today, according to hospital officials. By press time this noon, not one Medicare patient had been admitted to any Manchester hospital.

Some hospital officials attribute this to the July 4th holiday.

"I guess you can't say there was a crowd waiting at the door," Ernest F. Cummings, acting supervisor of the Elliot Hospital, stated, "but I think we will begin to see an influx of Medicare patients next week after the holiday."

Sister Mary Virginia, director of admissions at the Sacred Heart Hospital, also felt that the hospitals would be admitting Medicare patients after the holiday.

Two Out-Patients

"We did not admit any patients yesterday nor will we be admitting any today," said Sister Virginia. "We just don't have any beds."

Unlike the other two hospitals, Notre Dame Hospital did treat two out-patients under Medicare early this morning. Medicare is generally expected to affect the out-patient department service more than any other department of the hospital.

HOSPITALS Page 12

Medicare Now At Work In US

By United Press International

Medicare became a fact of life today. Hospital administrators said they were ready for it.

The federal health insurance program that could open hospital doors to about 19 million Americans over 65 went into effect at midnight.

Its advent was welcomed by President Johnson, in a statement issued at the White House yesterday, as "a blessing for older Americans."

For the first time in history, the President said, "nearly every older American will receive hospital care—not as an act of charity but as the

MEDICARE Page 14

HOSPITALS

(Continued from Page One)

Sister Mary Lucille Blanchette, administrator of the Notre Dame Hospital, stated: "Some patients will be admitted later this afternoon and I expect a few of these patients will be under Medicare."

Long Waiting List

The Notre Dame Hospital has a large waiting list with many people over 65 under Medicare requesting hospital admittance on or after July 1.

Another aspect of the Medicare program will go into effect today. The Medical Care Appraisal Committee will begin the special function of reviewing patients of all ages and categories regardless of their source of payment.

They will determine admissions giving priority to the most acute cases and decide upon their length of stay. Special consideration will be given by the committee to the recommendations of the patient's physician.

Periodic Check

Sister Mary Callista, supervisor of the Sacred Heart Hospital, said: "The utilization review team will operate mainly upon the recommendations of the patient's doctor. However, a periodic investigation of the patient's condition will be made."

The reviewing committee requires at least three members of the hospital's active staff, and at least one member who has no direct financial interest in the hospital.

"There are many patients who will just stay and stay as long as they are able to pay," said Dr. Mary Atchinson, director of the New Hampshire Division of Public Health. "The purpose of this review team is to provide for a more orderly system helping to alleviate the crowded condition in the hospitals by making extra beds available."

Dr. Atchinson added, "I doubt Medicare will aggravate the crowded, understaffed conditions of our hospitals. Most of our hospitals are prepared to meet the problems the federal program may bring and I doubt hospital conditions would change their high standards because of the Medicare program."

New Bedford Standard Times

Queries Answered on Medicare

WASHINGTON (AP) — Here are answers to some of the questions most frequently asked about medicare, starting today for all Americans 65 and older:

Q. If the hospital I choose is overcrowded, does medicare guarantee me a bed?

A. No. Medicare just helps pay the bill.

Q. If I have to go back into the hospital two or more times, do I pay the $40 "deductible" each time?

A. No. You pay just the first $40 of hospital charges in each "spell of illness."

Q. What's a "spell of illness."

A. To medicare it's a period of time, not an ailment. It starts the day you enter a hospital. It ends 60 days after your discharge from the hospital. Or from a nursing home — after next Jan. 1, medicare will provide posthospital convalescent care in nursing homes for those needing it.

Q. Suppose I go back to the hospital for a different sickness?

A. To medicare it doesn't matter. It's all one "spell of illness" if the new admission comes within 60 days of the last discharge.

Q. What if I'm sent back later than 60 days from the discharge?

A. Then it's a new "spell of illness," with a new $40 charge and a whole new set of benefits — full coverage by medicare for the first 60 days of hospitalization, then all but $10 a day for the next 30 days.

Q. Do I have to go back to the same hospital?

A. No. Your benefits follow you from hospital to hospital and from city to city. Just show your red, white and blue card. Any participating hospital can tell instantly, by check to a computer in Baltimore, Md., whether you have used up all your "benefit days."

Q. Suppose that I decide,

(Continued on Page 4)

when recovering from an operation, to use up my full benefits by staying in the hospital for some additional days of bedrest. Does medicare cover the extra days?

A. No. You must be sick to get medicare benefits. You can enter a hospital and remain there only at the doctor's say so.

Q. Couldn't the doctor be persuaded to let me stay on, as a medicare beneficiary?

A. He might give in to persuasion or pressure. But under medicare rules, every hospital must have a "utilization review" committee controlling the use of beds. The committee can overrule doctors and order the discharge of patients who are able to go home or into nursing homes.

Q. If I'm in a hospital when medicare starts, does medicare pick up the bill?

A. Not for past days. Medicare picks up as of July 1, and you'll still have to pay the $40 deductible as well as the charges for the days preceding medicare.

Q. I've signed up to pay $3 a month for the voluntary doctor bill insurance. It has a $50 deductible; how often do I have to pay that?

A. Just once each year, regardless of how much your doctor bills add up to in a year.

Q. Should I cancel my old health insurance policy?

A. If you are 65 but your wife is not, she's not covered by medicare. You may want to keep her policy in force.

Q. We are both over 65. Should we buy the "supplemental" plans offered to over-65 persons by Blue Cross, Blue Shield and other private insurers for additional protection?

A. That depends on your own needs and inclinations. Some policies are designed to cover medicare's "deductibles" and provide benefits beyond the limits of medicare. Another type of policy pays off in cash benefits for each day of hospitalization; the money could be used for the inevitable costs of an illness, or for "extras," such as a bedside telephone or a private room instead of the semiprivate accommodations paid for by medicare.

Q. Medicare's doctor bill insurance covers 80 per cent of a doctor's "reasonable charges," after the $50 deductible. Does the doctor send his bill to medicare or to me?

A. Either one. He can send it to medicare's local "intermediary" agency — in most cities, the local Blue Shield organization — which will pay him 80 per cent of what it deems a "reasonable charge" for his treatment or operation; the other 20 per cent would come from you. Or he could send the whole bill directly to you.

Q. In the latter case what do I do?

A. Pay it, then apply for reimbursement to the "intermediary."

Q. Which is the likeliest method?

A. Judging by statements at last week's meeting in Chicago of the American Medical Association, most doctors will want to bill the patient directly.

Q. Will that cost me more?

A. It could. The doctor would not be bound by any "reasonable charge" limitation. He could charge any amount he felt entitled to. When you've paid his bill and applied for reimbursement, you get back only 80 per cent of the "reasonable charge," regardless of the actual size of the bill.

Q. Are medical costs going up?

A. They have been, regardless of medicare, and many believe they will climb faster. President Johnson has appealed to the profession to resist "growing pressure toward higher prices for hospital and medical services." And a White House spokesman said this week: "The President feels sure doctors will not drive a hard bargain with needy patients by demanding direct, immediate reimbursement."

NEW BEDFORD, MASS.,

Most Hospitals In U.S. Ready For Medicare

Consensus Is No Flood of Patients Will Materialize

By United Press International

Medicare became a fact of life today. Hospital administrators said they were ready for it.

The Federal health insurance program that could open hospital doors to about 19 million Americans over 65 went into effect at midnight.

Critics had predicted darkly it could result in a flood tide of elderly patients seeking admission to the hospitals.

But nearly all hospital administrators questioned across the country thought they were equal to the task.

In New Bedford, St. Luke's Hospital had one medicare admission as of 1 p.m. Union Hospital had none. Both hospitals reported a number of patients over 65 who became eligible for medicare benefits as the clock struck midnight. Necessary paperwork was being done in both hospitals today to "enroll" the medicare patients on hand.

It was estimated more than 15,000 patients in hospitals throughout Massachusetts became eligible for medicare benefits today.

Can Meet Problem

The nearly universal feeling was that somehow, some way the country's hospitals could cope with this as they had with short staffs, lack of facilities and other problems.

Basically, medicare provides up to 60 days of hospital care with the patient paying the first $40 and, if additional hospital treatment is required, medicare will cover the costs over $10 a day for another 30 days.

The second part of medicare, which is optional, costs the oldster $3 a month and provides, after a $50 initial payment by the patient, the bulk of the money for doctor bills.

Civil rights also was an issue, principally in the South. The Department of Health, Education and Welfare said more than 600 hospitals had failed to comply with desegregation requirements in time to qualify for participation in medicare on opening day.

"No hospital will be cleared for participation in medicare unless the department has convincing evidence that the hospital is in fact in compliance," HEW Secretary John Gardner said, emphasizing that token pledges would not be enough.

Individual physicians meeting in Chicago this week for the American Medical Association convention had predicted that "bedlam" would break out when medicare went into effect.

However, an American Hospital Association spokesman in Chicago said Thursday, "We expect no big rush in as far as in-patient hospitalization is concerned.

"Twenty-five per cent of the patients (in hospitals) today are 65 or older. What happens is that they will be discharged on paper, and will be readmitted tomorrow (Friday) as medicare patients. We expect no more than a 5 per cent increase through the first couple of months."

No Great Impact

Fred Edmunds, executive director of the Hospital Planning Association of Southern California, summed up the feelings of the majority of the nation's hospital administrators. "The impact of medicare will not be great numerically." But he said he could be wrong.

The timing of the advent of medicare would help, the American Hospital Association spokesman said. The July 4 weekend is traditionally the lightest of the year in terms of hospital admissions, he said.

One place in the nation expected a rush—the St. Petersburg-Tampa area in Florida. The AHA said because that area is a retirement haven, hospitals were braced but ready.

In most places across the United States hospitals were running at near or over capacity before medicare.

AMA Urges Hospital Boycott If Bills Disputed

CHICAGO (UPI)—The American Medical Association ignored the possibility of federal antitrust suits Thursday and urged boycotts of hospitals that didn't allow doctors to bill patients separately.

The AMA's stormy 115th annual convention came to a close on the eve of perhaps the biggest change ever to hit the U. S. medical profession—the advent of medicare.

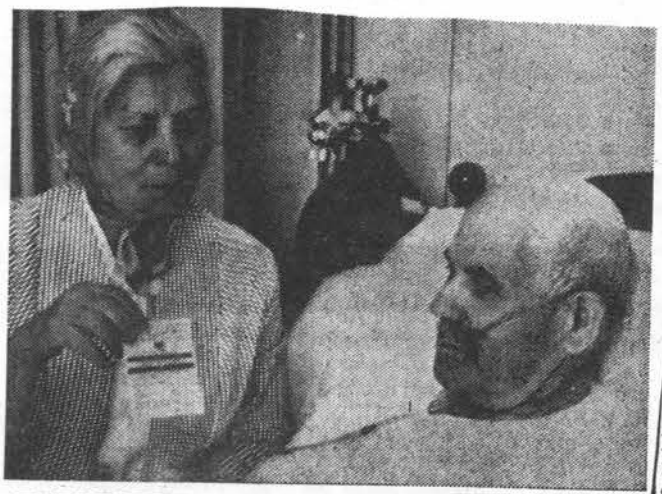
The AMA's new president, Charles L. Hudson of Cleveland, asked the AMA's policy-making house of delegates to reconsider its resolution calling for the boycotts which it passed Wednesday. A debate flared after Hudson warned the AMA might get hit with a federal antitrust suit. Tex., a member of the AMA

Joseph B. Copeland of Austin, board of trustees, asked reconsideration to avert costly litigation

NEWS TRIBUNE
WALTHAM, Mass.
July 2, 1966

FINAL

★★★



EARLY BIRD — Abraham M. Berman, 65, entered Maine Medical Center as a Medicare patient at 12:01 A.M. — just one minute after the federal medical aid to the aged program went into effect. Here, his wife shows him his Medicare registration card. Berman, suffering from a heart ailment, was rushed to the hospital when he became short of breath. (AP Wirephoto)

Expect Stiff Medicare Test Come Tuesday

BOSTON (UPI) — The long lines of patients expected during the first 24 hours of Medicare did not materialize at New England hospitals, but experts now say the real test will come Tuesday.

Hospitals were not swamped beginning at 12:01 A.M. Friday as a slightly above normal flow of patients over 65 needing emergency care were treated.

The most persistent problems occurred when hospitals ran out of government forms or patients forgot to bring their Medicare identification cards.

"If we are by the worst of it, I think this thing is going to work. If Medicare grows over the next six to 10 months, we will be able to grow with it and handle any problems that come up," a spokesman for a Springfield Hospital said.

But one administrator warned that holiday periods are always slow. "There are a lot of people out there who need care, and now the government is paying the bills," he said.

Despite fears for a greater influx of patients Tuesday New England states appear ready to handle the increase.

In Massachusetts a spokesman for the Blue Cross-Blue Shield said the first day's Medicare claims forms submitted by hospitals totalled 5,100 patients.

"It's like an everyday occurrance here," said William Graham, reimbursement consultant for the Massachusetts Hospital Association. "There has been no problem. The influx has not happened."

The unanimous word from administrators and directors around New England was that patient admissions was in a slow pre-holiday period.

New Hampshire's 34 hospitals noted no unusual problems aside from an increase in paperwork. The same held true at other regional hospitals.

Hospitals Happy With Smooth Medicare Start

At 9 a.m. on the first day Anna Winston, 71, of New York City, showed up in the emergency room at Mt. Sinai Hospital complaining of "aches and pains." Within an hour she became one of the hospital's 19 first-day Medicare admissions.

"I knew I'd wind up in the hospital because I was very sick," Mrs. Winston said. "I should have been here a month ago, but I couldn't get into this or any other place."

Asked her opinion of the new program, she said:

"I feel very strong about Medicare. This is a very, very rich country—why shouldn't we have it? And why shouldn't it work?"

The biggest problem faced by the hospitals is the increased load of paper work. Mt. Sinai added 41 clerks just to handle all the new forms and extra bookkeeping. Other hospitals are also taking on new help.

At St. Joseph's Infirmary in Atlanta, Business Manager David Messinger recalled that he had spent 20 years in the Air Force as a medical budget officer. He shuffled the forms piled high on his desk and said, "I'm right back home again. I haven't had much sleep in three days. I can't sleep any more, trying to figure out what to do about Medicare."

Most frightening to him is the requirement for itemized billing for laboratory tests. There are 223 lab tests listed by the hospital, and special billing forms are required—and at least two sets must be filled out for Medicare.

By the end of the first day at Massachusetts General Hospital had 941 patients, of whom 260 were over 65 years. During the day the hospital admitted 67 new patients, 18 of them under Medicare. Eight of the Medicare patients entered the hospital after 5 p.m.

"The newness of it all gave us a hectic night," said John Stella, night admitting officer.

An information desk was set up on the main floor at Detroit's Henry Ford Hospital, where more than 200 elderly persons came with questions about the program.

One elderly woman insisted a girl behind the counter was wrong when she explained that Medicare doesn't cover all expenses. "You're trying to line your pockets with my Medicare money," the woman shouted, and swung her purse at the girl.

The girl ducked and the blow glanced off her hairdo. She retreated into a nearby office and the woman stomped out.

"They're generally surprised to learn that everything isn't paid for," said Miss Thelma Cogswell, clinics admitting officer at Massachusetts General Hospital.

She said the clinic patients were used to being "whisked through" the formalities of being checked in. But yesterday there were delays because of the Medicare forms to be filled out. Miss Cogswell added:

"The hardest part at this point is that nothing is cut and dried. If we had been given a few simple rules to follow it would be a lot easier."

Queen of Angels Hospital in Los Angeles didn't have a single Medicare admission until mid-afternoon, when a doctor called to advise he was sending in a male heart patient.

"The hospital census always goes down to rock bottom on July 4," said a hospital spokesman.

Also affecting admissions, he said, was the fact that California put into effect its own program March 1, absorbing early the influx of patients.

Some hospitals reported that a few elderly persons had shown up to "get their Medicare." They weren't sick, but they mistakenly thought they had to report to the hospital.

"The people who come in under Medicare often are too old and too sick to know about the program," said Alan Transue, credit manager of Research Hospital and Medical Center in Kansas City.

"They don't have cards, they can't find cards, they don't know what we are talking about," he said.

(Associated Press)

THE WOONSOCKET CALL

WOONSOCKET, R. I., FRIDAY, JULY 1, 1966

For 19 Million U.S. Elderly

Medicare Now In Effect

By STERLING F. GREEN

WASHINGTON (AP) — The massive medicare program providing hospital insurance for all 19 million of the nation's senior citizens went into effect today, hailed by President Johnson as "a blessing for older Americans."

Swinging into operation with the program was an optional doctor-bill insurance plan for which 17.3 million elected to pay $3 a month.

The two programs were brought into being at 12:01 a.m. in one of the biggest operations in medical history.

Doctors and patients reserved any prognosis, but the President pronounced it a success in advance. He called it "a test of our willingness to work together."

By Public Health Service count, 6,714 institutions — or 91 per cent of all the country's 7,374 general hospitals with roughly 93 per cent of the beds — opened their doors for the insured care of any American aged 65 or over.

The non-participating hospitals were mainly in the South. Most were barred from medicare payments by their failure to comply with the no racial discrimination provisions of the Civil Rights Act.

To make extra sure that no one dies for want of access to a participating hospital, the government ruled Thursday night that federal hospitals — veterans', military and others — may be used for critically ill medicare patients in emergencies.

Previously it had been announced that any other non-participating hospital could be used — private or public, with medicare picking up the bill — if a bed in a participating hospital could not be found to avert the threat of death "or serious impairment of the health."

Despite the serious gaps in participation — only 25 per cent of Mississippi hospitals were in the pool — administration aides were jubilant over the generally high participation nationwide.

"We've done far better in the South than we had dared to hope a month or two ago," one Public Health Service official said.

"And more hospitals will be desegregating when they begin to feel the pressure from unhappy local residents, both white and black," he added.

Twenty-three states entered medicare with 100 per cent participation by their qualified hospitals, and some others came close to that.

In his medicare's-eve statement, President Johnson said he had no doubt of the success of the twin medicare programs if these three things happen:

"If hospitals accept their responsibility under the law not to discriminate against any patient because of race."

"If doctors treat their patients with fairness and compassion. I feel sure that most doctors do not plan to drive hard bargains with needy patients."

"If old patients cooperate in scheduling treatment and do not demand unnecessary hospital and medical services."

He concluded: "I have no doubt for the future. I believe that July 1, 1966, marks a new day of freedom for our people."

The government has poohpoohed forecasts that a tide of elderly patients will swamp the hospitals. Hospital administrators generally agree that there will be some difficult local situations but that they can handle the expected average increase of not more than 5 per cent in the patient load.

This judgment was reinforced as each recent day brought scores of new hospitals into compliance, officials expect that many more will meet both the medical care standards and the civil rights test during July.

The states which already had 100 per cent certification of hospitals for compliance, as of midnight, were Alaska, Arizona, Colorado, Connecticut, Hawaii,

Continued On Pg. 2 Medicare

Let Patients Pick Up Tab –AMA Head

By WILLIAM J. CONWAY

CHICAGO (AP) — Dr. Milford O. Rouse combines professional skill with sharp business sense.

He made that clear in his first news conference since his selection as the president-elect of the American Medical Association.

He said he prefers, under medicare, to give the 65-or-over patient an itemized account which the patient can take care of himself. Then the patient will be reimbursed, he said, under the new insurance system for the elderly.

"I'm not your insurance broker," he said in capsuling his attitude Thursday. "I'm your doctor. I'm trying to help you."

Dr. Rouse said he won't try to block medicare.

But, he said, "I can see no way to do it (handle medicare) except on a basis of direct billing."

Dr. Rouse is 63. He's of medium height, balding and tanned and has a rather slim silhouette.

"How do you keep so trim?" an interviewer inquired.

"I'm a gastroenterologist," he replied with a smile.

The implication, apparently, is that a doctor whose speciality includes the stomach and digestive tract is careful about what he eats.

Dr. Rouse was born in Jacksonville, Tex., son of a Baptist minister, teacher and author. He went to high school in Vernon and once worked for a newspaper there, the Vernon Record.

Dr. Rouse earned his M.D. at Baylor University in 1927 and went into practice in Dallas, Tex., a year later.

He will be installed as the AMA's 122nd president next June at the annual convention in Atlantic City.

He has been a member of the policy-making AMA House of Delegates since 1953 and speaker since 1963.

Dr. Rouse was asked if many doctors will increase their fees in the medicare era that began today.

"I don't think so," he replied. "I'm going to charge what I

Medicare Queries Flood RI Health Plans Office

PROVIDENCE — On the eve of Federal Medicare, Blue Cross and Physicians Service report that telephone calls to the Plans have tripled during the past week as senior citizens have been inquiring about various aspects of Medicare.

Arthur F. Hanley, executive director of the two local health plans, said that an average of 3,000 telephone calls a day have been received during the week. "We've been swamped with calls," he said.

"Our average telephone call volume has been approximately 1,000 calls a day since Medicare became a topic of wide local interest several months ago," Hanley said, "and before that time we averaged about 600 incoming calls a day."

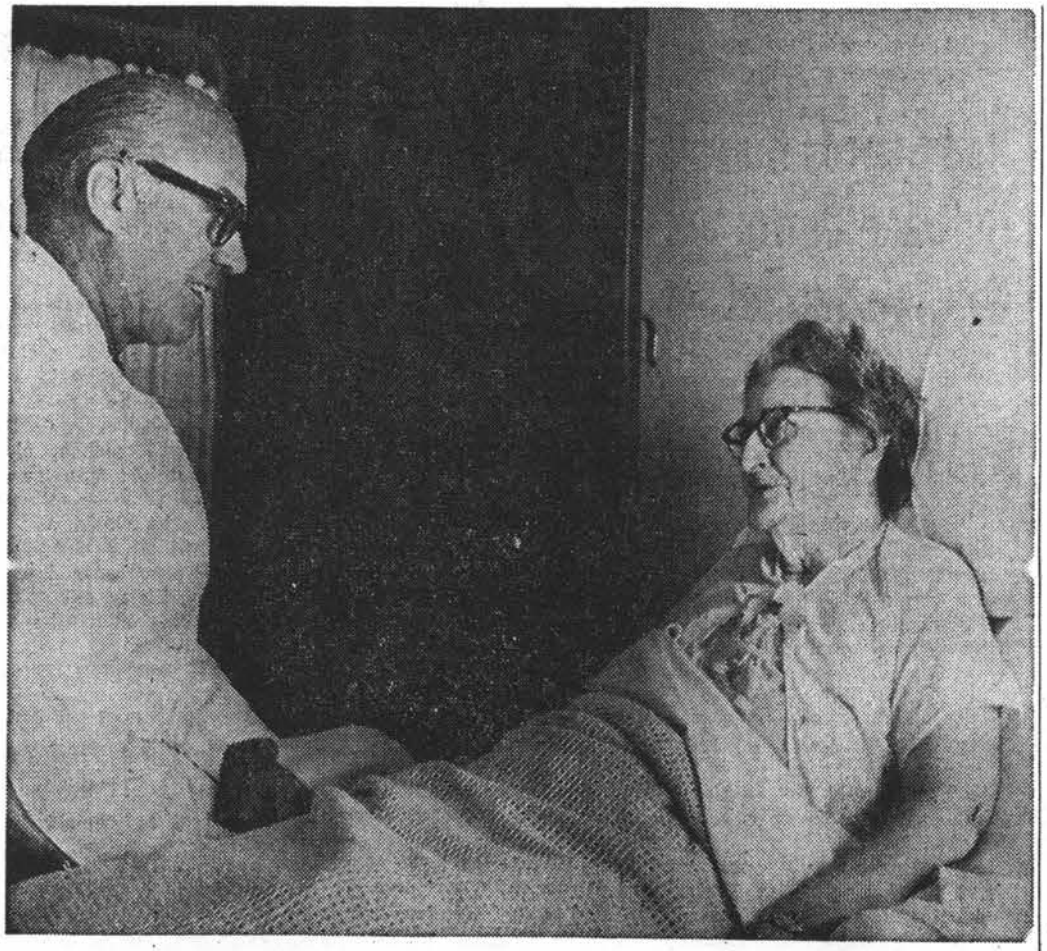
The executive director said that personal visits to the health plans by senior citizens have also increased sharply during the past week. "Our senior citizens are seeking assurance that their health care protection is in order before the July 1 effective date of Medicare," Hanley said.

Many questions pertain to membership in the new Blue Cross and Physicians Service 65 Plan that will supplement Medicare, and costs $4.45 a month, Hanley explained.

Blue Cross has been selected by the U.S. Department of Health, Education and Welfare to administer the Part "A" or hospital insurance part of Federal Medicare. Physicians Service has been selected as carrier for the Part "B" or medical insurance part of the federal program. Some 100,000 Rhode Islanders over age 65 are expected to be included under Medicare.

Hanley also reported that the two local health plans are prepared to begin processing claims as soon as they begin arriving, and that Blue Cross and Physicians Service look forward to continuing to service the health care needs of the state's senior citizens.

New Britain Herald
New Britain, Conn.
July 2, 1966



CITY'S FIRST PATIENT ADMITTED UNDER MEDICARE

Miss Winifred K. Kelly, 66, of 98 Hart St., became the first patient admitted at New Britain General Hospital under the Medicare health insurance program yesterday. She was admitted as an emergency medical case at 1:15 p.m., more than 13 hours after the health program became effective, and is a patient at the hospital for the 11th time. A retired registered nurse, she was assigned to psychiatric and social work by the War Shipping Administration during World War II in New York City and Galveston, Tex., a chief nurse on transport ships, a social work supervisor at the New York Foundling Home and evening supervisor of nursing at NBGH for five years prior to her retirement in 1962. Shown with Miss Kelly is Dr. Bliss B. Clark, executive director of the hospital. (Herald Photo)

THE WOONSOCKET CALL

AND EVENING REPORTER

WOONSOCKET, R. I., SATURDAY, JULY 2, 1966

First Day Of Medicare

EDITOR'S NOTE — Members of a special AP task force kept a close watch throughout the first day of medicare in a group of hospitals around the country. The following account is based on their reports.

NEW YORK (AP)—Down the corridors of Miami's Jackson Memorial Hospital figures in white passed each other with a cheerful greeting: "Happy medicare!"

For the nation's hospitals Friday was indeed happy medicare —the first day of the Social Security hospital program for persons 65 years and older had gone smoother than anyone had dared hope.

Still, there were problems: mountains of paper work, missing forms, bewildered patients, lost medicare cards, and one woman who got mad and swung her purse at a hospital worker.

By midafternoon, in the usually frantic emergency room at Jackson Memorial, interns sat with their feet propped on a table.

"It's the quietest day we've had," said Dr. James Connaughton, who joined the Miami hospital last month after graduation from the University of Indiana.

The situation was virtually the same in hospital after hospital across the United States. Fear expressed by some that medical facilities would be swamped by elderly people evaporated as the day wore on like any other before a July 4 holiday.

Northwest Hospital in Seattle, the first in the nation to be certified for medicare, admitted not a single medicare patient. Six elderly patients already in the hospital, however, were automatically switched over to medicare at its start, 12:01 a.m. Friday.

"Heaven help us when Tues-

Suburban Edition

★ ★ ★

16 Pages—7 Cents 40c Per Week By Carrier

Goes Smoothly

day comes," said Alfred E. Riley, business manager of St. Elizabeth's Hospital in Chicago. Riley said he looks for a big inflow of patients then because of the people who wanted to be home for the holiday or delayed entry because so many doctors would be away for the weekend.

At 9 a.m. on the first day, Anna Winston, 71, of New York City, showed up in the emergency room at mammoth Mt. Sinai Hospital complaining of "aches and pains." Within an hour she became one of the hospital's 19 first-day medicare admissions.

"I knew I'd wind up in the hospital because I was very sick," Mrs. Winston said. "I should have been here a month ago, but I couldn't get into this or any other place."

The biggest problem faced by the hospitals is the increased load of paper work. Mt. Sinai added 41 clerks just to handle all the new forms and extra bookkeeping. Other hospitals are also taking on new help.

At St. Joseph's Infirmary in Atlanta, business manager David Messinger recalled that he had spent 20 years in the Air Force as a medical budget officer. He shuffled the forms piled high on his desk and said,

Continued On Pg. 2 Medicare

–Medicare

"I'm right back home again. I haven't had much sleep in three days. I can't sleep any more, trying to figure out what to do about medicare."

An information desk was set up on the main floor at Detroit's Henry Ford Hospital, where more than 200 elderly persons came with questions about the program.

One elderly woman insisted a girl behind the counter was wrong when she explained that medicare doesn't cover all expenses. "You're trying to line your pockets with my medicare money," the woman shouted, and swung her purse at the girl.

The girl ducked and the blow glanced off her hairdo. She retreated into a nearby office and the woman stomped out.

"They're generally surprised to learn that everything isn't paid for," said Thelma Cogswell, clinics admitting officer at Massachusetts General Hospital in Boston.

She said the clinic patients were used to being "whisked through" the formalities of being checked in. But Friday there were delays because of the medicare forms to be filled out. Miss Cogswell added: "The hardest part at this point is that nothing is cut and dried. If we had been given a few simple rules to follow it would be a lot easier."

By the end of the first day at Massachusetts General the hospital had 941 patients, of whom 260 were over 65 years. During the day the hospital admitted 67 new patients, 18 of them under medicare.

Queen of Angels Hospital in Los Angeles didn't have a single medicare admission until midafternoon, when a doctor called to advise he was sending in a male heart patient.

"The hospital census always goes down to rock bottom on July 4," said a hospital spokesman.

Also affecting admissions, he said, was the fact that California put into effect its own program March 1, absorbing early the influx of patients.

Some hospitals reported that a few elderly persons had shown up to "get their medicare." They weren't sick, but they mistakenly thought they had to report to the hospital.

"The people who come in under medicare often are too old and too sick to know about the program," said Alan Transue, credit manager of Research Hospital and Medical Center in Kansas City.

"They don't have cards, they can't find cards, they don't know what we are talking about," he said.

At the Boston Hospital one woman outpatient refused to produce her red, white and blue card—until she had a chance to go to the ladies room and unpin it from her underwear.

At Ochsner Foundation Hospital in New Orleans, Herbert Leonard, an oil jobber from Ponchatoula, La., said he objected to medicare and wouldn't have signed up if his private insurance company hadn't reduced his hospital coverage due to the federal program. "I still think an American would rather pay his own way," he said.

When medicare went into effect St. Joseph's in Atlanta transferred 50 age-eligible patients to the program. During the day six checked out and three more were admitted.

E.D. Rivers, 70, of Lakeland, Ga., Georgia governor from 1937-40, entered the hospital for a periodic checkup. His admission form bore the green-ink stamp "Medicare 65."

"I've been in Social Security for some little bit now," Rivers said. "I paid in a lot of money. They don't put it on the basis of need, but on the basis of right."

Madge English, 72, of Dallas, admitted to Parkland Memorial Hospital at midmorning for treatment of a broken hip, said of medicare: "It's a wonderful thing. It's God's blessing to the old people."

Dr. Fred Bonte, chief of radiology at Parkland, said, "It's a lot easier than we thought it would be." Five medicare patients were admitted Friday and 82 others in the hospital were automatically transferred.

Said administrator Jack Price: "I'm not surprised at the small number of medicare admissions. After all, old folks don't like to go to the hospital any more than anyone else."

7/2/66 - Hartford Courant Conn.

Medicare First Day Normal at Hospitals

By PHILIP NOTOPOULOS

The first day of Medicare brought no great increases in the number of elderly persons in city hospitals.

The federal health insurance policy for persons over 65 went into effect Friday but hospitals said the day went smoothly.

Whitney Spaulding, associate executive director of Hartford Hospital, reported there was no surge in admissions of elderly patients and that no such increase was even expected.

"A large increase in the backlog of over-65 patients that some people had feared just has not materialized," he said.

Spokesmen at St. Francis Hospital also reported the numbers of elderly people admitted were about normal, and the case was much the same for McCook Hospital and Mt. Sinai Hospital.

Area Hospitals Full

Greater Hartford hospitals are now full and all have waiting lists of several months, officials explained, which accounts for the lack of an increase in elderly patients.

Except for emergency cases, admission rests upon application through a physician. "You just can't come and present yourself and expect to be admitted just because you are now covered by Medicare," one spokesman said.

Since hospital admissions are not on the basis of age or ability to pay, there would have to be a genuine increase in the number of elderly people being sick to bring about a rise in admissions of them, a St. Francis spokesman remarked.

The only area in which some uncertainty existed was in the outpatient departments.

Hartford and St. Francis hospitals reported several Medicare patients Friday, and said that it is possible that there would be more elderly patients receiving outpatient care due to Medicare, although it was too early to be certain.

The only visible effects Friday of the beginning of Medicare were the greater amount of paperwork and clerical help to handle it, as Hartford Hospital added three new clerks and St. Francis one.

New Haven Journal-Courier
New Haven, Conn.
July 1, 1966

Hospitals Across Nation Brace For Medicare Rush

WASHINGTON (AP) — Hospitals throughout the land braced themselves for the July 1 opening of a new era of old age security for Americans—medicare.

The government foresaw a smooth July 1 start despite some scattered forecasts of overcrowding, some Republican charges of negligent planning, and the decision of many Southern hospitals to discriminate rather than participate.

President Johnson, in a statement taped for television and radio use, said medicare will succeed if hospitals accept their responsibility not to discriminate becase of race, doctors continue to threat their patients with fairness and compassion, and patients cooperate and do not demand unnecessary services.

"This program is not just a blessing for older Americans," Johnson said, "it is a test for all Americans — a test of our willingness to work together."

Starting at midnight the first of 19 million Americans 65 and older who now hold red, white, and blue medicare cards will be admitted for government-insured hospital care at any of 6,704 hospitals. Some 17.3 million of them also have signed up voluntarily for doctor-bill insurance under medicare.

FRANCO-ANGLO PARLEY

LONDON (UPI)—French Premier Georges Pompidou will arrive July 6 for talks with Primie Minister Harold Wilson.

Officials now scoff at fears that elderly men and women will swamp hospital facilities.

Kenneth Williamson, Washington director of the American Hospital Association, agreed. In an interview he called that idea "just plain silly."

An almost-final tally of compliance with the antidiscrimination provision of the Civil Rights Act showed that 91 per cent of the country's estimated 7,373 general hospitals have been cleared.

That opens to medicare patients about 95 per cent of all the hospital beds in the country. However, 669 hospitals were still barred from participating, by count of the Public Health Service.

The Bristol Press

BRISTOL, CONNECTICUT, SATURDAY, JULY 2, 1966

Medicare's Plan B In Plain English

Editor's Note: Medicare—the federal government's new health insurance program for senior citizens—became effective July 1. Like all large-scale programs, it often is presented to the public in technical language and hard-to-follow sentences. This article, the second of a two-part series, attempts to offer a clear, simple explanation of medicare's Plan B, which provides payment of doctor bills. An explanation of Plan A, which covers hospital care, appeared on Page 10 of yesterday's edition.

Medicare is a health insurance program for the elderly that makes the individual policyholder and the federal government partners in sharing hospital and doctor bills.

The program, which became effective July 1, has two parts, called Plan A and Plan B. Plan A was discussed yesterday in the first article in this series. This article will examine the basic makeup of Plan B.

What Is Plan B?

The plan is similar to CMS (Connecticut Medical Service), which is a health insurance program presently offered in this area by a privately owned company. Like CMS, Plan B covers doctor bills.

Enrollment in Plan B is optional and costs the policy-holder $3 a month. Most senior citizens find that the coverage is worth many times that amount in benefits to them for doctor care.

How You Are Billed

If the policy-holder collects social security, his monthly charge for the plan is deducted from his social security check before it is mailed to him.

If he does not collect social security—**and over 1,000 senior citizens in Bristol fall into this category**—he is billed directly for $9 every three months by the Social Security Administration.

First Deadline Past

To be eligible for Plan B coverage, **persons who are now 65 or over** should have enrolled in the program by May 31. Those who did not sign up before the deadline now have to wait until October 1967 for their next chance to register.

If an applicant can offer a good reason for not having enrolled before May 31, the deadline may be extended in his case. He would be able to apply immediately, instead of having to wait until a year from October.

Persons who will soon become 65 are encouraged to file for Plan B coverage three months before their 65th birthday, so that the benefits will be immediately available to them when they come of age.

What Does Plan B Cover?

Basically the plan covers **three kinds** of doctor services or related services. The coverage includes:

(1) Medical and surgical services by a doctor—in your home, in his office, or in a hospital. Dental service is covered also, but only if the service is covered also, but only if the service is considered major dental surgery.

Routine physical checkups, routine dental care, some eye and hearing examinations, and immunization shots are among the services not covered by the plan.

(2) Other medical services and supplies. The coverage includes X-ray treatments, splints, casts, braces and other medical equipment, and artificial arms and legs.

Among the medical items which are not covered are false teeth, eyeglasses, hearing aids, and orthopedic shoes.

(3) Home health services. These services are offered by approved medical agencies which treat persons in their own homes. The Bristol Visiting Nurse Association, for example, is a home health agency.

A patient is entitled to up to 100 visits in his home each year by nurses or other health workers, including therapists. Before he can receive the services, however, his doctor must make an examination to be sure there is a true need for the care.

Full-time nursing care, housekeeping services, and prescription drugs are among the types of services not covered by this provision of the plan.

Cost To The Patient

Under Plan B the patient pays the first $50 a year toward the cost of medical services. After that first $50, medicare will pay four out of every five dollars he needs for doctor bills that year.

How Payment Is Made

The doctor — **if he is the patient's private physician** — may be paid for his services in two ways.

(1) He may bill the Social Security Administration and receive direct payment from that office. The only thing the patient must do in this case is to sign a form confirming that he actually received the services the doctor says he rendered.

(2) The patient may apply for the money and then pay his doctor. The process in this situation is more complicated, and it involves some additional work for the patient.

First he must go to his doctor and get receipts for the services rendered. The receipts must show date, place, and the nature of the services rendered, plus the cost of the services.

The patient then submits the information to Connecticut General Life Insurance Co., which acts as an agent or middle man for the government. Connecticut General will send the money directly to the patient, who can then personally square his account with his doctor.

If the doctor is not a private physician but is a staff specialist at a hospital, the hospital files for the money due and settles accounts between the patient and the doctor.

Additional information on Plan B and applications for enrollment are available from Adolph J. Tenukas, the district field representative for the Social Security Administration. He is available at City Hall every Tuesday from noon to 3 p.m. He also may be reached at his New Britain office, 60 Court Street, from 9 a.m. to 5 p.m. Monday through Friday.

Tenukas has asked that persons entering a hospital carry with them their wallet-size medicare health insurance enrollment card, which must be presented to hospital officials at admittance.

New Britain Herald - 6-30-66

Hospitals in Area Set for Medicare Start Tomorrow

On the eve of the start of Medicare tomorrow, New Britain area hospitals have completed arrangements for full participation in the health insurance program.

The participating hospitals are named by Joseph Pawlina, manager of the local Social Security office, are the New Britain General Hospital, New Britain Memorial Hospital, Bradley Memorial Hospital, Southington, and Cedarcrest Hospital, Newington.

13,000 Eligible

More than 13,000 area residents 65 or over are eligible to receive benefits under program.

According to Pawlina, more than 6,000 hospitals in the nation have already been approved for participation with more applications being approved every day. Only a few hospitals in the

(See Page 2, Col. 4)

—HOSPITALS

(Continued)

country failed to apply. The law required a formal application from hospitals desiring to participate in Medicare. There is no such requirement, however, for the coverage of doctors' services under the medical insurance program.

Except in strict emergency situations, services received in a non-participating hospital are not covered. Pawlina defined emergency services as those which are necessary "to prevent the death or serious impairment of the health of the individual and which require the use of the most accessible hospital available which is equipped to furnish such services."

Pawlina pointed out that while physicians and hospitals have the major role in providing services, other members of the health community will also be providing covered services. These include home health agencies, independent laboratories, and, starting Jan. 1, 1967, skilled nursing homes that qualify as extended care facilities. The New Britain General Hospital nominated the Aetna Insurance Co. to serve as a fiscal intermediary for the handling of Medicare benefit payments under hospital insurance; the New Britain Memorial Hospital nominated the Travelers Insurance Co. The Connecticut General Life Insurance Co. was appointed by the Social Security Administration to handle claims for services received locally under the medical insurance part of Medicare, such as physicians' services. Pawlina invited New Britain residents to write, phone, or visit the Social Security District Office, 60 Court St., for answers to their questions about the health insurance program.

NEW HAVEN JOURNAL
June 28

6,505 Units Qualify For Medicare

WASHINGTON (AP) — Hospitals providing 91.9 per cent of the nation's hospital beds now are certified under the Civil Rights Act for participation in medicare, the White House reported Monday.

The announcement came simultaneously with a new list of 221 hospitals issued by the Department of Health, Education and Welfare as having been cleared under the rule forbidding racial discrimination.

That brought the total of certified hospitals to 6,505, or 88.4 per cent of the 7,356 hospitals which are considered qualified to care for elderly patients when medicare begin on Friday.

The variance between the percentage of beds qualified and the percentage of hospitals so listed is due to the fact that many of the qualified hospitals are above average size.

Many of the 850 hospitals not yet cleared for rights compliance are in the South. Although dozens of hospitals are being cleared daily, it appears there may be large gaps in hospital participation in Mississippi, South Carolina, Alabama, Louisiana, and some other Southern states.

A White House spokesman said that, on the basi of beds available, Mississippi is the only state with fewer than 50 per cent cleared for civil rights compliance at this time.

The Health, Education and Welfare tally of hospitals showed some other state with fewer than half their institutions certified, although the average for the 11 Southeastern states as a whole is about two-thirds.

The count showed 28 out of 133 hospitals cleared in Mississippi, 67 out of 144 in Louisiana, 82 out of 146 in Alabama, 88 out of 176 in Georgia, 41 out of 93 in South Carolina, 76 out of 119 in Virginia and 125 out of 166 in North Carolina.

On the other hand, the department reported 100 per cent compliance by the hospitals of 19 states — Alaska, Arizona, Colorado, Hawaii, Idaho, Indiana, Iowa, Maine, Massachusetts, Minnesota, Montana, Nevada, New Hampshire, New Jersey, Oregon, Rhode Island, South Dakota, Vermont, and Wyoming.

Compliance was close to complete in nearly a score of other states, indicating that elderly patients will have little difficulty in any region outside the Southeast in finding a participating hospital.

The Social Security administration meanwhile still is in process of checking the health-care standards of hospitals. A spokesman said Monday that 5,048 have been cleared so far, but that several hundred others are in process and close to final clearance.

Social Security officials expect that more than 95 per cent of all hospitals seeking to participate will meet the technical standards.

Medicare Starts Today

Hospitals' Year Of Plans Pays Of

Connecticut hospitals are not being caught napping as the many pressures of Medicare begin today.

According to Dr. T. Stewart Hamilton, president of the Connecticut Hospital Assn., they have been preparing for its advent for a year.

This planning, Hamilton said, has taken several forms: talks have taken place with Connecticut Blue Cross and other government-approved intermediaries for settling hospital accounts with Medicare patients.

In addition, the physician's role in Medicare has been thoroughly discussed with Connecticut State Medical Society officials, and between physician-medical groups at area and local hospital levels.

Statewide conferences have also taken place, at which Social Security and other governmental representatives have explained their procedures.

The CHA co-ordination effort, keeping member hospitals up to date on legislation and other factors, is effected through four of the association's councils, those responsible for professional practice, governmental relations, administrative practice and prepayment.

Construction and expansion activity among local hispitals over the past year, Dr. Hamilton said, "has also had in mind the mounting demands of Medicare."

With all the preparation, hospitals in the state recognize that there will be many problems.

As the CHA spokesman put it, "We're not unmindful of the complexities and challenges this program presents, and the many shifts and changes that may be necessary in hospital services and facilities."

Regarding the scale of Medicare payments, Dr. Hamilton said, "It is still to be determined whether financing is adequate to meet Connecticut's demand for the best in hospital care."

He also noted the "major problems of activating Medicare services while hospitals themselves face noticeable personnel shortages."

As to the attitude of hospitals, as Medicare becomes a reality, Dr. Hamilton stated, "All of us share the desire to see the program succeed as smoothly as possible.

New Bedford Standard Times



—Standard-Times Staff Photo by Ronald Roi

FIRST IN CITY — Nurse Dorothy Davis attends Mrs. Rose Faford, 80, of 362 Main St., Fairhaven, at St. Luke's Hospita today. She was first patient admitted here under medicare.

Homemaker-Home Health Certificates Given to 17

Certificates have been presented to 17 Homemaker-Home Health aids here by Massachusetts Department of Public Health for satisfactory completion of homemaker-home health aid training program. The homemaker-home health aide staff in New Bedford now numbers 30. Additional homemaker-home health aids were needed to meet demands of Medicare.

Homemaker-home health aids under the supervision of the area visiting nurses and district nurses will furnish the health services in the patient's home under Medicare.

Both the basic hospital plan and the voluntary medical plan provide the services of a homemaker-home health aid in the patient's home.

These services will be given under the physician's orders and under the supervision of a registered nurse on the staff of a certified home health agency.

The certified agencies in Greater New Bedford are the New Bedford Visiting Nurse Association, Inc.; the Community Nurse Association of Fairhaven; the Marion Visiting Nurse Association, Inc. and the District Nurses from the towns of Dartmouth, Acushnet and Mattapoisett.

The duties of homemaker-home health aids include the personal care of patient and household services.

The treatment plan of each patient is established by the physician and the registered nurse supervises the personal care given by the home health aid.

Medicare will in no way alter the present program of this United Fund Agency, and it will continue to provide homemaker-home health aids to help maintain, strengthen and safeguard the care of children and the functioning of dependent, physically or emotionally ill or handicapped children and adults in their own homes.

Homemaker Service of Greater New Bedford, Inc. was inaugurated Feb. 15, 1965 and from that date until May 31, 1966 has provided 24,189½ hours of service. The need for such a service in the community is indicated by the rapid growth as shown by 2,215½ hours of service in May of 1966 as contrasted with 995¾ hours of service in May, 1965.

Certificates were presented by Mrs. William L. Jenney, the vice-president, to Mrs. Josephine Barratt, Mrs. Helen Buckles, Mrs. Dorothy Coggin, Mrs. Christine Corey, Mrs. Anna F. Day, Mrs. Nella D. Dufresne, Mrs. Eva A. Gomes, Mrs. Vivien Gonsalves, Mrs. Bernice G. Hardy, Mrs. Edna Martin, Mrs. Doris E. Marlowe, Mrs. Verna W. Moores, Mrs. Elsie Paull, Miss Annette Richard, Mrs. Dolores A. Rose, Mrs. Antonia Santos and Mrs. Bertha Shard.

SEWING FIRST-AID KIT

A new sewing aid can go on the wall by ironing board, or where otherwise needed, to provide on-the-spot "first aid" repairs. Pins, needles, threads, ruler and tape measure all are mounted on a strip of hopsack, which is edged in fringe and decorated with felt motifs.

Medicare Jam Doesn't Occur

Patient Influx Expected Tuesday

WASHINGTON (UPI) — A funny thing happened to medicare on the way to its trial as "the great experiment" — it didn't jam up the nation's hospitals on its first day.

Though hospitals braced for it and doctors predicted "bedlam," the anticipated flood of medicare admissions Friday turned out to be just a trickle at hospitals from coast to coast.

In scores of spot checks, hospital administrators had the same thing to say: "It's business as usual."

New England Quiet

In New England, the long lines of patients expected during the first 24 hours of medicare did not materialize, but experts now say the real test will come Tuesday.

A slightly above normal flow of patients over 65 needing emergency care were treated at New England hospitals. The most persistent problems occurred when hospitals ran out of government forms or patients forgot to bring their medicare identification cards.

Social Security Administrator Robert M. Ball, the man in over-all charge of the new health coverage for 19 million Americans over 65, said a government check of 100 hospitals disclosed admissions "running at normal rates" and the program beginning "very smoothly."

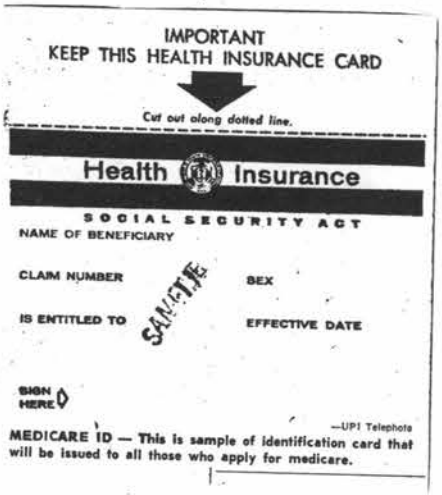
Although General Hospitals in Cook County, Chicago, and Los Angeles County, Calif., disagreed on which was the nation's largest, they were unanimous on medicare's impact: Practically unnoticeable.

Reason Given

The reasons advanced for the unexpectedly low admission rate were many.

Some officials said Friday is always a day of fewer admissions and summer is the slack season. Others said some eligibles facing elective surgery stayed home because of the July 4 holiday.

In Florida it was reported some patients preferred to go into hospitals a few days ago, on their own insurance, to avoid the expected crowd Friday.



—UPI Telephoto

MEDICARE ID — This is sample of identification card that will be issued to all those who apply for medicare.

SOUTHERN STATES

Florida

Louisiana

Arkansas

Texas

Mississippi

Tennessee

South Carolina

North Carolina

Georgia

Alabama

Kentucky

Huntsville News
Huntsville, Ala.
July 2, 1966

Nothing is free

As the government and the medical profession seek to discharge their duties to older people under the medicare law, everyone should be reminded again and again that there is no such thing as a "free" service. Nothing in this world is free and nothing new has been created under medicare. By law, the taxpayers are paying some of the medical bills of a selected group of people. As time goes on, the law may be revised to include the care of other age groups. Medicare may eventually be extended until it becomes a national health service such as was adopted in Britain nearly 18 years ago.

The British plan of government medical care which was to provide free service to all is threatened with a disastrous breakdown. A British Medical Association reports that, "Unless vast new sums of money are made available – from some source or another – the present concept of a hospital service must be abandoned. . .Half of the nation's hospitals are more than 80 years old, and only two new general hospitals have been built since 1939. The British Medical Association report concludes: 'If the public wishes to have an unrestricted health service, it must be prepared to pay for it. . . .'"

The medical profession in the United States is going to do everything possible to facilitate the operation of medicare. It will do its utmost to preserve the all-important, doctor-patient relationship that is so vital to the high medical standards to which we have become accustomed. It is the obligation of the people, all of us, to remember that medicare does not mean "free" medical care. The more that is demanded in the way of service from hospitals and doctors, the more it is going to cost unless we wish to end up with a bankrupt medical system as Great Britain appears to have done.

Daily World
Opelousas, Louisiana
July 3, 1966

MUGWUMP

By JOHN R. THISTLETHWAITE

Medicare Cripples Our Neediest

MEDICARE begins today in Louisiana with a situation so sadly ridiculous that you will not believe it. I didn't, anyhow, until I checked it out with welfare authorities. This is the story:

THE REALLY NEEDY old age recipients in the Louisiana welfare program -- those certified as medically deprived -- are now in far worse financial condition if they signed up for Medicare (Title 18-b) than if they did not.

If these people did NOT sign up for Medicare, the state pays their doctor bills (two calls per month) and most of their medicines, just as was done under the Kerr-Mills federal aid act.

On the other hand, if they DID sign up for Medicare -- as almost 100 per cent did -- then they must pay their $3-monthly or $36 per year premium and also the first $50 of their doctor bills each year, before they get a penny of help. And Medicare doesn't pay but 80 per cent of their doctor bills above the first $50.

On top of that, Medicare pays for no drugs.

TO RESTATE for clarity:

If medically deprived old-age welfare recipients signed up for Medicare, they must pay a total of $86 in a given year after which Medicare will pay only 80 per cent of their doctor bills.

If they DID NOT sign up for Medicare they get doctor bills and most medicine bills paid. The only medicines for which welfare does not pay are "shots" and steroids.

How you like that?

MEDICARE is a good deal for all oldsters who are not plastic-card (medically deprived) welfare recipients, including the rest of the old people on welfare. For $3 a month, at their advanced age, they get a $50 deductible policy which takes care of 80 per cent of their doctor bills. For example, surgery and recuperation costing $2000 in doctors' bills would only cost them $400 and Medicare will pay the rest.

Because it is such a good deal, everybody in creation urged these old people to sign up. This newspaper gave reams of space and daily front page articles as the deadline neared to sign.

Welfare figures here indicate that more than 99 per cent of the medically deprived old age recipients in this vicinity signed up. And they did so on the advice of all whom they trust.

Nobody had any idea that this would result.

THE WAY OUT for them, of course, is to fail to pay the $3 monthly Medicare charge. The policy thus will never go into effect. By not paying for Medicare, it appears that the entire benefits provided by the welfare's plastic card will continue.

Perhaps it would be wise, however, for them to go ahead and pay the $3 for the first couple of months, to keep enrolled while awaiting developments.

For something surely will be done. Such a punitive situation against the most medically needy among our indigent people cannot be continued.

All of this refers only to holders of plastic cards among our old age welfare people. They represent under 25 per cent of the total; the neediest percentage. All others should continue under Medicare as they will have no coverage for physicians' services unless they do.

MEANWHILE, on Pg. 3 today there is an explanation from state welfare headquarters of the situation -- which supports what we have said above but does not spell it out.

Under Title 18-a, you will see that Medicare pays for hospitalization but not doctor bills (although it does not say so; it omits the negative). Title 18 covers those who have signed for Medicare.

Under Title 19 -- covering those who did not sign for Medicare and others eligible for welfare medical care -- you will see that the same medical payment program which has been in effect under Kerr-Mills is continued.

And there you have it: In Louisiana, medically needy and indigent old people who signed for medicare get hospitalization but not drugs, and they must lay out $86 a year before they get only 80 per cent help on doctor bills. Those who did not sign for Medicare get the full deal.

THERE MUST BE some reason for this situation. We have some smart people in our state welfare office in whom Louisiana can place full confidence. When one has to deal with federal regulation, some odd situations develop.

And so when the situation is clarified more fully we will report further. For there has got to be an explanation for ' sorry situation.

GREENSBORO DAILY NEWS
SATURDAY, JULY 2, 1966

First Day Of Medicare

Yesterday, with the inauguration of Medicare, marked another milestone in this country's social and humanitarian progress.

The battle over what is essentially an insurance program to care for the hospitalization and medical bills of the nation's elderly has been fought, with long argument and strong protest from the medical profession, and won in the Congress. The program, actually an extension of Social Security, clearly has the approval of the majority of the American people—not merely the elderly who come under its provisions but younger people who otherwise face the prospect of shouldering medical costs for parents and grandparents. And the younger citizens of today will have the same burdens of their own as they march on with time and its inflictions.

Medicare, in some form and by whatever name it might have been called, was inevitable. The population has grown older; the costs of hospitalization and medical care have risen; and the helplessness of the aged has cried out for correction. The approach has been gradual, but it has been steady; we see no departure therefrom. As evidence of that, we cite the permanence of Social Security and the failure of any party in Great Britain to oppose the medical care program which has existed for two decades in that country.

Our emphasis is upon principle. Despite all the preparations that were made for Medicare's advent, no one can say precisely how it will work out. Months at least will be required to evaluate and determine what changes need to be made. Certainly we believe in preservation of the longstanding personal relationship between doctor and patient and in a free choice of physician and hospital. At least an attempt has been made to assure continuation of such relationships; the administrative phase of Medicare follows largely the procedure of existing hospital insurance and clearance of claims will be through contracts with privately operated and experienced companies.

All must recognize that the program, by its scope and newness, imposes heavy and trying burdens upon hospitals and physicians; and no one has a greater responsibility to recognize this than the governmental agency which administers it.

There are certain compensating gains, however, in that hospitals should be paid for many cases which they have been writing off and absorbing in costs of paying patients. The same is true of physicians. While their charity work is greatly appreciated, it is unfair to burden them with the load that they have been carrying; and Medicare, with supplemental insurance, should cut down on charity work to an appreciable degree.

The new program, in turn, places a responsibility all its own upon the physicians who will still have to admit patients to hospitals and are a vital part of the procedure to determine that Medicare patients do not abuse the new program or clog hospitals already congested by staying longer than their illnesses require.

We do think that hospital management and personnel and the medical profession should seek in every way to make the program a success in its alleviation of human suffering and its effort to deal with what all recognize as a growing and inescapable problem.

As a final word, we do believe that the AMA's house of delegates who overrode the recommendation of the association's study committee and called on physicians to bill patients individually and leave collection of Medicare claims to them made a serious mistake which could backfire. These claims, it seems to us, should be handled as other hospital and medical claims are handled. Many elderly patients will not be able to fill out the forms; and generally there may be confusion and delay. A smoothly running doctor's office, with the know-how, could do much to expedite claims and make the operation easier for all concerned.

Good will remains an essential to the patient-doctor relationship which we earnestly hope will be maintained.

Medicare we have with us today; and if the record of health care in other countries means anything, it is here to stay.

BILL OF RIGHTS—No law . . . abridging the freedom of speech . . . or the right of the people to petition the Government for a redress of grievances.

AMARILLO GLOBE-TIMES

Louise Evans, Editor, Editorial Pages

PAGE 46 **Amarillo, Texas, Thursday, June 30, 1966**

'Medicare' Starts What Might Be Rocky Road to Success Tomorrow

Hopes are high and fingers are crossed as the July 1 debut of medicare approaches. Addressing the National Council of Senior Citizens in the White House Rose Garden in early June, President Johnson chided "the few of little faith" and predicted that, "Together we will make this program work."

All the same, the President is taking no chances. A recent White House conference of medical care leaders discussed every problem and took every possible step "to make sure that the reality of medicare matches the hopes of the last 20 years (that is, since government health insurance was first proposed in Congress)."

Meanwhile, the American Medical Association scheduled a day-long medicare seminar in Chicago on the day before the annual A.M.A. convention opens. The purpose was to examine the final medicare regulations, which the Social Security Administration had prepared.

Medicare actually is a dual program consisting of compulsory hospital insurance, financed from the proceeds of a special payroll tax, and voluntary medical insurance. Under the compulsory program, persons aged 65 years or older need pay only the first $40 of the cost of 60 days of hospitalization. The government pays the remainder. Moreover, the government will meet all costs in excess of $10 a day for an additional 30 days of hospital care.

The premium for voluntary medical insurance — the first notices have just been mailed out — amounts at present to only $3 a month. Coverage includes government payment of 80 per cent of "reasonable charges" (after the first $50) for medical services. These include doctors' and surgeons services in the patient's home, at the doctor's office, or in a clinic or hospital, 100 home health visits, and various other benefits.

A rocky start for medicare is probable. In a special report to President Johnson, the Department of Health, Education and Welfare estimated that at least 1,000 of the country's 8,000 hospitals would fail to meet either the program's civil rights standards or its quality standards. Around 6,900 hospitals have agreed not to refuse admission to patients on account of their race or color. Most of those which have declined to do so to date are in the South.

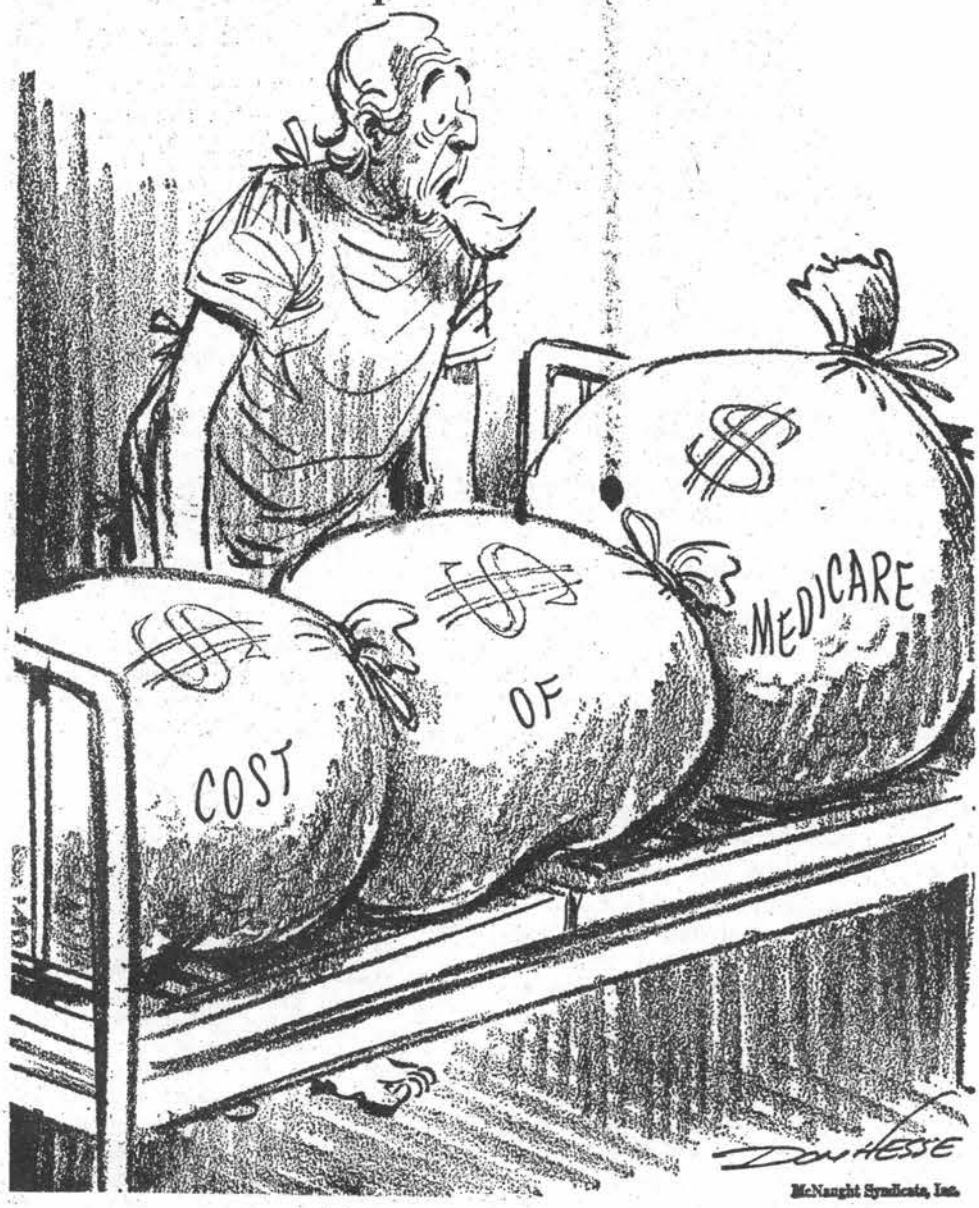
Taking a longer view, the National Disease and Therapeutic Index predicts that the impact of medicare will be small in relation to the normal annual growth of private patient visits. Such visits increased by 35 per cent between 1960 and 1965, or four times faster than the population grew in the same period.

"If the relationship between population growth and patient visit volume continues," NDTI stated in a recent study, "by 1970 we would expect — even if medicare were not available — a total private visit volume of 1.71 billion, compared to the current estimate of 1.31 billion."

Medicare benefits would add only about 60 million visits to the projected 1970 total. This, if it comes to pass, would seem to be a manageable burden for the medical profession.

Paper Globe-Times Place Amarillo, Texas Date July 1, 1966

The Hospital Bed Is Made...



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Paper News & Observer
Raleigh, N. C.

Place

Date
July 3, 1966

Implacable Performance

Set it down as indisputable fact that it is the law of the land that racial discrimination is illegal in all such public institutions as schools and hospitals, as well as hostelries and cafes. This law should be enforced. But other such laws as Medicare and aid to education were not passed merely as police devices for civil rights. And it could not have been the intention of Congress that, when close questions as to what constitutes observance of civil rights law arise, arbitrary judgments of one or two of a multitude of administrative agents should quickly rule as to whether children get the benefits of educational aid or the sick receive the care to which they are entitled.

Some benefit of the doubt should be given to the sick and the children dependant upon essential facilities. And the fact that doubts do exist—and mistakes happen—is evident in the approval, then denial, then approval again of Watts Hospital in Durham during the time which news from Washington described as "the last minute frenzy in the compliance office" as to Medicare. Undoubtedly some of that frenzy may have been caused by reluctant local hospital officials. Some at least may have been caused by the intransigent attitude of some inspectors. The only real victims were the patients facing the Fourth of July as a time not of independence but a sort of exile from hope and promise.

Of course, any suggestion that "deliberate speed" rule in this Medicare business would be met by the old true cry that the colored folks have been waiting for a hundred years. Still waiting a few days in some sympathy for the old sick, where the question of hospital accreditation is a close one, wouldn't prolong too much the approach to perfection. Most of them haven't many days left. And new power never lost much ground as a result of a little pity even in implacable performance.

The Atlanta Journal

"Covers Dixie Like the Dew"

Since 1883

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EDITORIALS 18 JULY 1, 1966

Medicare Begins, and a Time of Testing

MEDICARE went into effect Friday, and with that event the country entered a new era in the provision of health services.

The distinguishing difference is that a whole segment of the people now has these services as a matter of right, paid for by them through a government insurance plan, rather than as a matter of need in individual cases, with the benefits donated, as in a dole, by taxpayers at large.

The latter system formerly had prevailed. But in reality it had prevailed only in the richer states. Most of the poorer ones, such as Georgia, had never moved to fully participate so that their citizens might obtain as much coverage under the Kerr-Mills Act as could, say, the citizens of New York or Michigan.

Such regional differences, which always have discriminated against the South most of all, will not prevail under Medicare. This is one reason we advocated this insurance plan, financed under Social Security, as an improvement over the more limited "dole" approach of the past.

Let there be no mistake about whether this is what the people of the country want. Not only did their elected representatives enact the plan; every responsible poll has shown approval.

One of these recently indicated 62 per cent approval of the public at large for Medicare (72 per cent in the East, 64 in the Midwest, 56 per cent in the South and 53 per cent in the West). Significantly, it also indicated this: Two thirds said they would prefer having Medicare to lowering taxes. Government sponsorship was preferred to private insurance plans, which always have left large gaps.

This program, in short, was enacted because people felt a great need for it in this time when medical bills often become such crushing blows that a lifetime of hard work and saving is wiped out by an immediate medical need.

The American Medical Association fought the plan with huge expenditures of money and powerful lobbying. But we think the whole country should note the sensible words spoken Tuesday by Dr. Charles L. Hudson, the new AMA president.

He said the plan does not mean "a bottomless pit of professional destruction and despair," an observation which seems obvious to most people but which runs counter to some extravagant statements previously made by professional spokesmen. Dr. Hudson added that it was "wasteful to our collective professional energy to belabor the past." He himself has worked with federal officials on Medicare regulations, and he said he will continue to work with them on the new program.

At its convention this week in Chicago, the AMA adopted a resolution calling for direct billing of patients, leaving it to them to collect their insurance reimbursements. This system would bypass, for doctors, much of the machinery of Medicare. Its adoption was, in part, a desire to protect doctor-patient relations but probably, for the most part, a desire to demonstrate that the profession is not reconciled to Medicare.

How many doctors will follow this course, and how their bills will be calculated, remains to be seen, and the success of Medicare will be vitally affected by these developments.

But the plan is law. We hope that it will be accepted, if not in good spirit by all at least without serious effort to subvert it.

The Miami Herald

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Editorials

America's Adventure In Health

TODAY STARTS the great adventure in health called Medicare.

The complexities and meaning of this change for the millions of Americans over 65 are discussed elsewhere on this page. They are momentous and the beginning that is made today may be a beginning in an even larger sense.

Already there is talk of extending health care to other groups, perhaps eventually to everyone.

If this is what the future holds, the services that begin today will be only the curtain-raiser on a program so vast it will dwarf any other activity of the government.

This is tomorrow's debate. For now the hope is that Medicare will provide more health services for older Americans. The action of the American Medical Association this week in urging all doctors to bill their Medicare patients directly will make one part of this program more difficult.

AMA's House of Delegates voted to leave the collection of Medicare insurance up to the patients rather than accept assignments, as is usual in insurance cases, and get paid directly by the companies that act as agents for the government.

This is a complication that will work a hardship on many elderly ill who may be confused by the paper work and unable to get the help they need.

The indignation of the doctors over what they regard as government interference in their professional affairs is being taken out on the patients. A better way should be found of expressing dissent.

Medicare is not a wholly perfect instrument and we have pointed this out before. But it is the law and it should be allowed to work for the benefit of the elderly who need medical services.

We hope the physicians will live up to their ancient and honorable precept that the good of the patient always comes first.

Hollywood Sun-Tattler

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FRIDAY, JULY 1, 1966

Use, Don't Abuse, Medicare

For the first time, starting today, the Federal government will help pay hospital, doctor and other health bills for a large segment of the civilian population as a matter of right rather than need.

More than 19 million Americans past 65 will be eligible for Medicare benefits.

This should make life easier for them.

But the bill for Medicare will be a big one for the taxpayers to bear. Including benefits which states may extend to the medically indigent, cost of the Medicare package may exceed $4 billion in the first year. And the cost is certain to keep rising as more and more people live longer and longer.

★ ★ ★

TO KEEP MEDICARE'S COST from soaring wholly out of reach, self-discipline will be essential.

The beneficiaries must refrain from seeking needless medical and hospital attention.

Their families must refrain from encouraging older folks to use high-cost health facilities on the slightest pretext.

Doctors must refrain from sending patients unnecessarily to hospitals, ordering expensive tests not really required, prescribing needless drugs, performing unwarranted surgery, holding patients in hospitals longer than sound medical judgment dictates.

Hospitals must refrain from unjustifiably raising prices; physicians must strive to hold their fees within reasonable limits.

The will to make the program work must be supplied by all — the administrators of the law, the providers of the services, the beneficiaries of the program, and the taxpayers who supply most of the money.

Otherwise, as the outgoing president of the American Medical Association points out: "The impact of this vast venture on health facilities throughout the country would be staggering and the cost could reach impossible proportions."

SAN ANGELO
STANDARD-TIMES

EDITORIALS

OPINION PAGE

Plan Due Fair Trial

Today is M Day — the day Medicare, long discussed, long championed and long battled by large segments of our population, becomes a reality.

How well the system will operate is a matter of conjecture. That it will have profound effect is recognized fact.

At present, two worries are paramount. That despite publicity and government educational efforts, many of those participating in Medicare remain in the dark about what it will and will not cover; and that an unfortunate number of hospitals in the South will remain at loggerheads with the federal government over signing civil rights act compliance agreements, thus preventing otherwise eligible older citizens from receiving their just Medicare benefits.

Happily, most hospitals have made themselves eligible for Medicare participation — it is to be hoped that a common ground for removing obstacles that remain can be found.

As to the first problem, it is perhaps unavoidable that some persons remain uninformed despite good intentions and earnest efforts.

Whatever the arguments have been and will be against it, Medicare deserves a fair trial. To act otherwise is to risk punishing eligible participants who have no part of the quarrel. In the end, Medicare will be what the government, the medical profession and the general public make of it — not what is written on paper. The most crucial time of all is at hand.

Johnson's personal reason for promotion of Medicare

By Marianne Means

WASHINGTON — Not long after Lyndon Johnson was elected to Congress in 1937 his father died. Sam Johnson left behind a stack of hospital bills that the young congressman, already burdened with campaign costs, paid off in small chunks over a period of several years.

President Johnson therefore has a deep personal reason for growing impassioned—as he always does—when he talks about medicare and how it will relieve the financial pressures upon millions of families.

Medicare Friday began to protect 19 million elderly persons against major hospital and doctors' costs. It is not Utopia: It pays less than half of all medical expenses and does not even attempt to help out on such necessary but expensive items as private nurses and drugs taken outside a hospital. But it is the largest federal effort on behalf of the public welfare ever to be undertaken in this country in peacetime. It affects, besides the elderly and their families, some 250,000 doctors and more than 7000 hospitals and their employes.

Southern hospitals and the American Medical Association have battled against medicare to the bitter end.

Hundreds of Southern hospitals have been dragging their feet about enrolling in the medicare program. Under the new civil rights law, they cannot receive federal funds so long as they are segregated. As the deadline for participation neared, however, the applications were pouring in and on the eve of medicare only about 200 Southern hospitals were still holding out. The government has made no effort to pressure the holdouts.

The administration is braced for a sudden avalanche of problems.

Opponents have warned that dying grandmothers will be turned away from Southern hospitals that do not participate in medicare. Others have predicted that this will prove to be a step toward total socialism. Still others have warned grimly that hospitals will pop at the seams from the sudden onslaught of those hordes which put off medical care until the government could help them.

Administration officials concede the danger only of the latter possibility.

Even so, to President Johnson and administration officials medicare's benefits seem well worth the risk of overcrowding.

Bible verse

FOR THOU art my lamp, O Lord: and the Lord will lighten my darkness.—II Samuel 22:29.



THE HOUSTON CHRONICLE
AND HERALD

Notebook

AUSTIN AMERICAN

Medicare Big Item In Fiscal Year

July 1 is the start of a new year, so far as the federal government is concerned.

Texas has a couple of months longer to run on its fiscal year, before it starts a new one, Sept. 1.

The fiscal year marks the switchover to new appropriations and annual budget operations. This year, it marks the beginning of one of the nation's biggest permanent spending programs, Medicare.

Congress barely completed the annual task of making new appropriations to run the government in the new fiscal period. Its annual task of raising the national debt limit will follow soon, considering the increased spending demands of stepped-up military activity. Even withdrawing troops from France will cost a lot of money.

Texas state government appropriations are made on a two-year basis, with many phases restricted within the bill itself to one or the other of the fiscal years. Unspent balances at the end of two years ordinarily lapse into the general revenue fund, as the Legislature cannot vote money beyond the two-year period.

In the past, the Legislature has made efforts at two changes in the state's New Year's Day. One was to conform to the federal July 1; the other to put the fiscal year back to the calendar year. But the need for the several months from the end of a regular session of the Legislature in which to set up and start the spending from appropriations, including a "margin of safety" for a special session, if required, has caused rejection of both moves. The main handicap is the difficulty of conforming financial reports covering federal aid programs.

—RAYMOND BROOKS

AUSTIN AMERICAN

forum

The readers of the Austin American-Statesman reflect many diverse opinions and viewpoints. Therefore the American-Statesman presents editorial page columnists whose opinions and viewpoints also are widely diverse. They do not necessarily represent those of the American-Statesman itself. We reserve our own comment for the Editorials.

Page 4—Austin, Texas Friday, July 1, 1966

EDITORIAL

Medicare Problems

The July 1 deadline for launching Medicare finds the federal government faced with unresolved problems and unexpected controversies.

Members of Congress are complaining that anticipated costs have ballooned the cost of Medicare far beyond the original estimates. The Health, Education and Welfare Department still is trying to get all hospitals to desegregate. And facilities and manpower shortages antedated Medicare and will continue to exist, HEW Secretary John W. Gardner says.

Medicare has been called a "three-layer cake" — the basic hospital insurance plan financed under Social Security, the voluntary supplementary plan for doctor bills paid for by contributions from participants and tax revenues and Title XIX extension of the Kerr-Mills program for the elderly to cover most needy persons.

The most volatile issue turned out to be those that were least expected when Medicare was enacted: The reimbursement guidelines for hospitals and doctors, Title XIX and segregation.

The reimbursement guidelines set up by HEW will add $75 million a year cost to the hospital insurance program, the Senate Finance committee staff has estimated. If extended to Title XIX, the guidelines could cost an added $40 to $50 million a year, the staff said.

Finance Committee members in a May closed hearing objected to advance payments, to reimbursing hospitals for depreciation of assets acquired with federal funds and to a 2 per cent "bonus" payment that was provided in addition to the actual cost of hospital services. Chairman Russell B. Long, Louisiana Democrat, said the added costs could result in an increase in Social Security taxes.

HEW officials defended the guidelines. They said the depreciation allowances were needed to permit the expansion of hospital services. The bonus payment, they said, provides hospitals with a return on money invested in facilities and allowed for "certain unrecognized specific costs" that other guidelines did not account for. The advance payments were provided because hospitals have to lay out money for Medicare services before they are reimbursed.

Sen. Clinton P. Anderson, New Mexico Democrat, a principal author of Medicare, complained that these guidelines were not discussed at hearings on the legislation last year.

The HEW Department made concessions on the guidelines that will reduce the added costs by about $9.5 million a year.

Title XIX provided the lawmakers with another surprise. HEW officials told Congress last year that Title XIX would add about $238 million to the cost of the Kerr-Mills program in all 50 states if they all took part. The costs already exceed the estimates by $262 million for Title XIX programs approved for seven states and Puerto Rico. Awaiting approval is a vast program set up by New York, which would require $217 million in federal matching funds.

Health manpower shortages also could increase the cost of Medicare. At a June 15 White House conference on the implementation of Medicare, participants said competition for scarce manpower would result in higher ages and fringe benefits, which will be passed on to all patients.

HEW officials insist that facilities scarcity is not a serious problem. They say Medicare will increase hospital use by about 5 per cent. The increase can be absorbed in most areas, they say. However the department has identified 88 crisis counties where hospitals are so close to capacity that increases will seriously overload them.

Segregation will reduce available facilities in some parts of the South. Hospitals are refusing to desegregate, despite federal promises to bar them from the Medicare program and cut off all federal aid. Nationwide, 85.8 per cent of the hospitals accounting for 88.2 per cent of the beds have desegregated, HEW officials say. But in seven Southern states less than 80 per cent of hospital beds comply with desegregation regulations of HEW. In Mississippi only 10.6 per cent of the hospital beds are in compliance.

The full impact of Medicare cannot be assessed. That depends on what older people will do after July 1, what kind of Title XIX the remaining states will set up and whether the HEW Department will extend its reimbursement guidelines to other health programs.

Two things are regarded as certain. Some persons will not get all the health care they want, and Medicare will cost more than was anticipated when it was enacted.

Daily Mail
Anderson, S.C.
July 1, 1966

A Date For The History Books

This is a date that will be fixed indelibly in American history books, for it marks the beginning of the medicare program, and, some believe, the start of a road that will eventually lead to fully socialized medicine.

At present medicare protection is available only to those over 65, and, at that, the only "free" portion is hospitalization and some nursing home care.

Those over 65 may secure assistance in payment of doctor bills by a $3 per month payment into the fund. That is matched by the government, which is to say by taxpayers, most of whom are under 65.

Already, however, there is talk in Washington of extending at least a portion of the medicare benefits to the general population. Many are of the opinion that this next step will eventually be taken, and some pessimistic physicians and their national organization, the American Medical Association, fear the adoption of a socialized medical care program, such as that in England and some countries on the European continent.

As the present medicare plan gets under way there are still great clouds of doubt and confusion not only among physicians but among hospitals as well.

The medicare bill was passed and signed into law on July 30, 1965, but approved hospitals have not yet received final instructions as to procedures that are to be followed. Doctors, also, are uncertain as to billing practices.

For the time being, therefore, both patients and those who care for them may be forced to "play it by ear" pending clarification of many of the fine points.

The prospect of overcrowding at hospitals, specifically in Anderson, is unlikely. About 10 per cent of the average patient load at hospitals is represented by over-65 patients, but they stay about 50 per cent longer than younger patients.

Since many of these cases are already being cared for under some assistance program already in effect, the additional load is not expected to strain Anderson Memorial Hospital facilities, although, as with almost every other new practice, an initial rush may develop. This, however, should soon level out to a constant hospital load on a slightly higher plateau than at present.

Hospital Administrator George Little and his staff are prepared to work both the Social Security Administration and with eligible patients, and the hospital routine is likely to continue without material interruption.

One unanswered question that is causing some concern is the matter of physician's fees, and the portion thereof that will be assumed by the section of the medicare program covering this phase of treatment.

So far no firm guidelines have been set. Whether they will be in line with fees already being charged is a matter yet to be established. Also pending is the matter of treatment by specialists who, as a rule, have a higher scale of fees than most family physicians. If a doctor charges more than medicare will pay, it may be up to the patient to meet the difference or to find a physician willing to work for smaller fees.

It is all, as we said, a grand experiment, but it should work out well especially for elderly patients, many of whom have heretofore had inadequate medical care.

It is to be hoped that all concerned —hospitals, physicians, and patients, will work in harmony to give the system a fair trial rather than attempting to scuttle the program by refusing to co-operate, or, in the case of patients, by making unreasonable demands upon agencies attempting to administer the program in a fair and equitable manner.

Texas

THE PORT ARTHUR NEWS

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Open Letters from Arthur Port

Arthur Port

To Medicare:

The nation stands eager, uncertain and anxious, awaiting one of the most momentous answers in its history:

How will Medicare work out?

Under the gun of the challenge are the hospitals and the doctors, who face an impact that nobody can appraise fully until it happens.

The elderly are filled with anticipation and hope.

The realists fear that many will be disappointed at not promptly realizing all the benefits they believe they're entitled to.

Many hospitals—including all those in metropolitan Port Arthur—are expanding, not just to meet demands of Medicare but also to accommodate their growing overflow of conventional patients.

Speculation runs rife as to the total cost of this mammoth adventure in taking care of the ailing. Many see the program as opening the door to eventual "socialized medicine." Others accept it as a humanitarian endeavor to assure hospital and medical care for the elderly.

No wonder the nation is eager, uncertain and anxious—but hopeful.

Arthur Port

Pg-1

Herald Durham Morning

DURHAM, N. C., SATURDAY, JULY 2, 1966

Apology Wired For 'Boner' On Watts Medicare Status

Related Story On 1B

A U.S. Public Health Service official Friday wired a public apology to Hal Crain, president of Watts Hospital, for confusion resulting when he briefly withdrew the institution's certification to treat medicare patients because of "new information regarding its racial situation."

The official, Robert M. Nash, chief of the office of Equal Health Opportunity for the Public Health Service in Washington, sent his regrets for the error.

Nash Wednesday told Herald Washington correspondent Wes Hayden that Watts Hospital, certified earlier in June to provide medicare treatment, had been withdrawn from the certification list because of its lack of racial integration.

However, another Public Health official Thursday announced that Watts had been restored to the certification list Wednesday night. The spokesman said the decision to withdraw certification had "been a boner."

Sen. B. Everett Jordan, meanwhile, demanded the Public Health Service issue an apology to Watts officials for the resulting confusion and anxiety.

Nash, in announcing withdrawal of Watts' eligibility for medicare payments, said that he had been informed that Watts' physicians, both white and Negro, were referring all Negro patients to Lincoln Hospital.

The text of Nash's telegram to Crain follows:

"Please accept my apology for the error in reporting Watts Hospital as being in violation of Title VI, Civil Rights Act.

"The information I released to the press on June 29 was in error.

"The basis for this confusion rests in the fact that there is also an all-Negro hospital in Durham, that is, Lincoln Hospital, and such hospitals usually exist as the result of the exclusion of Negro patients and Negro physicians from other hospitals.

"This is true in Durham. I am sure you will understand that such situations present a reasonable basis for questioning present practices.

"Watts hospital has, however, taken measures to redress the wrong, and, on the basis of the information available to me at this time, is in compliance with Title VI of the Civil Rights Act."

* * *

* * *

U.S. Hospitals Easily Absorb Initial Impact

WASHINGTON (AP) — With hospital-like efficiency the nation's medical plant easily absorbed Friday the first-day impact of medicare — and, in many Southern cities — desegregated thousands of hospital beds.

City after city reported, "no rush," "everything normal," "no problems," "going smoothly." Some hospital officers predicted heavier admissions after the Fourth of July. Others cautioned that the full impact is still a month or more away.

"An auspicious start," commented U.S. Surgeon General William H. Stewart.

Stewart and Robert M. Ball, Social Security administrator, estimated that 94 per cent of the nation's general hospitals, representing 95.9 per cent of the beds, were prepared and qualified to participate in medicare.

They met reporters jointly in Social Security's Telecommunications Center in Baltimore, Md. There, a nationwide wire network will feed data on the 19 million medicare policyholders into and out of computers.

The totals given by Ball and Stewart were a bit higher than those from other federal offices, but all sources agreed on this: Hospital participation was far broader, especially in the South, than authorities had dared to hope for a month or two ago.

Most of the several hundred Southern hospitals outside the program had failed to comply with the no-racial-discrimination provisions of the Civil Rights Act.

Washington Sidelines

Medicare's Test Begins

WASHINGTON —Medicare is ushering in a virtual revolution in medicine and hospital administration in the United States. The full effects may not be realized for several years.

The burden that will be placed upon hospitals is still a matter of conjecture. Medicare comes, really, in two parts. The part that pays hospital bills is available without charge starting today to nearly everyone aged 65 or more. The second part covers doctors' bills and some other medical expenses for people 65 and more. This optional protection, which starts July 1, costs $3 a month per person. The Social Security administration as of June 3 had processed applications of 17,337,000 oldsters for the voluntary coverage. This service, incidentally, has the deductible feature familiar to most health insurance plans. Benefits start after the patient has paid $50 of his own money.

Still another service begins on Jan. 1, 1967. Medicare will then provide funds for up to 100 days in an extended care facility like a nursing home in each illness after a hospital stay of at least three days.

The fear is widespread that the nation's medical, nursing, and hospital disciplines just won't be able to accommodate the upsurge of older persons seeking help under Medicare. This could cause political disturbances. Old people who have been told that their ills will be taken care of could be awfully cold to tales of doctor, nurse, and hospital bed shortages. The Johnson administration already shivers at the memory of 1946, when voters who couldn't get meat expressed their indignation very pragmatically at the polls.

On the other hand, California, which implemented the federal Medicare program with special state legislation put into effect last April 1, reports no great hospital crush. Dr. Ralph C. Teall, president of the California Medical Association, on April 27 said that the state's first month of experience with Medicare appeared to refute predictions that hospitals would become clogged when the program went into effect nationally. "We should have seen a tremendous pressure on hospitals during the past month," Dr. Teall said, "but the pressure has been only relatively minor."

In any event, a shortage of medical specialists already pinches, regardless of the pressures, however debatable, of Medicare. The Federal Nurses Training Act of 1964 is aimed at assuring a 1970 total of 680,000 registered nurses even though the Surgeon General's Consultant Group had forecast a need for at least 850,000 professional nurses by that time.

The ratio of physicians to civilian population has fast deteriorated in recent years. We should be turning out about 1,000 doctors of medicine a year, but we are falling far short of that number. In 1961, the Dean of the Yale Medical School, Dr. Vernon M. Lippard, calculated that our needs could be met only by "the establishment of at least 20 new schools of medicine during the 1960s."

RICHARD SPONG

The New Haven Journal-Courier

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Editorial Page
New Haven Journal-Courier Fri July 1, 1966

Paragould Daily Press
Paragould, Ark.
July 1, 1966

'Free-dom'

And speaking of freedom and the land of the free, here's something we should not overlook right now:

There is no such thing as *"free"* service.

Nothing in this world is free and this includes medicare. By law, the taxpayers are paying some of the medical bills of a selected group of people.

As time goes on, the law may be revised to include the care of other age groups. Medicare may eventually be extended until it becomes a national health service such as was adopted in Britain nearly 18 years ago.

The British plan of government medical care which was to provide free service to all is threatened with a diastrous breakdown. A British Medical Association report states that, "Unless vast new sums of money are made available — from some source or another — the present concept of a hospital service must be abandoned. . .Half of the nation's hospitals are more than 80 years old, and only two new general hospitals have been built since 1939. If the public wishes to have an unrestricted health service, it must be prepared to pay for it. . ."

The medical profession in this country, I'm sure, will do their utmost to preserve the all-important, doctor-patient relationship so vital to the high medical standards to which we have become accustomed. But, the people, all of us, must remember that medicare does not mean *"free"* medical care. The more that is demanded in the way of service from hospitals and doctors, the more it is going to cost unless we wish to end up with a bankrupt medical system as Great Britain appears to have done.

As I have said many, many times before in these columns — there is no such thing as a free lunch!



Medichief

Arthur E. Hess, above director of the Medicare program says he thinks the medical care for the aged plan "certainly is going to work." The 50-year-old native of Reading, Pa., has ben with the Social Security Administration for 27 years. (AP Wirephoto)

Questions and answers

Medicare:

WASHINGTON (AP) — Here are answers to some of the questions most frequently asked about medicare, starting today for all Americans 65 and older:

Q. If the hospital I choose is overcrowded, does medicare guarantee me a bed?

A. No. Medicare just helps pay the bill.

Q. If I have to go back into the hospital two or more times, do I pay the $40 "deductible" each time?

A. No. You pay just the first $40 of hospital charges in each "spell of illness."

Q. What's a "spell of illness."

A. To medicare its a period of time, not an ailment. It starts the day you enter a hospital. It ends 60 days after your discharge from the hospital. Or from a nursing home — after next Jan. 1, medicare will provide posthospital convalescent care in nursing homes for those needing it.

Q. Suppose I go back to the hospital for a different sickness?

A. To medicare it doesn't matter. It's all one "spell of ill- comes within 60 days of the last discharge.

Q. Do I have to go back to the same hospital?

A. No. Your benefits follow you from hospital to hospital and from city to city. Just show your red, white and blue card. Any participating hospital can tell instantly, by check to a computer in Baltimore, Md., whether you have used up all your "benefit days."

Q. If I'm in a hospital when medicare starts, does medicare pick up the bill?

A. Not for past days. Medicare picks up as of July 1, and you'll still have to pay the $40 deductible as well as the charges for the days preceding medicare.

Q. I've signed up to pay $3 a month for the voluntary doctor bill insurance. It has a $50 deductible; how often do I have to pay that?

A. Just once each year, regardless of how much your doctor bills add up to in a year.

Q. Should I cancel my old health insurance policy?

A. If you are 65 but your wife is not, she's not covered by medicare. You may want to keep her policy in force.

Q. We are both over 65. Should we buy the "supplemental" plans offered to over-65 persons by Blue Cross, Blue Shield and other private insurers for additional protection?

A. That depends on your own needs and inclinations. Some policies are designed to cover medicare's "deductibles" and provide benefits beyond the limits of medicare. Another type of policy pays off in cash benefits for each day of hospitalization; the money could be used for the inevitable costs of an illness, or for "extras," such as a bedside telephone or a private room instead of the semiprivate accommodations paid for by medicare.

Q. Medicare's doctor bill insurance covers 80 per cent of a doctor's "reasonable charges," after the $50 deductible. Does the doctor send his bill to medcare or to me?

A. Either one. He can send it to medicare's local "intermediary" agency — in most cities, the local Blue Shield organization — which will pay him 80 per cent of what it deems a "reasonable charge" for his treatment or operation; the other 20 per cent would come from you. Or he could send the whole bill directly to you.

Q. In the latter case what do I do?

A. Pay it, then apply for reimbursement to the "intermediary."

The Gatesville Messenger

AND STAR-FORUM

GATESVILLE, TEXAS, FRIDAY, JULY 1, 1966

No Hospital Rush Under Medicare Foreseen Here

Medicare, the government's new health program for the elderly, goes into effect today but Coryell Memorial Hospital authorities are expecting no "rush" of patients.

"We've surveyed this thing carefully, and we don't expect Medicare to increase our patient load by more than ten per cent or so," John Gilmer, hospital administrator, said Thursday.

Of course, the ten per cent increase will probably aggravate an already serious space problem at the hospital, Gilmer agreed. Four beds were recently purchased and placed in previously single-bed private rooms, converting them into semi-private two-bed rooms.

The hospital now has 39 beds, plus four beds in the maternity ward. Of this number, only 14 are in private rooms.

Gilmer said he foresees no significantly heightened demand for hospital beds under Medicare because "most of our over-65 population has had hospitalization insurance and our elderly people have already been coming to the hospital whenever necessary."

Periodic checks throughout the year showed that about 40 per cent of the hospital's patients are over 65 and that 90 per cent of them have had commercial hospitalization insurance.

"It will probably be a different story in the larger cities," Gilmer said.

Coryell Memorial Hospital has been designated as fully qualified to participate in Medicare. This means it meets both civil rights and medical requirements.

Gilmer said he did look for an upsurge in the demand for diagnostic and therapy treatment, and that this would increase use of the hospital's X-ray laboratory and emergency facilities.

"But the biggest load under Medicare will probably be on the doctors," he said.

PULITZER PRIZE 1964 1965

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14 FRIDAY, JULY 1, 1966 B

LETTERS TO THE BULLETIN

Doctors Cautioned On Medicare Fees

In regard to Medicare and the A.M.A. attempting to make it a national policy for doctors to submit bills directly to their elderly patients: who is going to do the paper work and bookkeeping for the "Over 65" group? Where is the cash coming from for the elderly to pay the possibly hiked bills before receiving the 80% reimbursement from the government?

Why, oh why, are doctors acting as though folks over 65 are their only means of support? Isn't there a much greater lucrative potential for doctors in the population explosion of the "Under 65" group?

I'm hoping the doctors will go along sensibly with this wonderful Medicare law. Shame on those who use it as a political battering ram.

"Over 65"

The article appearing in last Sunday's Bulletin, "Medicare: How Much Can the Aged Expect From It," certainly presents an alarming and disheartening outlook on medical service not only for our older people but also for our entire society.

It would appear incredible that a responsible and humane group of men and women, such as we have a right to expect our medically trained personnel to represent, should decide on the option of billing the patient directly on the score that thereby the doctor will be under no obligation to accept the "reasonable fee" as his full compensation.

Justification for this procedure might be warranted to save the doctor's time and extra office expense, but it would certainly appear unconscionable for him to use this as an outlet to raise his fees beyond the "reasonable" limits.

In the quoted words of Dr. Walter W. Sackett, Jr., of Miami, Florida, "It's our right under the law, and we intend to exercise it."

For the sake of our respect and regard for the medical profession, we can hope this attitude is representative of only a small minority of our physicians.

James Culbertson
Carney's Point N. J.

Rocky Mountain News — Denver, Colorado

The Weirton Daily Times

Sat., July 2, 1966

A Goat Named 'Medicare'

Criticism of medicare already is under way and gaining momentum.

It is going to be an interesting thing to watch and listen to the critics in months to come.

Medicare is destined to be the scapegoat for all the problems of doctor-patient-hospital relationships.

To hear its critics unburden themselves, hospitals never were overcrowded before, doctors never were overburdened and patients never had trouble paying bills and fees for the high cost of sickness.

The high cost of sickness wasn't a pressing problem, to hear the critics of medicare tell about it. People unable to meet it were entitled to unlimited free service, or drew on relief funds. People able to meet it without a struggle were charged all the traffic would bear and never murmured. All others paid for the high cost of illness catch as catch can. Being wiped out by a dependant's lingering illness was part of the American way of life.

Men and women over 65 and living in forced retirement on fixed incomes had no problems, and if they did have problems their families underwrote their bills.

All in all, to hear the critics of medicare tell about it, everything was going fine until July 1, 1966 — then everything turned sour.

Fortunately, critics of medicare are a minority.

Many were critics of pre-paid hospital care and medical costs when these now commonplace procedures were regarded as revolutionary.

It is unfortunate — this tendency to turn a controversial idea into a scapegoat. But it is fundamental human nature to do it, and it will happen to medicare.

There will be times in the months ahead when critics of medicare will make it sound as if no problems existed before July 1, 1966.

If they're not careful, they will make it sound as if sickness was unknown before medicare went into effect.

Nation's Hospitals Take Medicare In Their Stride

BALTIMORE, Md., July 1— (UPI) — The nation's hospitals, most of them prepared for a deluge of patients that never came, took the first day of medicare in stride Friday.

It came as a surprise to critics who had predicted turmoil.

Nearly every American 65 years or older became eligible at 12:01 a.m. for benefits under the health insurance amendment to the Social Security Act. But most of those who intended to use the plan apparently decided to wait until after the July 4 weekend.

For the Colorado story on Medicare, see Page 5.

Social Security administrator Robert H. Ball told reporters that the vast program began "very smoothly with no indication of hospital overcrowding."

Ball thus confirmed reports from hospital administrators across the country that the jam-up forecast by some failed to materialize.

Outlook

Sunday, July 3, 1966 HOUSTON CHRONICLE Section 1, Page 23

Area facilities in medicare

ALMOST 93 percent of the nation's hospital beds had been certified under civil rights law for participation in medicare when the program started Friday.

Houston area hospitals that are qualified are:

M. D. Anderson Hospital, St. Joseph, Westbury, Hermann, Travel Clinic, North Houston, Northshore, Southern Pacific, Rockglen, St. Luke's Episcopal, Texas Institute for Rehabilitation and Research, Memorial Baptist System, St. Elizabeth's, Gulfway General, Hedgecroft, Ben Taub General, Rosewood General, Medical Arts, Houston State Psychiatric, Homestead Rd., Sharpstown General, Methodist, Methodist Annex, Pavilion Center.

Also certified for medicare: Deaton Hospital, Galena Park; St. Thomas Hospital, Houston; Twelve Oaks Hospital, Houston; San Jacinto Methodist Hospital, Baytown; Lockwood Hospital, Houston; Bellaire General Hospital, Houston; Riverside General Hospital, Houston.

Also, Gulf Coast Hospital, Baytown; Pasadena Bayshore, Southmore, and Pasadena General, Pasadena; Community, Jacinto City; Tidelands General, Channelview.

Hospitals qualified by Friday in East Texas, Gulf Coast, and Southwest Texas:

Alice: Physicians and Surgeons; Alvin: Alvin Memorial; Anahuac; Chambers Memorial; Aransas Pass; Aransas; Austin: Austin State, Austin-Travis County Tuberculosis, Brackenridge, Holy Cross, St. David's Community, Seton.

Beaumont: Baptist, Beaumont Municipal, Hotel Dieu, St. Elizabeth; Beeville: Beeville, Memorial; Bellville: Bellville; Brenham: St. Jude.

Brownsville: Mercy; Bryan: Bryan, St. Joseph; Buffalo: Leon County; Buna: Buna Medical Center; Cameron: Newton Memorial, St. Edward-Rischar; Carrigan: Polk County; Carthage: Panola General; Center: Shelby General.

Cleveland: Leggett Memorial; Columbus: Columbus; Conroe: Montgomery City; Corpus Christi: Ada Wilson, Doctors', Memorial Medical Center, Osteopathic, Parkview General, Spohn, Thomas Spann.

Cuero: Burns, Cuero, Stratton; Eagle Lake: Laughlin; Edinburg: Grandview; El Campo: Wharton County Nightingale; Elgin: Fleming; Fredericksburg: Fredericksburg, Keidel Memorial; Freeport: Community.

Galveston: University of Texas Medical Branch, St. Mary's; Georgetown: Georgetown Medical and Surgical; Giddings: Lee Memorial; Gladewater: Hancock, Hart, Gladewater Municipal; Goliad: Goliad County

Gonzales: Holmes Memorial, Crews, Texas Rehabilitation; Groves: Doctors'; Hallettsville: Renger Memorial; Harlingen State Tuberculosis.

Huntsville: Huntsville Memorial; Jacksonville: Nan Travis, Newburn Memorial; Jasper: Mary E. Dickerson Memorial; Kerrville: Sid Peterson Memorial; Kingsville: Kleberg County; La Grange: Fayette Memorial; La Marque: Galveston County Memorial; Liberty: Yettie Kersting Memorial.

Livingston: Polk County; Lockhart: Lockhart; Longview: Camp Normal Industrial, Good Shepherd, Markham; Lufkin: Memorial; Luling: Edgar B. Davis Memorial; Marshall: Memorial, Texas & Pacific General; McAllen: McAllen Municipal.

Mexia: General Mexia; Mission: Mission Municipal; Navasota: Grimes Memorial; New Braunfels: New Braunfels; Orange: Orange Memorial; Palestine: Memorial.

Port Arthur: St. Mary's-Gates Memorial; Port Lavaca: Traylor Memorial; Raymondville: Raymondville Memorial; Refugio: Refugio County; Richmond: Polly Ryon Memorial; Rio Grande City: Dr. Rodriquez, Narro Medical Center; Robstown: Robstown Riverside; Rockdale: Richards; Round Rock: M. D.; Rusk: Rusk Memorial.

San Benito: Dolly Vinsant Memorial; San Juan: San Juan; San Marcos: Hays Memorial; San Saba: San Saba Memorial; Sealy: Sealy; Seguin: Guadalupe Valley; Shiner: Frank M. Wagner Memorial; Sinton: Charles H. Ewing Memorial, Sinton; Smithville: Smithville.

Sweeny: Sweeny Community; Taylor: Johns, Johns Annex; Teague: City; Temple: Kings Daughters, Santa Fe, Scott and White Memorial; Trinity: Trinity Memorial; Tyler: Broadway, East Texas Tuberculosis, Medical Center, Mother Frances, Glenwood.

Palacios: Wagner General; Victoria: Citizens Memorial, De Tar, Hchf; Weslaco: Lee Memorial; Wharton: Caney Valley Memorial, Gulf Coast Medical Center; Winnie: Winnie - Stowell; Yoakum: Huth Memorial; Yorktown: Yorktown Memorial.

HOLLYWOOD SUN TATTLER
HOLLYWOOD, FLA.
JULY 2, 1966

ON THE BUSINESS FRONT

Medicare Impact Good For Industry

By TOM E. HINDS
Sun-Tattler Business Editor

The launching of Medicare yesterday is providing a real shot in the arm for both the drug and hospital supply industries, according to H. Heintz and Co., a major Wall Street-based brokerage firm with local offices at 1911 Harrison St.

"We can already see an immediate impact on the h ospital supply area, with government programs likely to add 10 per cent to the industry's already healthy $1.5 billion annual volume, Hentz research director Lewis Kopel said.


HINDS

Reflecting thes optimism, Kopel notes that one major hospital supply firm hit a new high on the New York Stock Exchange within the last few weeks in the face of an otherwise declining market.

In the drug area, he said, implementation of state and federal Medicare benefits should generate increased demand for pharmaceuticals over the longer term. Actually, while Medicare does not cover drugs, treatments for various ailments will require prescriptions.

★ ★ ★

WHILE SUCH DRUGS may be purchased on a generic basis where prices are considerably lower, the vast majority of prescription drugs undoubtedly will be priced in much the same fashion as they are now.

Medicare coverage itself will add some eight million persons over 65 to the 11.5 million already insured in this age group. An additional 35 million will be added over the next 10 years through state aid programs. The medicinal needs of this group should have a favorable impact on the pharmaceutical industry.

★ ★ ★

THE RESUMPTION of a good flow of new drugs, too, as the Federal Drug Administration succeeds in clearing up the rising backlog of new product applications, will add further impetus to drug company earnings, which should continue to grow in the years ahead regardless of cyclical swings in the economy.

The hospital picture in the meantime presents the most pressing area for immediate supply business. Hospital administrators and other experts in the field estimate a current hospital bed shortage of at least one million, and this shortage of hospital and nursing home space will become even more acute as Medicare programs wing into action, and as the 7,500 participating hospitals begin to experience an anticipated 5 per cent step-up in bed utilization.

★ ★ ★

"MEDICARE SHOULDN'T AFFECT us too much, said S. A. Mudano, Memorial Hospital administrator. "We only have so many beds and the majority of them have been occupied without Medicare. We can accommodate only so many patients."

Mudano said Memorial Hospital has 350 beds now but by late summer a 70-bed addition will be ready. On the drawing boards is another 40-bed addition, a $300,000 gift from Edwin M. Rosenthal, Hollywood philanthropist.

★ ★ ★

SOME HEALTH, EDUCATION AND WELFARE Department officials estimate it would require $6 billion in building and equipment costs just to catch up with present needs, and this does not include financing from private sources.

Under the existing federal Hill-Burton hospital construction program, which has helped meet some of the rural and suburban bed shortages over the last 20 years, a $303 million expenditure has been authorized for the current year, and this is expected to stimulate at least twice that amount from private sources.

★ ★ ★

GOVERNMENT OFFICIALS claim that 113,000 of the nation's 751,000 general hospital beds are substandard, while each year an additional 22,000 beds are rated as obsolete. Also about one third of the country's 6,800 general hospitals is in need of modernization.

The most immediate direct impact of Medicare, according to the Hentz executive, should be experienced by the hospital supply segment of the industry, where any increase in hospital modernization and expansion programs, along with admissions, is directly reflected in increased sales.

The Jackson Sun

JACKSON, TENNESSEE, FRIDAY, JULY 1, 1966



FIRST PATIENT—Jackson-Madison County General Hospital nurse, Miss Dora Thomas, makes Mrs. Edith Struder comfortable following her admittance this morning as the first patient to use Medicare which became effective at midnight last night.
—(Sun photo by Gene Martindale)

19 Million Senior Citizens Get Medicare 'Blessing'

WASHINGTON (AP) — The massive medicare program providing hospital insurance for all 19 million of the nation's senior citizens went into effect today, hailed by President Johnson as "a blessing for older Americans."

Swinging into operation with the program was an optional doctor-bill insurance plan for which 17.3 million elected to pay $3 a month.

The two programs were brought into being at 12:01 a.m. in one of the biggest operations in medical history.

Doctors and patients reserved any prognosis, but the President pronounced it a success in advance. He called it "a test of our willingness to work together."

By Public Health Service count, 6,714 institutions — or 91 per cent of all the country's 7,-374 general hospitals with roughly 93 per cent of the beds — opened their doors for the insured care of any American aged 65 or over.

The nonparticipating hospitals were mainly in the South. Most were barred from medicare payments by their failure to comply with the no racial discrimination provisions of the Civil Rights Act.

To make extra sure that no one dies for want of access to a participating hospital, the government ruled Thursday night that federal hospitals — veterans', military and others — may be used for critically ill medicare patients in emergencies.

Previously it had been announced that any other nonparticipating hospital could be used — private or public, with medicare picking up the bill — if a bed in a participating hospital could not be found to avert the threat of death "or serious impairment of the health.

Despite the serious gaps in participation — only 25 per cent of Mississippi hospitals were in the pool — administration aides were jubilant over the generally high participation nationwide.

"We've done far better in the South than we had dared to hope a month or two ago," one Public Health Service official said.

"And more hospitals will be desegregating when they begin to feel the pressure from unhappy local residents, both white and black," he added.

Twenty-three states entered medicare with 100 per cent participation by their qualified hospitals, and some others came close to that.

In his medicare's-eve statement, President Johnson said he had no doubt of the success of the twin medicare programs if these three things happen:

"If hospitals accept their responsibility under the law not to discriminate against any patient because of race."

"If doctors treat their patients with fairness and compassion. I feel sure that most doctors do not plan to drive hard bargains with needy patients."

"If old patients cooperate in scheduling treatment and do not demand unnecessary hospital and medical services."

He concluded: "I have no doubt for the future. I believe that July 1, 1966, marks a new day of freedom for our people."

The government has poohpoohed forecasts that a tide of elderly patients will swamp the hospitals. Hospital administrators generally agree that there will be some difficult local situations but that they can handle the expected average increase of not more than 5 per cent in the patient load.

This judgment was reinforced as each recent day brought scores of new hospitals into compliance. Officials expect that many more will meet both the medical care standards and the civil rights test during July.

The states which already had 100 per cent certification of hospitals for compliance as of midnight were Alaska, Arizona, Colorado, Connecticut, Hawaii, Idaho, Indiana, Iowa, Maine, Maryland, Massachusetts, Minnesota, Montana, Nebraska, Nevada, New Hampshire, New Jersey, North Dakota, Oregon, Rhode Island, South Dakota, Vermont and Wyoming. The territories of Guam, Samoa and the Virgin Islands also had full participation.

At the other end of the scale were Mississippi with 33 of 133 hospitals certified for rights compliance, South Carolina with 46 out of 93, Louisiana with 78 out of 144 and Georgia with 107 out of 176.

Florida had 159 complying out of 188, Virginia 84 out of 119, North Carolina 138 out of 166 and Tennessee 138 out of 163.

If nonparticipating hospitals are used for emergency patients, Robert M. Ball, Social Security director, has ruled, medicare will pay such a hospital only for the period of emergency — not for any care given after it becomes possible to discharge the patient or transfer him to a participating hospital.

And if an emergency admission to a federal government hospital is sought, Ball said, the decision is up to the medical officer in charge and is subject to the availability of beds.

The presidential appeal to doctors not to "drive hard bargains with needy patients" apparently was prompted by a resolution passed Tuesday by policy-makers of the American Medical Association. The AMA recommended that doctors should bill patiens directly for services under medicare.

This would permit doctors to set their charges at any amount they chose, leaving it to the patient to seek reimbursement from the government's medicare "intermediary" agency — in most cases, the local Blue Shield plan. The "intermediary" would reimburse for only 80 per cent of what it considers a "reasonable charge" for the treatment given. The patient would have to absorb the difference, however large.

If, on the other hand, the doctor sent his bill to the "intermediary" for payment, his compensation would be limited. He would get his 80 per cent of the specified reasonable charge, and could collect no more than the other 20 per cent from the patient.

New AMA - -

But, he said, "I can see no way to do it (handle medicare) except on a basis of direct billing."

Dr. Rouse is 63. He's of medium height, balding and tanned and has a rather slim silhouette.

"How do you keep so trim?" an interviewer inquired.

"I'm a gastroenterologist," he replied with a smile.

The implication, apparently, is that a doctor whose specialty includes the stomach and digestive tract is careful about what he eats.

Dr. Rouse was born in Jacksonville, Tex., son of a Baptist minister, teacher and author. He went to high school in Vernon and once worked for a newspaper there, the Vernon Record.

Dr. Rouse earned his M.D. at Baylor University in 1927 and went into practice in Dallas, Tex., a year later.

He will be installed as the AMA's 122nd president next June at the annual convention in Atlantic City.

He has been a member of the policy-making AMA House of Delegates since 1953 and speaker since 1963.

Dr. Rouse was asked if many doctors will increase their fees in the medicare era that began today.

"I don't think so," he replied. "I'm going to charge what I charge now," he added.

* * * *

New AMA Leader To Bill Patients

CHICAGO (AP) — Dr. Milford O. Rouse combines professional skill with sharp business sense.

He made that clear in his first news conference since his selection as the president-elect of the American Medical Association.

He said he prefers, under medicare, to give the 65-or-over patient an itemized account which the patient can take care of himself. Then the patient will be reimbursed, he said, under the new insurance system for the elderly.

"I'm not your insurance broker," he said in capsuling his attitude Thursday. "I'm your doctor. I'm trying to help you."

Dr. Rouse said he won't try to thwart medicare.

Jackson Sun
Jackson, Tenn
July 3, 1966

The Jackson Sun

Associated Press JACKSON, TENNESSEE, SUNDAY, JULY 3, 1966 AP Wirephoto

Doctors Urged: Bill Patients In Medicare

By ROBERT GOLDENSTEIN

CHICAGO (AP)—The medicare program is picking up steam with the nation's doctors free—if they choose—to charge whatever they wish for their services and to require elderly patients to handle the paperwork in seeking reimbursement from the government.

The American Medical Association, with 214,000 members, strongly urged doctors at their annual convention just ended to bill medicare patients directly, rather than collect their fees from the government.

Consideration of medicare and its ramifications was the highlight of the week-long convention attended by 15,000 doctors.

The AMA's House of Delegates, its policy-making body, overruled an AMA Advisory Committee when it adopted without dissent recommendations of the Board of Trustees and delegations from Florida, Iowa and Illinois.

The final action put the AMA on record as calling on "each and every member of this association" to submit his bill directly to the patient, rather than choose the assignment method.

Both mehods are permissible under the medicare act.

But the AMA House of Delegates refused to take a stand on the issue at a special convention in October, stating: "The American Medical Association opposes any program of dictation, interference, or coecrion, whether direct or indiret, affecting the freedom of choice of the physician to determine for himself the extent and manner of participation or financial arrangement under which he shall provide medical care to patients under Public Law 89-97.

In opposing an all-out AMA stand in favor of direct billing, the Reference Committee on Insurance and Medical Service contended such action would be "inconsistent."

The AMA not only came out for direct billing by all doctors, but adopted a Florida delegation resolution recommending that no special review or mediation committees be set up in hospitals solely to handle medicare cases. It recommended that the standard mediation or review mechanism of the county medical society be utilized.

Under direct billing, the doctor sends his bill to the patient and, after the patient has paid $50 in doctor bills within a year, he can seek reimbursement from the government of 80 per cent of the remainder of what is considered a reasonable fee.

For example, if a doctor charges $250 for a surgical operation where the "reasonable fee" for that type of surgery is set at $150, the patient would pay the first $50 to qualify for reimbursement, 20 per cent of the next $100 (or $20), all charges above the allowable $150 reasonable fee (or $100) — for a total of $170. The government would pay the remaining $80 of the $250 bill. In addition, the patient pays $3 a month for his Part B medicare premium.

If the doctor's charge is below the reasonable fee rate, his charge is accepted as a reasonable fee.

The AMA Board of Trustees in its report to the House of Delegates said this week: "The matter of fees for physicians' services should be the subject of agreement between physician and patient but the physician who accepts an assignment has no assurance as to the amount that the carrier will determine to be the reasonable charge for his services.

Under the assignment method the doctor collects 80 per cent of his "reasonable" fee from the government and 20 per cent from the patient, after the patient has paid $50 in doctor bills within a year.

The doctor also would be required to fill out forms under this method, to seek the government payments.

In another medicare action taken at the convention, the House of Delegates called for certain specialists to refuse to replace any hospitalized-based doctors who are barred from

Doctors Urged - -

(Continued from Page 1)

the institutions for billing patients directly.

The doctors involved are pathologist, radiologists, anesthesiologists and other specialists who practice inside a hospital.

The policy making body took the action despite warnings from the Board of Trustees that the move might cripple the AMA with lawsuits.

After the delegates completed their action on medicare, Dr. Milford Rouse of Dallas, the AMA president-elect, told newsmen he will continue to bill his patients directly.

But Dr. James Z. Appel of Lancester, Pa., the outgoing president, urged doctors to plan immediately to correct deficiencies in the program. He also urged doctors to refrain from raising their fees or from frustrating efforts of the elderly from gaining reimbursement under the plan.

And the new AMA president, Dr. Charles L. Hudson of Cleveland, made no mention in his inaugural speech of attempting to overturn medicare.

President Johnson sent a telegram to Dr. Appel at the convention saying, "I am positive that with your dedicated help and cooperation, we can and will succeed in benefiting the many Americans who are greatly in need of this service."

He said he will continue to seek the counsel of organized medicine in the months ahead.

To Medicare List

number of Tennessee's 197 hospitals meeting Civil Rights standards to take part in the program of medical care for the elderly which began Friday.

The new facilities winning approval include Haywood County Hospital, Brownsville, and St. Mary's at Humboldt.

GAINESVILLE, FLORIDA -

GAINESVILLE SUN- July 3, 1966

Medicare Started Slowly in Florida

MIAMI (AP)—"Happy Medicare," shouted doctors and nurses at Jackson Memorial Hospital in Miami as they passed one another in the halls.

Some had expected a mass of new admissions. It never came.

The story was the same throughout most of the state.

By midafternoon at Jackson, largest hospital in the southeast with 1,220 beds, interns in the usually frantic emergency room were sitting with their feet propped on a table.

"It's the quietest day we've had," said intern James Connaughton.

Said resident physician Ronald Fox: "The boss has called down here three times. They were expecting the worst. There is nothing."

Only 10 patients were admitted under Medicare, three or four more than the number of over-65 patients who would ordinarily be admitted on a Friday.

At Miami Beach, where one in three residents is over 65, admitting offices were also quiet. Mount Sinai Hospital reported there were only 11 admissions under Medicare, two emergencies and nine scheduled—about normal.

At Mound Park Hospital in St. Petersburg, where every third person is also over 65, a total of 11 persons were admitted under Medicare, three more than usual.

Of Mound Park's 511 patients, 211 were automatically shifted to Medicare.

But despite the initial lack of increased admissions, some hospital officials predicted the flood would come after the July 4 holiday.

"Wait until July fifth," said Clifford Myers, head of the credit office at Jackson. "That's when the trouble begins."



Born into slavery 112 years ago, Mrs. Sarah Edwards of Orlando walked of her own free will into the Florida Sanitarium Hospital Friday morning to become one of the hospitals first Medicare patients. She is suffering from "infirmities of old age" and has entered hospital to be "built up." Her doctor says she is "doing fine for age."

"I definitely think the number of Medicare patients will pick up after the 4th of July," said John Rauch, administrator of Orlando's Holiday Hospital. "However, we do not expect any disruption of service."

The administrator of Daytona Beach General Hospital, Homer R. Bentley, predicted an early influx of Medicare patients after the weekend. He said he thought patients would feel that if they waited a week or more the available beds might be filled.

One of the oldest Medicare recipients in the country, a 112-year-old former slave, was admitted to Florida Sanitarium Hospital in Orlando. Mrs. Sara Edwards walked with little aid as her 72-year-old daughter and 57-year-old granddaughter accompanied her to the hospital.

Her physician, Dr. Joseph G. Seltzer, said Mrs. Edwards was suffering from "infirmities of old age."

In Volusia County, 140 of 437 patients in five hospitals automatically qualified for Medicare. H. O. Dudley, administrator of West Volusia Memorial Hospital, said he expected five to 10 Medicare admissions early next week.

At Halifax District Hospital, 405-bed Daytona Beach institution and by far the largest in Volusia County, administrator E. K. Prentice said: "We're going crazy with phones ringing."

He said that of the hospital's 302 patients, 86 were shifted to Medicare and 11 new Medicare cases were admitted.

An association of doctors in St. Augustine announced that its 16 members have decided under an option in the Medicare law to bill their patients and have them reimbursed by the agency acting for the federal government.

Dr. W. Wayne O'Connell, president of the Flagler Hospital medical staff, said this procedure was decided upon to preserve the present doctor-patient relationship without intermediaries coming between them.

"No one is being denied treatment whether they have Medicare or not," said O'Connell. "The only difference will be in the billing."

At Sarasota Memorial Hospital, administrator Don Laurent said the changeover was going smoothly. He said 120 patients of the hospital's 500 qualified for Medicare. The first patient admitted after it went into effect was a 92-year-old woman scheduled for surgery.

July 1, 1966

Medicare Effect Not Felt Here

The first day of the Medicare program brought no immediate increase in the number of patients at Alachua General or University Hospitals.

The program took effect today.

At Alachua General, assistant administrator Charles Sweat said that there had been no effect by 11 a.m.

"Since midnight last night, we haven't had a Medicare patient admitted," he said.

"We have 32 patients who are eligible already in the hospital."

Sweat said the hospital had 118 patients.

Stuart Wesbury Jr., associate director of the University of Florida Teaching Hospital, reported there had been no visible increase of older patients entering the hospital this morning.

"We have had no unusual patient load," he said. "The only unusual thing we have experienced so far has been the necessity of processing new paper work for patients over 65."

Since the UF hospital is a referral hospital, patients, regardless of age, are admitted only after referral by their physicians. Admissions are determined mainly on the basis of medical consideration and the hospital's teaching program.

Bristol Press
July 2, 66



FIRST: Mrs. Lillian Grace Avery, becomes the nations 1st Medicare beneficiary as she signs Medicare forms Friday at Edward Hospital, Naperville, Ill., with her husband, Robert (L) and Hospital Administrator Eugene Morris helping. Her case was the first transmitted by Blue Cross system in its role as Medicare Intermediary and it was the 1st which the Social Security Administration in Baltimore handled under Medicare. (UPI Telephoto).

Woman, 85, First Patient

She Likes Medicare

Mrs. Iva Raymer is 85 years old. She has been an Oklahoman since she moved from Texas to Marlow in 1905. Yet, she can not forget the state of her birth—Missouri.

"You'll have to show me," she joked when she was asked about the benefits of medicare.

Mrs. Raymer, who owns her home at 8 NE 38 Terr., is the first person in Oklahoma City admitted to a hospital under medicare. She was placed in Deaconess Hospital shortly before midnight Thursday—when medicare went into effect—for treatment of a heart and stomach ailment.

Medicare?

"Well, a welfare man told me to sign up. I signed up, but I don't know much about it. I heard a doctor quit some place in the United States. I heard an Oklahoma hospital closed up because of it," she said.

Medicare?

"It helps a widow woman drawing a little pension. All I have is social security."

Medicare?

"I think it is a good thing...if they

See MEDICARE, Page 2



Carefree Medicare Patient

Mrs. Iva Raymer, 85, a happy-go-lucky Oklahoma Cityan, talks with Rev. R. E. Butterfield, administrator of Deaconess Hospital, Friday. She was the first patient admitted to a hospital Friday under medicare.

Medicare

Continued From Page 1

carry it out. So much of this stuff is graft," she said.

"If I was healthy and could get around," she indicated the one place she would not be was the hospital.

Mrs. Raymer said her husband—a worker for Oklahoma Natural Gas Co.—was killed in an accident 15 years ago.

She said she has worked all her life. "I picked cotton and every other thing. When I was a kid growing up, I worked. I didn't do what the kids do now."

Mrs. Raymer explained how hard the task was of raising a family.

"You got a job, if you raise six kids, if you don't do nothing else."

Mrs. Raymer said she believes that medicare is a good thing for older people—and she looks at it as more of a reward for a lifetime of work.

She noted how urgent her hospital needs were.

"I'd have got to the hospital somehow or other regardless of medicare," she said.

Floyd Ellington, assistant director of Social Security in Oklahoma City, said the medicare plan was implemented smoothly Friday. He noted there was no great rush of elderly patients to the hospitals.

He said about the biggest problem was the fact that hospitals had to re-register their hospitalized patients above 65. The hospitals called his office to get various insurance numbers for the patients.

Hollywood Sun-Tattler

HOLLYWOOD, FLORIDA, SATURDAY, JULY 2, 1966

First Day Of Medicare Goes

(First Patient Here — Photo On Page 4A)

By JIM BEATTIE
Sun-Tattler Staff Writer

Memorial Hospital in Hollywood greeted the birth of Medicare with a big sigh of relief, officials announced today. At 12:01 a. m. Friday, 79 of the hospital's 275 patients switched over to Medicare with the minimum of confusion.

By this morning, hospital authorities said that no new Medicare patients had been admitted but that two applications for admittance had been received.

"There were no problems at all," Sal Mudano, hospital administrator, said." Things went better than we had ever hoped for. We do expect, however, that after the holiday period there will be many more applications from people over 65."

At Golden Isles Hospital in Hallandale, the situation was almost identical, according to Administrator Jim McKelvey.

Six of the hospital's patients switched over to Medicare. Austin Verity, 78, of 913 NE 4th St., Hallandale became the first medicare patient to qualify.

"We have had a good number of telephone calls concerning Medicare," McKelvey said. "There have been a few misunderstandings, but generally things went beautifully.

"The main problem I forsee is the confusion over the $40 patients must pay before they are accepted. Many old folks don't realize this, but our staff is explaining it to them as best as we can."

McKelvey said that he was expecting an "influx of patients" after the holiday weekend.

An Associated Press survey of the nation's hospitals indicated that the first day of Medicare had gone better than anyone had dared hope.

Smoothly Here, Over U.S.

Still, there were problems: mountains of paper work, missing forms, bewildered patients, lost Medicare cards, and one woman who got mad and swung her purse at a hospital worker.

By midafternoon Friday in the usually frantic emergency room at Jackson Memorial in Miami, interns sat with their feet propped on a table.

"It's the quietest day we've had," said Dr. James Connaughton, who joined the Miami hospital last month after graduation from the University of Indiana.

(Continued Page 2A, Col 7)

Few Hitches Develop On 'Medicare Day'

(Continued from Page 1A)

The situation was virtually the same in hospital after hospital across the United States. Fear expressed by some that medical facilities would be swamped by elderly people evaporated as the day wore on like any other before a July 4 holiday.

"Heaven help us when Tuesday comes," said Alfred E. Riley, business manager of St. Elizabeth's Hospital in Chicago. Riley said he looks for a big inflow of patients then because of the people who wanted to be home for the holiday or delayed entry because so many doctors would be away for the weekend.

THE BIGGEST problem faced by the hospitals is the increased load of paper work. New York city's mammouth Mt. Sinai added 41 clerks just to handle all the new forms and help.

By the end of the first day at Massachusetts General the hospital had 941 patients, of whom 260 were over 65 years. During the day the hospital admitted 67 new patients, 18 of them under Medicare.

Queen of Angels Hospital in Los Angeles didn't have a single Medicare admission until midafternoon, when a doctor called to advise he was sending in a male heart patient.

"The hospital center always goes down to rock bottom on July 4," said a hospital spokesman.

Some hospitals reported that a few elderly persons had shown up to "get their Medicare." They weren't sick, but they mistakenly thought they had to report to the hospital.

At the Boston Hospital one woman outpatient refused to produce her red, white and blue card—until she had a chance to go to the ladies room and unpin it from her underwear.

At Ochsner Foundation Hospital in New Orleans, Herbert Leonard, an oil jobber from Ponchatoula, La., said he objected to Medicare and wouldn't have signed up if his private insurance company hadn't reduced his hospital coverage due to the federal American would rather pay his program. "I still think an own way," he said.



Staff Soapbox...

Fight for freedom!

Susan Wulfekuhler

Paragould Daily Press
Paragould, Ark.
July 2, 1966

Our country has so few democratic principles left that I wonder how long it will be before it becomes a socialist state.

Something has gone way off base when hospitals have to raise their rates because of the Medicare program. While needy people receive free medical treatment, we who remain will go broke trying to meet higher costs for ourselves and families.

However, this is not my only bone to pick with Congress and the present administration!

It seems to me that, with a war going on in Viet Nam, our President could find a better use for federal troops than sending them to 'protect' Martin Luther King in Mississippi.

It frightens me when one so-called ally after another takes up with our enemies.

If the present situation does not improve, before long the United States may be standing by itself against the rest of the world.

The time has come for our government officials to realize that the faith and support of other countries, not to mention the millions of people in our country, cannot be bought. Confidence is built with deeds, not with endless spending.

While many honest, hard-working people struggle to make ends meet after the government has taken its toll on their salaries, some parasites who won't work for fear of not getting their Social Security checks get a big hunk of the sum.

Although I'm all for having these benefits for people who are unable to work, the sad fact is that many lazy "citizens" sponge off society—and, what's even worse—they get away with being leeches! There must be a way to sift out the moochers from the needy.

Perhaps I'm wrong for criticizing when I myself don't have a workable solution, but I love my freedom too much to see it slip away from my grasp.

My contemporaries and I want a chance to be leaders in a free society that dwells in peace. We would like to work in our chosen field and bring our children up to love God first and their country second.

Too many Americans take our freedoms for granted.

On this Independence Day week-end, our heritage is in greater danger than perhaps any other time in the history of the United States.

We must fight for our freedom as fervently today as we did 190 years ago, or we will surely lose it.

Medicare underway in state

By THE ASSOCIATED PRESS

Medicare—criticized, praised and made the law of the land to accepting hospitals—went into effect Friday without major incident in Arkansas.

All but 23 of the state's 109 hospitals applied for and were approved for participation in the program to provide federally financed health care for the aged.

The elderly patient under Medicare will have to pay, in most cases, only a small percentage of his own medical bills.

There was no rush of patients to enter hospitals, as some physicians had anticipated. Others said that any major influx of patients under Medicare would not come until after the Fourth of July weekend.

In most hospitals it was a routine matter of switching elderly patients already in the hospital from welfare status to Medicare status. Scattered reports from around the state indicated that about 20 per cent of the hospital population was switched to Medicare.

The number switched in Medicare 50 and 60 at St. Joseph's Hospital, the only one in Jonesboro, amounted to 20 per cent of the adult patients outside the maternity ward.

At Levy Hospital in Hot Springs, the total was 45 per cent of the total number of patients.

On a statewide basis, more than a thousand patients probably were switched into the Medicare program.

The number was 23 at St. Bernard's, 25 at Ouachita Hospital in Hot Springs, between 50 and 60 at St. Joseph's Hospital in Hot Springs, 15 at Helena Hospital, and 50 or so at each of the three major Little Rock hospitals.

At Helena, the hospital had a small rush of patients—20 or so elderly Negroes—but the hospital delayed admitting them under Medicare because it had not been officially notified of approval for participation in the program.

Controller Bill Boetler said the hospital had been notified by telephone of approval by federal officials, but wanted to await receipt of the telegram confirming it.

Medicare bans discriminatory practices in the treatment or keeping of patients of different races.

In Garland County, a retirement mecca, Social Security Administration officials said that 5,867 of the county's 38,207 residents were eligible for Medicare.

The county's three hospitals have a total bed capacity of 348.

Hollywood Sun-Tattler
Hollywood, Fla.
July 2, 1966



MEDICARE PATIENT — At midnight Thursday, Mrs. Ella Fitch, 73, who has been a patient at Memorial Hospital, Hollywood, since June 21, became a Medicare patient. There were 79 patients over 65 in the hospital Thursday midnight and their accounts from that moment were transferred to the Medicare program. A rush for hospital beds by patients 65 and over did not materialize, as was anticipated by some. On the first day of Medicare operations on Friday, 270 out of the 325 beds at Memorial were occupied. Two persons over 65 applied for admission during the day. Mrs. Fitch, who lives at 2454 McKinley St., is shown with Mrs. David Short, a registered nurse.

Miami Herald
(Broward Edition)
Miami, Fla.
July 1, 1966

'Now I Can Have My Operation'

By JOAN SCHUMAN
Of Our Broward Bureau

FORT LAUDERDALE — For one 65-year-old woman, the beginning of Medicare today means an operation she never could have afforded.

"I had applied to lots of insurance companies, but was always rejected," Mrs. Joseph Orofino, 397 NW 48th Ct., said. "Because of Medicare I now can have my operation."

Mrs. Orofino, born in Italy, said she has worked for the last 30 years to help educate her children. She had nothing but praise for the government's new program.

Mrs. Orofino is one of an estimated 33 Broward County citizens who entered Broward hospitals today as Medicare patients.

Another estimated 645 persons now hospitalized began receiving the benefit of Medicare at midnight.

For a cataract patient, the new government program means no more waiting for his operation. "I would have had the operation anyway, but Medicare makes it possible more quickly," said the 79-year-old, who will be operated on Tuesday.

Mrs. Helen O'Conner, who entered Broward General hospital today for minor surgery, praised the program for what it will do for the underprivileged.

"I'm not just thinking of me; the program is wonderful for all older people," the Medicare recipient said.

Another cataract patient to be operated on Tuesday joked about the program, saying "it looks pretty good on paper, but let's see what happens when the bills start coming in."

William Nerz, 65, has failing eyesight. He hopes that under the new program his vision will be restored.

Many Broward hospital officials expect a small number of patients eligible for Medicare benefits to register today. Broward General's District Director Bernie Welsh attributed the low turnout to the July 4th weekend. Because many doctors are not operating over the weekend, he said Tuesday's turnout may be a better gauge to the program's popularity.

Hospital officials have been briefed throughout the week on Medicare procedures, but one confided Thursday "there's been nothing but confusion about the program around here all day."

Many officials said the first patients would be those with operations that had been detained until the program went into effect.

Cataract and genital urinary operations were cited as those most common for the Medicare recipients.

Paper St. Petersburg Independent

Place St. Petersburg, Fla.

Date July 2, 1966

Don't Take It Out On The Patients

Medicare got off to a smooth start yesterday, but with one regrettable exception.

Some doctors, encouraged by the politically-minded hierarchy of the American Medical Association, have said that they will refuse to cooperate with their patients in collecting claims for medical services. Ironically, they are doing this under the guise of "preserving the historical doctor-patient relationship."

The AMA House of Delegates earlier this week advised doctors to bill Medicare patients directly, instead of taking an assignment from the patient and receiving payment from the companies designated as Medicare agents, as is customarily done when private medical insurance is involved.

This would work a hardship on many elderly persons who may be confused about completing the necessary forms to obtain the reimbursement to which they are entitled. Almost every doctor, on the other hand, has nurses or receptionists on his staff who could fill in the forms with only a few minutes work.

Most of the present leaders of the AMA — the doctors' trade association — are still unreconciled to the whole Medicare program. They have recommended direct billing for only one reason: to encourage doctors to demonstrate their opposition to patients, the public, Congress and the Johnson administration.

But the true "doctor-patient relationship" is not a political, but an intensely personal one, in which the doctor is a trusted and helpful friend. We do not believe that most doctors in St. Petersburg will find themselves willing to deny individual patients that friendship and help, regardless of the AMA's advice. None of them, we're sure, will refuse to bill Medicare for their fees in cases where the patient is unable to make direct payment.

Many, possibly most, doctors resisted the principle of government medical insurance for the elderly, and still oppose it. But when it gets down to individual cases, how many will go so far as to take out their resentment on their patients?

Orlando Sentinel
Orlando, Florida
Friday Morning, July 1, 1966

Unanswered Questions On Medicare

THE BIGGEST health service plan in history is in effect in the U.S. today, with millions of Americans eligible for hospitalization, physicians' services and, later, nursing home care at virtually no cost to them.

Vast benefits are now available to 19 million in the U.S., including 811,596 Floridians 65 and over, but there are many unanswered



questions about Medicare, some of them extremely troubling to individuals.

In some parts of the South, there are not enough hospitals eligible to participate, although in the U.S. as a whole, 90 per cent are eligible. In Florida, 152 out of 188 hospitals, or about 81 per cent of the existing institutions, have qualified.

The problem in some Southern states is the Civil Rights Act, requiring hospitals to end racial discrimination in order to receive federal funds. This applies to Medicare as well as all other federal grants and aids.

✡ ✡ ✡

AS FOR THOSE hospitals which are eligible for Medicare, they may be hard - pressed to find enough beds, laboratory facilities and technicians, doctors and staff to serve the expected rush of patients. It is anticipated that Medicare will mean a 20 per cent increase in demands for service in hospitals.

How cooperating hospitals can meet the demand if all hospitals do not participate in Medicare is an unanswered question today. Perhaps they can't.

All five Orlando hospitals have been approved for Medicare patients, incidentally.

A PROBLEM of concern to some in the Central Florida area is the cancellation of their personal hospital and medical insurance by private companies.

Some would have preferred to keep their personal policies and not go under Medicare, but now find that their insurance has been canceled. (Those with noncancelable policies can keep them by continuing to pay the premiums.)

Those 65 and over, who are eligible for Medicare, can, however, buy special insurance policies to take up the gap in Medicare, to pay for services not covered by Medicare.

But the way is not clear for those 65 and over who do not want Medicare and cannot get private insurance. This question will be studied by the Social Security Administration and Congress, as will the question of military personnel who have reached the age of 65.

Heretofore, the military has been able to get free medical and hospital services at base hospitals and Veterans Administration hospitals. Will this continue for those 65 and over or will they, too, go to regular hospitals under the Medicare program?

Today no one knows for sure what the future policy will be about these various problems. But hopefully they will be resolved soon so that Medicare will have an opportunity to serve all aging suffering humanity, whose health needs have been neglected for many years.

The Key West Citizen

The Southernmost Newspaper In The U.S.A.

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Page 4 Sunday Morning, July 3, 1966

Bible Thought For Today

Then I would speak without fear of him, for I am not so in myself.—Job 9:35.

Only those are fit to live who are not afraid to die.—Gen. Douglass MacArthur.

Hospitals And Doctors

Monroe General Hospital wan't consigned to the dump heap when Dr. DePoo built his hospital on Southard Street. Galey Memorial Hospital on Fleming Street has managed to keep operating despite the presence of the two other larger hospitals. Suddenly, however, we're told that Monroe General will be closed if another hospital is erected . . . that the building and facilities are hopelessly outdated and inadequate.

The situation doesn't make sense.

Monroe General has been supported by the taxpayers of the county plus an additional tax levy on property owners in Key West. Supposedly, these public revenues were collected to repair and maintain the hospital as well as buy additional equipment. How could all of this suddenly become useless?

Understand, The Citizen supports the erection of either or both of the proposed new hospitals—one privately owned; the other, directed by a non-profit group. The Citizen is not against closing Monroe General — if and when the people of the county and city have access to better facilities.

The Citizen believes Monroe General Hospital should be kept operating until there is definite proof that it is no longer needed. Moreover, we think the taxpayers of Monroe County should make the decision to close it and dispose of the properties. The Citizen would like to know if the plans for closing the hospital included any discussion of what to do with the buildings.

Monroe General Hospital is located in an ideal spot near the water and golf course. It is valuable land and the buildings should be in good physical condition. Will these buildings be razed as our fairly new county jail was destroyed — without any attempt at renovation? Taxpayers can't keep on building new structures and discarding old ones which certainly must have some value.

The Citizen fully supports both groups of doctors now planning to build hospitals. Monroe Countians might as well realize that the new hospitals will not eliminate taxes for medical or health programs, however. Indigent persons must be helped. What the new hospitals will do is to give us a better, more modern operation.

Let's not burn our bridges behind us, though. The time to close Monroe General Hospital is when it is no longer needed.

FORT LAUDERDALE NEWS & SUN-SENTINEL
FORT LAUDERDALE, FLORIDA
JULY 2, 1966

Hospitals Absorb Medicare Impact; Caution Voiced

WASHINGTON. (AP — With hospital-like efficiency, the nation's medical plant easily absorbed the first-day impact of medicare Friday—and, in many southern cities — desegregated thousands of hospital beds.

City after city reported "no rush," "everything normal," "no problems," "going smoothly." Some hospital officers predicted heavier admissions after the Fourth of July. Others cautioned that the full impact is still a month or more away.

"An auspicious start," commented U.S. Surgeon Gen. William H. Stewart.

Stewart and Robert M. Ball, Social Security administrator, estimated 94 per cent of the nation's general hospitals, representing 95.9 per cent of the beds, were prepared and qualified to participate in medicare.

SOUTH SURPRISES

They met reporters jointly in Social Security's Telecommunications Center in Baltimore. There, a nationwide wire network will feed data on the 19 million medicare policy-holders into and out of computers.

The totals given by Ball and Stewart were a bit higher than those from other federal offices, but all sources agreed on this:

Hospital participation was far broader, especially in the South, than authorities had dared to hope for a month or two ago.

Most of the several hundred southern hospitals outside the program had failed to comply with the no-racial-discrimination provisions of the Civil Rights Act. They are therefore ineligible for federal payments under medicare or any other federal program.

LBJ NOTIFIED

President Johnson — known to have been seriously concerned a few weeks ago at predictions that elderly patients would suddenly swamp understaffed hospital facilities — was notified by telephone of medicare's flying start and strong participation.

Mr. Johnson received a wire from Dr. Edwin L. Crosby of Chicago, director of the American Hospital Assn., reporting hospitals "ready, willing and able" to execute medicare as planned.

Thousands of patients 65 and older who were already in hospitals became the instant beneficiaries of medicare at 12:01 a.m., by a mere bookkeeping transaction. Medicare automatically picks up their bills from July 1 until their 90 days of benefits expire, except for a $40 "deductible."

At the same moment, Eugene Schneider, 65, an embroidery worker from West New York, N.J., showed up at New York's Polyclinic Hospital for eye treatment — and became the hospital's first new medicare admission.

This is a sampling from scores of reports picked up by reporters across the country—

Louisville, Ky. — One woman who needed a leg amputation refused the operation until today. "She really shouldn't have waited," said her doctor, "but she was determined not to go in as a charity patient."

New Orleans — "Most hospitals already full. Only immediate change was a shuffling of papers . . ."

Chicago — "No general rush. Cook County Hospital, one of largest in country, reports fewer patients entering than normal."

San Francisco — "Seven Kaiser Foundation hospitals in the bay area report 80 patients converted to medicare overnight. No new ones thus far today; everything normal."

Texas — From Houston, "No problems and no bed shortages." From one Ft. Worth hospital, "We've been overcrowded right along and medicare seems to have caused no visible impact."

Reporters at White House news headquarters in San Antonio, Tex., were told by presidential press secretary Bill D. Moyers that "Mississippi still is the state with the least participation." But 42 per cent of Mississippi's hospital beds now are in compliance, Moyers reported, compared with 10.6 per cent on June 22 and 30.6 per cent as recently as Tuesday.



(AP Wirephoto)

MEDICARE PATIENT—Born into slavery 112 years ago, Mrs. Sarah Edwards of Orlando, walked by herself into the Florida Sanitarium Hospital Friday to become one of the hospital's first medicare patients. She is suffering from 'infirmities of old age' and has entered the hospital to be 'built up.' Her doctor says she is doing fine for her age.

Medicare Effect In Florida Varies

The Associated Press

When the doors at Tampa General Hospital swung open at 7:30 Friday morning a man in his 70's was waiting. He waved a card and shouted: "I want medicare."

His was the noisiest reaction reported in Florida on the first day of the federal program.

The man was met by the admissions supervisor, Mrs. Joyce Spedale, who asked him who his doctor was.

"What do I need a doctor for?" he demanded. "I would just have to pay $3 more."

When Mrs. Spedale sought to question him further, he walked out and called for a cab. His identity was not learned.

The advent of medicare produced considerable early impact at Halifax District Hospital, 405-bed Daytona Beach institution which is by far the largest of Volusia County's six hospitals.

"We're going crazy with phones ringing," said Halifax administrator E. K. Prentice.

CARE SHIFTED

He said that of the hospital's 302 patients, 86 were shifted to medicare Friday and 11 new medicare cases were admitted.

Hospital administrators around the state generally reported the number of admissions was normal. But many said it would be a different story Tuesday, after the three-day July 4 holiday weekend.

"We will be able to judge and evaluate the impact of medicare beginning July 5," said a spokesman at Miami Beach's Mount Sinai Hospital, where the administrator was out of town the day the revolutionary law took effect.

In St. Petersburg, where every third person is over 65, hospitals reported normal admissions. At Mound Park Hospital, four of the nine patients admitted were eligible for medicare. In addition, 211 of the hospital's 479 patients automatically qualified at midnight.

R. B. Donaldson, Florida Social Security district manager, said 700,000 Floridians are eligible for medicare and up to 200,000 visitors are expected to reap the federal benefits while in Florida hospitals.

An association of physicians in St. Augustine came out on medicare day with an announcement that its 16 members have decided under an option in the medicare law to bill their patients and have them reimbursed by the agency acting for the federal government.

Dr. W. Wayne O'Connell, president of the Flagler Hospital medical staff, said this procedure was decided upon to preserve the present doctor-patient relationship without intermediaries coming between them.

"No one is being denied treatment whether they have medicare or not," Dr. O'Connell said. "The only difference will be in the billing."

Hospitals Get Medicare OK

TALLAHASSEE. (UPI) — Florida A&M Hospital and Tallahassee Memorial Hospital received official clearance Friday as eligible to accept medicare patients.

Both hospitals had been given interim approval but didn't get the final official word until just before the new medical aid program took effect.

The action did not bring any spurt of elderly patients to the two facilities.

MIAMI HERALD BROWARD EDITION
MIAMI, FLORIDA
JULY 2, 1966

Paper, Not Patients, Floods Medicare

By JOAN SCHUMAN
Of Our Broward Bureau

FORT LAUDERDALE — "We're going around in circles, but not because of the flood of Medicare patients", one hospital administrator said Frilay.

Friday was the first day for the government's Medicare program.

"Our biggest problem is getting all the forms completed for the patients already hospitalized," Rudolph Ahorner, administrative assistant for Memorial Hospital, said. "We've had a flood of relatives in to complete the forms all day."

At midnight Thursday an estimated 645 patients became eligible for Medicare benefits.

As hospital administrators had projected, incoming Medicare patients were few Friday. A random sample of Broward's 12 hospitals showed 18 Medicare patients entering on Friday.

Bernie Welsh, Broward General's district director, attributed the low number to the Fourth of July week-end. He said Tuesday would give the hospitals a better idea of the program's popularity.

"They're making the people in the Jacksonville Blue Cross office work straight through the weekend, but all they'll have is a lot of people with nothing to do," said Thomas Meehan, acting administrator for Pompano Beach Hospital.

One medicare patient entered Pompano Friday. "There's been no line at Broward General," said Welsh. "We've had only four Medicare patients enter."

Meehan said the first Medicare patient, a retired man from New York "felt a little bit like a celebrity. But,' said Meehan, "he only had a sprained back so we've sent him home already."

Ahorner said he was greeted this morning by an elderly gentleman who, presenting his red, white and blue social security card, demanded a blood test.

"There was nothing we could do but explain that you have to be referred by a doctor," Ahorner said. "It will take a while before everybody understands how the program works."

Seven patients entered Memorial Hospital Friday. Most were scheduled for surgery.

"Many of the patients don't know exactly what they're supposed to do, but neither do we," said an administrator at Hollywood Hospital. "We're still playing it by ear."

"It's confusing, but the staff is taking it real well," said Ahorner. "Most are treating it like an adventure."

FORT LAUDERDALE NEWS &
SUN-SENTINEL
FORT LAUDERDALE, FLORIDA
JULY 2, 1966

Medicare Nurses OK'd

The Visiting Nurses Assn. has been approved to provide home nursing and health care under the medicare program that started Friday, announced James Clemmons, assistant district manager for the Social Security Administration.

Clemmons said the nurses association is the first agency certified by the Bureau of Health Insurance.

Other agencies which applied for the home health services part of the hallmark medicare program for over-65 citizens are expected to receive certification later, he added.

Payments under the home nursing plan will be made retroactive to Friday.

SUN SENTINEL
POMPANO BEACH, FLORIDA
JULY 1, 1966

12 Broward Hospitals Ready For Medicare

Twelve of Broward County's hospitals have completed arrangements for full participation in the Medicare program, which gets under way nationally today, Social Security District Manager Paul L. Byrley said Thursday.

The participating hospitals, among 6,000 approved institutions in the nation, are Broward General, Doctors General, Ft. Lauderdale Beach, Hollywood, Holy Cross, North District, Pompano Beach, South Broward, South Florida State, West Broward, Memorial and Las Olas.

Together they house 99 per cent of the county's 1,870 hospital beds, Byrley said.

The hospitals have nominated Blue Cross to handle benefit payments under the hospital insurance portion of the Medicare program.

In order to receive insurance benefits, patients covered by Medicare must use the services of approved hospitals "except in strict emergency situations."

Byrley defined emergency esrvices as those necessary "to prevent the death or a serious impairment of the health of the individual, and which require the use of the most accessible hospital available which is equipped to furnish such services."

Further information about the Medicare program is available at the Social Security District Office, 315 NE 3rd St., Ft. Lauderdale.

FT. LAUDERDALE NEWS
AND SUN-SENTINEL
Saturday, July 2, 1966 9A

Medicare Fees Arouse AMA Ire

CHICAGO. (AP) — The nation's medicare program went into effect Friday with a substantial faction of organized doctors of the American Medical Assn. at odds with the government and many hospitals over some fee collections.

The disagreement was underlined by resolutions adopted by the AMA's 238-member House of Delegates which some observers interpreted as a threat to boycott certain hospitals which claim the right to collect the fees of doctor specialists on their staffs.

At the 115th annual AMA convention this week, the House of Delegates, which sets policy for the AMA's 214,000 member physicians, urged doctors to shun payments from the government under the medicare program.

The delegates reinforced this resolution with another stemming from a long-standing dispute with many hospitals which ban fee collection from patients by hospital-based specialists such as radiologists, pathologists and anesthesiologists.

The delegates told the AMA membership it would be unethical for them to take the place of another doctor dismissed for attempting to bill his patients directly.

It was this resolution, and the refusal Thursday of the House to reconsider it, that brought up suggestions of a boycott.

An AMA spokesman said Friday he views the crucial resolutions as consistent with the right of physicians under the terms of the medicare law to choose direct billing of their patients or accept fee assignments from organizations administering medicare.

In a news conference the AMA's president-elect, Dr. Milford O. Rouse of Dallas, Tex., said he expects to continue billing patients directly under medicare, and let the patient be reimbursed by the government.

First Medicare Patient Is M.D.

TAMPA. (UPI) — The first patient admitted to Tampa General Hospital here today under the Medicare program was not only the father of a doctor, but is himself a retired doctor.

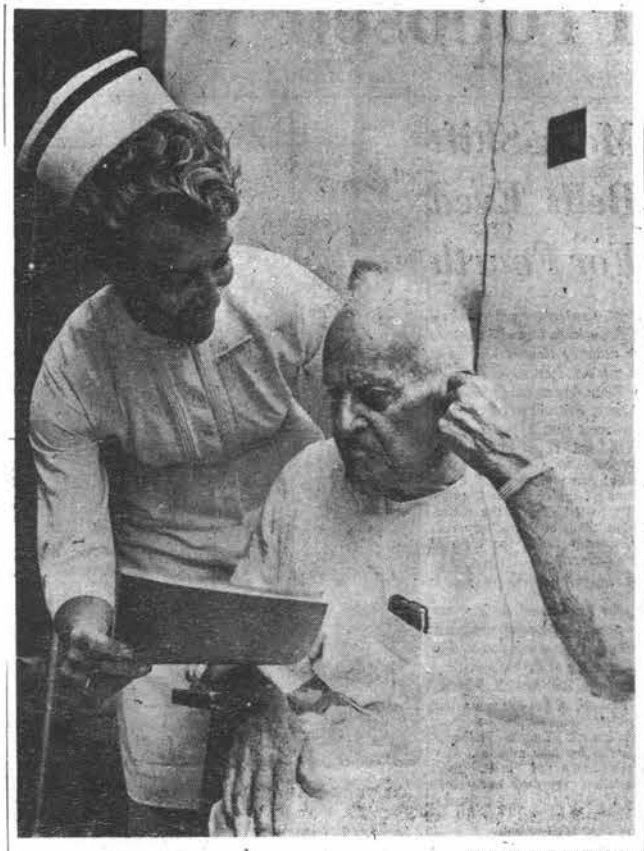
Arthur Zipser, 75, of Tampa and a retired podiatrist from Columbus, Ohio, was admitted at 2 a.m. Friday after suffering from an apparent gall bladder attack.

He is the father of Dr. Lester L. Zipser, a Tampa obstetrician and general practioner.

Paper Fort Lauderdale News

Place Fort Lauderdale, Florida

Date 6/30/66



(Staff photo by Ralph Weinlaub)

HE'S IN BROWARD GENERAL AHEAD OF MEDICARE
. . . Charles Ellis Sr., 87, with nurse Mary E. Winters

First 'Medicares' Now In Hospitals

FTL N 6/30/66

Who will be the first over-65 patient to enter Broward General and North District hospitals when the first day of the hallmark Medicare program starts tomorrow?

As an actually small number of "outside" Medicare recipients prepare to go into the two hospitals administered by North Broward Hospital District, a larger number of "inside" admissions have a headstart on getting a hospital bed under the new program.

One hundred and fifty over-65 patients eligible for Medicare benefits, are already in the two hospitals, District Director Bernie B. Welch said today.

Therefore, the 98 in Broward General and the 52 in North District ahead of the first day of the Federal program will be considered "the first recognized Medicare admissions in the hospitals," Welch said.

Contrary to general expectations, only seven or eight "outside" over-65ers will enter the two hospitals tomorrow for elective surgery such as cataracts and hernia.

Broward General has scheduled six Medicare admissions while North District expects one or possibly two admissions.

A real so-called "crush" of Medicare patients isn't anticipated until about the afternoon of July 4 for surgery July 5, Welch said.

He opined that one explanation for the relatively small numbers on the program's opening day was due to the holiday weekend with physicians planning a holiday rest and a "normal" slackening of hospital activities over a weekend.

Meanwhile, the two facilities are ready when Medicare gets into full swing.

HOSPITALS THINK THEY'RE READY

Medicare Becomes Fact of Life Today

United Press International

Medicare became a fact of life today. Hospital administrators said they were ready for it.

The federal health insurance program that could open hospital doors to about 19 million Americans over 65 went into effect at midnight.

Critics had predicted darkly it could result in a flood tide of elderly patients seeking admission to the hospitals.

But nearly all hospital administrators questioned by United Press International in a spot check across the country thought they were equal to the task.

The nearly universal feeling was that somehow, someway the country's hospitals could cope with this as they had with short staffs, lack of facilities and other problems.

Basically, Medicare provides up to 60 days of hospital care with the patient paying the first $40 and, if additional hospital treatment is required. Medicare will cover the costs over $10 a day for another 30 days.

The second part of Medicare, which is optional, costs the oldster $3 a month and provides, after a $50 initial payment by the patient, the bulk of the money for doctor bills.

Civil rights also was an issue, principally in the South. The Department of Health, Education and Welfare said more than 600 hospitals had failed to comply with desegregation requirements in time to qualify for participation in Medicare on opening day.

"No hospital will be cleared for participation in Medicare unless the department has convincing evidence that the hospital is in fact in compliance," HEW Secretary John Gardner said, emphasizing that token pledges would not be enough.

The number of non-complying hospitals represent about 8 per cent of the nation's houses of healing and most are in the Deep South.

Rep. L. H. Fountain, D-N.C., charged the federal government with depriving elderly citizens, white and Negro, of Medicare benefits in an effort to impose "illegal" desegregation demands.

• • •

Individual physicians meeting in Chicago this week for the American Medical Association convention had predicted that "bedlam" would break out when Medicare went into effect.

However, an American Hospital Association spokesman in Chicago said Thursday, "we expect no big rush in as far as in-patient hospitalization is concerned.

"Twenty-five per cent of the patients (in hospitals) today are 65 years or older. What happens is that they will be discharged, on paper, and will be readmitted tomorrow (Friday) as Medicare patients. We expect no more than a 5 per cent increase through the first couple of months."

GLOBE- TIMES

Amarillo, Texas

July 1, 1966

Houston Chronicle
Houston, Tex.
July 3, 1966

Aged gain free care; first impact on hospitals slight

By Moselle Boland
Chronicle Reporter

IN A FEW DAYS, Leon Williams will go to St. Joseph Hospital and get his eye trouble fixed up, thanks to medicare.

Williams, 77, lives with his wife in a small house at 3306 Holman. He has been unable to work since 1957. The childless couple "make do" on their $86 a month Social Security check.

But it does not stretch far enough to cover medical bills or hospitalization insurance.

A few months ago, Williams noticed he couldn't see too well. He is a man who likes to go downtown or stroll down the street for a chat with his cronies "to keep myself busy."

So he went to an optometrist to see about some glasses.

"I couldn't get much seeing out of them," he said.

The optometrist recommended that he check with a medical doctor who specializes in eye care. This doctor said an operation was needed to remove developing cataracts.

Until last Friday, Williams' chances for such an operation would have been slim.

His condition would have crippled him, but it did not threaten his life.

The only place he could have turned to for help would have been Ben Taub General Hospital, which for years promptly cared for his emergency medical problems.

But Ben Taub's operating rooms constantly are filled with patients whose lives hinge on an operation. Only occasionally can they squeeze in "elective" surgery.

Now Williams can pay his own way. He was enrolled in medicare, and the bulk of his bills will be paid by the government insurance.

"I ain't worried about getting the rest of the money for it," he said. "I'll manage."

His doctor arranged for the operation at St. Joseph.

Persons like Williams constitute a huge question mark for Houston administrators, whose institutions are qualified to treat patients under medicare.

For one thing, they cannot estimate the number of elderly persons who have lived for years with non-fatal, but painful conditions such as varicose veins, cataracts, hemorrhoids, hernias, or ear problems.

Now that hospital care is available to them, they may jam available beds, at least for the next six months or so.



Medicare will clear the vision of Leon Williams

Harris County probably has enough beds to eventually care for everyone seeking treatment, says Newell France, chairman of the Houston Area Hospital Assn.'s medicare committee.

But these beds may not be available in a specific hospital at a given time.

Available bed space teeters between acute and critical in some Houston hospitals now. One of these is France's own institution, St. Luke's Episcopal. It usually is full.

Its policy, like most other area hospitals, is to take the sickest first, then those who come for treatment from out of town.

Persons with medical or surgical problems which can be put off without endangering life go on the waiting list when necessary.

The only effect medicare can have on such a hospital is to increase the size of the waiting list.

If the patient does not want to wait, he must seek hospitalization in an institution which does have a bed available.

Elderly persons now constitute 12 to 20 percent of the Houston hospital population, France says.

He expects this to increase to 27 to 30 percent with medicare.

More critical than bed space probably will be the personnel to care for the patients in these beds.

Shortages already exist in such areas as nurses, X-ray and laboratory technicians and physical therapists.

"We expect it to become more severe," France said.

"It could be a disaster," another administrator commented.

Sister Mary Colombiere, president of District 9, Texas Nurses Assn., and director of nursing at St. Joseph, forecasts wider use of licensed vocational nurses, under supervision of registered nurses, as the patient load increases.

But, she sees this increased demand as a possible incentive to recruit more girls into the nursing profession.

Until the program is under way for some time, hospitals have no way to determine whether the "reasonable costs" being borne by the government will cover actual hospital costs.

Some experts believe medicare will not cover these costs and will force an overall hike in hospital bills to close the gap.

"Hospital costs have been going up every year anyhow, and we will just have to wait and see if medicare affects this," France commented.

To some hospitals, medicare will be a boon. Ben Taub and Hermann are two of these. They will be reimbursed for patients who formerly were treated without charge.

It also may ease somewhat the overcrowding at Ben Taub, since some patients—like Williams—now will seek treatment at private hospitals.

Persons signed up for medicare who already are in hospitals have not been overlooked.

Their benefits under the program started Friday when it went into effect. Eligible costs since that time are being paid under medicare, said Edgar Bowers, of the Houston Social Security office.

Hospitals have been asked to notify Social Security of any eligible patients whose enrollment in the plan has not been completed. These will be rushed through, Bowers said.

The Port Arthur News

Sunday Editorials

PORT ARTHUR, TEXAS, SUNDAY, JULY 3, 1966

"Our liberty depends on the freedom of the press and that cannot b Jefferson

Hospitals Gird for Impact of Medicare

Impact of the launching of a mammoth program like Medicare inevitably produces confusion and criticism.

Many millions of Americans—most of them willing to give the big experiment a fair trial—are watching to see how it gets off the ground and finds a level course.

The Health, Education and Welfare department in general and the Social Security administration in particular have striven vigorously to orient the public as to the purpose, scope and operation of the venture. A majority of the people have a pretty good concept of what it's about.

It will take years, though, to acquaint a host of others with the plan's benefits and limitations.

* * *

Full brunt of the burden will fall on the hospitals, who find it difficult to foresee with assurance the extent of the load.

Most hospitals are already over-populated —that's why in our own area they are adding hundreds of beds and installing new treatment facilities.

St. Mary's, oldest medical institution in the south- and mid-county, is in the midst of an expansion effort to meet its full share of the responsibility. It is soliciting public participation to supplement funds put up by its sponsors, the Sisters of Charity of the Incarnate Word, and also federal assistance.

Park Place, the Mid-County, and Doctor's hospitals likewise are enlarging their accommodations.

* * *

Physicians and surgeons, while inherently opposed to the philosophy of government-connected care of the ill, will accept their own obligations, we believe.

One of the great unknowns of the innovation is its costs to the American taxpayer. Some preliminary estimates are startling.

Friday Evening, July 1, 1966 FORT WORTH STAR-TELEGRAM

Medicare Patient Load In City Reported Light

(Related Stories on Page 3, Sec. 1 and Page 5, Sec. 3)

Mrs. J. R. Worlow clasped a cane with her right hand, sat quietly and waited to see a doctor.

Mrs. Worlow, who will be 75 Sunday, was keeping an appointment she made about two months ago.

She searched through a small white purse for her medicare identification card.

She was one of more than 20 persons 65 and older who received medical attention at four Fort Worth hospitals after the program became effective at 12:01 a.m. today.

Mrs. Worlow said she signed up for medicare when she found out about it.

"It sounds like it might be nice," said the mother of eight.

Mrs. Worlow of 1916 Grainger, a Fort Worth resident 37 years, glanced around the room occasionally as if eagerly anticipating her first medical examination.

Four city hospitals — Peter Smith, All Saints, Harris and St. Joseph—reported no great increase of patients who qualify for medicare receiving medical attention today.

However, most administrators said the July 4 holiday might have something to do with the slow arrival of medicare patients.

"Nobody wants to be in the hospital on July 4 regardless of his age," a Harris Hospital spokesman said.

One administrator said the private physicians will feel the largest increase of medicare patients.

Sister Mary James, administrator at St. Joseph, said the relationship between patient and physician will not be changed by medicare. "Patients still need to see their doctors before they come to us," she said.

A spokesman at Harris Hospital said the hospital was operating at 91 per cent occupancy and, in the medical-surgical area at 110 per cent occupancy.

"We've been overcrowded, especially in the medical-surgical areas where medicare will affect us most.

"We're pushed to the limit now, but I don't think medicare will make it easier or harder at this point," the Harris Hospital spokesman said.

The spokesman said the increase of patients resulting from medicare will be lighter than many persons expect.

Bill Austin, administrative assistant at Peter Smith Hospital, said the patients 65 and older there represent only about 10 per cent of the patients.

He did not know if medicare will ease the patient load for the county hospital, but he said things will probably remain about the same.

Between midnight and midmorning today, 12 patients 65 and older registered at Peter Smith, with five of that number new patients.

Austin said the first place the change will be felt is in the doctors' offices.

FORT WORTH STAR-TELEGRAM

Section One Saturday Morning, July 2, 1966 PAGE NINE

Nurse Shortage Discussed By Hospital Administrators

Hospital administrators met Friday — first day of medicare — to discuss the shortage of nurses and how to combat the problem.

Carl Jackson All Saints Hospital administrator and chairman of the administrators' organization, said, "There is a definite shortage of nurses. We're trying to decide what could be done to get more girls interested in the career. We are also concerned about what impact the minimum wage law will have on hospital charges."

Two Tarrant County hospitals raised their room rates effective Friday, but spokesmen for both said the raise was preplanned and had nothing to do with medicare becoming effective on the same day.

Harris Hospital raised its room rates $3 across the board. Arlington Memorial raised its rates from $2 to $5.

An undetermined number of patients 65 and over, qualifying for medicare, were admitted to Tarrant County hospitals on Friday, first day medicare took effect.

Many of these already were in hospitals when the new federal law took effect.

Jackson, for instance, said 66 qualifying persons were in All Saints when medicare went into effect, and "slept through" the transition period.

In addition to those 66, he said, three more patients came in Friday under medicare.

He said he did not believe patients under the federal program would stay in hospitals longer than they would have previously because, "I believe as patients are ready to go home, their doctors release them and they go home."

He said medicare patients represent about 20 per cent of the total present occupation at All Saints. He said a survey of patients over the year preceding medicare showed 15 per cent were 65 or older.

The Austin Statesman

The Oldest Afternoon Newspaper in Texas

Austin, Texas, Friday, July 1, 1966



American-Statesman/UPI

FIRST ON MEDICARE — First patient to be processed at Brackenridge Hospital under the Medicare program was 76-year-old Dennie Tobin, one of the 45 eligible patients already in the hospital when Medicare became effective Friday. He's shown with Mrs. Dick Townsend, R.N. Total Medicare enrollment at noon in Austin was placed at 98.

In Austin

Medicare Patients Near 100

Medicare patients actually enrolled in the program at local hospitals neared the 100-mark at noon Friday.

Four hospitals reported 98 persons processed.

At Brackenridge Hospital, the figure was put at 40., with more expected to be added later to the Medicare rolls. When the program became effective at 12:01 a.m. Friday, the hospital had 45 persons in the hospital who were 65 years of age and older and eligible. The hospital has a 244-bed capacity.

Seton Hospital reported 25 Medicare patients processed and three others scheduled to check in Friday afternoon. Seton has 139 beds.

At St. David's Community Hospital, 18 persons were reported processed. Capacity is 124 at the hospital.

Holy Cross Hospital reported "15 in the house", according to

(See 100, Page 6)

● 100

(Continued from Page

Sister Gerharda. At the start of the program, 25 to 30 patients in the hospital were listed as eligible. Holy Cross has 120 beds.

It was obvious from Friday figures that there has been no great rush in Austin to take advantage of the program. With few exceptions, those signing up for Medicare already were in the hospitals.

TEMPLE DAILY TELEGRAM

TEMPLE, TEXAS, SATURDAY, JULY 2, 1966

Expansion Of Santa Fe Hospital Being Planned



HOSPITAL LEASE SIGNED — O. H. Osborn of Chicago, right, signed a lease of the Santa Fe Hospital facilities Friday to the Santa Fe Memorial Hospital Association. Osborn signed the lease for the Santa Fe Hospital Association for S. E. Flemings, left, vice-president of the new organization. Osborn also will be president of the Board of Trustees of the Memorial Hospital. (Staff Photo)

Will Take Public Patients

By WOODY MONTGOMERY
Telegram Staff Writer

Temple's Santa Fe Hospital will be enlarged and opened to public patients, it was announced Friday.

When the transition from a private hospital for Santa Fe Railway employes to public hospital is completed, Temple will have three public hospitals. The other two are Scott and White Memorial Hospital and King's Daughters Hospital.

A new corporation leased the Santa Fe Hospital facilities Friday and will operate the facilities as the Santa Fe Memorial Hospital.

Announcement of the change was made Friday after a meeting of the board of trustees of the Santa Fe Hospital Association and the naming of a new board of trustees.

An immediate renovating job was ordered by the new trustees to increase the hospital from 125 beds to 142 beds. This will be done by using parts of the north and south wings of the building.

The board also directed that long-range plans be formulated for the betterment of the hospital and an eventual phasing out of old buildings and replacement of them by new buildings.

The trustees plan to employ a consultant soon to start work on formal plans for new buildings and improvements.

The Santa Fe Memorial Hospital has been chartered by the State of Texas and has been approved by the Internal Revenue Service as a non-profit organization.

The new corporation is composed of members of the board of trustees of the Santa Fe Hospital Association. They also are members of the new hospital's board of trustees.

The change will open Santa Fe Memorial Hospital to the public for the first time in the institution's 75-year history.

Trustees of the new hospital are O. H. Osborn of Chicago, president; S. E. Flemings of Denver, vice president, and E. G. Manning and P. E. Johnson, both of Temple, L. R. Morrison of Cleburne and J. W. Luke of Chicago. All were members of the old board of trustees.

Dr. Terrell Speed of Temple was named to the new board of trustees and a "prominent person in the Central Texas area" will be named to the board later, a spokesman said.

Lewis M. Rampy, who has been administrator of Santa Fe Hospital, was appointed to the same position with the new hospital.

The change was made after a two-year study of the operation of the hospital by the association.

"The association felt it would be in a better position to offer the best hospital service to the railroad employees and the general public if it ceased to operate the hospital," Rampy said.

"The Santa Fe Memorial Hospital will continue to operate for the Santa Fe railroad employes but now we are in a position to treat and admit persons other than railroad employes," Rampy said.

The hospital will continue to operate its clinic for railroad employes. At present, it will not operate an out-patient clinic, Rampy said.

"Hospital admittance will be subject to the admission policies," he said. "If a member of the Accredited Medical Staff refers a patient to the new institution, he will be admitted."

Rampy said no staff changes are expected. The hospital will use its staff and the staff of doctors at Scott and White Memorial Hospital as it has in the past.

"It is a big step for us and a big step for Temple," Osborn said.

The Santa Fe Hospital was constructed in 1891 and has been operated for Sante Fe Employes since that time.

Austin American
AUSTIN, TEXAS
Friday, July 1, 1966

Radiologists, Pathologists

Medicare Changes Other Hospital Fees

By CAROL McMURTRY
Staff Writer

Under the gun of Medicare and prodding from state and national organizations, Austin radiologists and pathologists are cutting the money cord that bound them to the city's four major hospitals.

Starting Friday with Medicare, private patients will receive separate bills from radiologists at all hospitals and from pathologists at Seton and St. Davids. Holy Cross works under a different arrangement and final terms have not been worked out at Brackenridge for pathologists.

The separate bills for radiological and pathological fees, rather than receiving these charges with the total hospital bill, marks an abrupt change from long established policy.

Formery fees for these two types of physician's services were included in the regular hospital bill. Anesthesiologists have long sent their bills separate from hospital charges.

The more-or-less divorce between radiologists and pathologists and hospitals stems from the new Medicare law and from resolutions passed by the American Medical Association and the Texas Medical Association.

Medicare divides payment of hospital benefits into one section and payment to physicians in another section.

The AMA, in October, 1965 and the TMA, in April, 1966, passed resolutions calling for "medical specialists" to make arrangements "which are both legal and ethical under which they accept the full responsibility for establishing, presenting and collecting fees for their professional services."

Both radiologists and pathologists have for years contracted with hospitals on a percentage basis.

A 1957 attorney general's opinion held that hospital's collecting fees for medical specialists was contrary to law, but the long established practice did not alter with the state attorney's opinion.

Even with the separate billings, doctors do not anticipate an increase in overall fees.

Dr. R. N. Snider, president of the Travis County Radiological Society, said from now on radiologists would practice in hospitals on the same basis as other physicians with "no change in the overall cost of radiological costs anticipated because of separate billings."

Snider estimated that 90 per cent of the radioogists in Texas would change to some form of separate billing.

One of the difficulties in separating the "medical specialists" from the hospital has been in making an accurate determination of what part of the bill is hospital cost and what part is doctor cost.

A final determniation has not been made at Brackenridge, but hopefully will be completed for pathologists in the next few weeks.

The $5 cost for a red cell count in advance of Medicare will remain the same after Friday, but what is yet to be decided is how much of that $5 Brackenridge should receive and how much Brackenridge pathologists should receive.

One of the problems is that last year big Brackenridge made 255,000 clinical laboratory examinations and that number is expected to be exceeded when the city's present year ends on Sept. 31. That makes for a lot of cost determination.

Paper Express

Place San Antonio, Tex

Date 7-1-66

'Medical Mediocrity Sets In'

Dear Sir:

On Friday the medical profession takes on the coloring of a bureaucracy—in degree. It is idle to pretend that it will not be changed. From here on American medicine will proceed under reduced incentives. An ocean of stifling gray will descend over it.

As for quality, we know what it will tend to become since bureaucracies are all alike. In time it will operate at about the same level of initiative as the post office or the Army. Now try, if you will, to imagine a Jonas Salk or a Thomas Edison emerging from either of these institutions.

Men who work 20 hours a day developing an idea or perfecting a technique do not come from such places. Politicians fail totally to understand that fewer than 5 per cent of the people contribute virtually all of the ideas and discoveries and that, from the standpoint of human advancement, one originator like Edison is worth thousands of ordinary people. Bureaucracy is stifling to such men. However, except for them, progress slows to a crawl.

Medicine, on Friday, will take a long step toward mediocrity. After the gray has settled in, it will be distinguished far more by its quantity than by its quality. It will become, in short, an exact reflection of successful politics and politics is always obsessed by quantity.

William Dysard

Medicare Foes' 'Reason'

Dear Sir:

It becomes clearer each day just what the doctors' real objection to Medicare is. They had me puzzled for a long time because it is clear that their practice will increase as old people start getting the medical care they could not afford before.

The medics' real fear is that the government will set fee schedules. This, of course, is repugnant to our "public spirited humanitarian." He wants to be able to continue to charge all the traffic will bear. What he fears most is being paid what he is worth.

H.M.

Pampa, Texas

The Pampa Daily News

A Watchful Newspaper

EVER STRIVING FOR THE TOP O' TEXAS

TO BE AN EVEN BETTER PLACE TO LIVE

The Pampa News is dedicated to furnishing information to our readers so that they can better promote and preserve their own freedom and encourage others to see its blessing. Only when man is free to control himself and all he produces, can he develop to his utmost capabilities.

We believe that freedom is a gift from God and not a political grant from government. Freedom is neither license nor anarchy. It is control and sovereignty of oneself no more, no less. It is thus consistent with the Human Relations Commandments, the Golden Rule and the Declaration of Independence.

A Time for Perspective

As the medicare law goes into effect today, the United States enters a new phase of government control over the health and well-being of private citizens. Regardless of the wisdom or the merit of politically oriented government programs such as medicare, it is highly important for everyone to retain a sense of perspective.

Medicare marks no great breakthrough in scientific achievement. Passing a law creates nothing. In the case of medicare, there is a law now which, in effect, simply says that all of the cumulative achievements of medical science over a period of centuries is to be made available to certain group of citizens, and paid for to a major extent by taxation.

There are serious flaws in the program which, it is to be hoped, may be corrected as time goes on. The medical profession is concerned that it may result in a lowering of medical standards through the over taxing of medical facilities and the danger of medical care generally becoming a political football. But, doctors are cooperating with appropriate authorities to help do everything in their power to make medicare work.

They will go on in the future as they have in the past, seeking to expand the frontiers of knowledge and bring the benefits of that knowledge to as many people as possible. This has been the goal of the American Medical Association since its founding in 1847. As early as 1913, the AMA began studying health insurance and helped develope voluntary health insurance and prepayment plans to pay for medical and hospital care. The voluntary plans proved successful. The problem now is to see that tax-supported medical care plans do not impair what has become the best medical system in the world.

Repealing Human Nature

Right now, the United States is busily engaged in the creation of the most gigantic structure of public welfare that the world has ever seen. The resources which we have at hand to turn over to government for distribution to groups of citizens entitled to benefits under ever-broadening welfare legislation are immense. Of course, all this wealth was created under a different philosophy which put a premium on individual initiative and provided the incentive of rewarding the productive people and enterprises.

The history of this country should have demonstrated one fact: That all men simply are not equal, never were and never will be. An editorial in the Colorado Trumpet and the Public Ledger points out that: "The Declaration of Independence asserts that all men are created equal, but it says nothing about the duty of a government to maintain citizens at an equal level thereafter." A good example of welfare state "equality" is provided by the following: "Two families living side-by-side are a dramatic example of government favoritism. The one with an income of $3,100 a year is entitled to special tutors and medical checkups for their four-to-six-year - old children, summer jobs or free summer seminars on college campuses for their high school kids, and Youth Corps benefits for the school dropouts. They reap numerous other special privileges as well, but the family next door with an income of $3,300 a year gets nothing."

As taxes go up and dollars go down in value, it becomes more and more apparent that the superwelfare state may bankrupt us, but it cannot ever make us equal—except perhaps in the sharing of universal national poverty.

The El Paso Times

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SUNDAY, JULY 3, 1966

A New Adventure

WITH MEDICARE now the law of the land, a close check is being kept to see what impact it is having on the nation's hospitals and physicians.

So far, there has been little difference from the normal demand made on the hospitals and doctors. We hope that trend continues.

There is no questioning the fact that Medicare is a departure from our former way of life. Everything new has its critics as well as its supporters.

The Times may be described as being somewhat on the side of the anxious watchers: we hope Medicare works out to the advantage of the nation's senior citizens, but we have our fears that it may run into serious difficulties.

The idea of Medicare is praiseworthy. Anything that will ease the worries and pains of old age is worthy.

We must not forget, however, that Medicare is something new for the American people. No one knows exactly how it will work.

Significantly, on July 1, the same day Medicare went into effect in the United States, all British subjects, old or young, were being offered a paying alternative to the free National Health Service. A company called Independent Medical Services Ltd., is seeking to sell Britons for cash what they have been getting free from the welfare state for nearly two decades. The new endeavor has the backing of the British Medical Association.

Medicare has been denounced by many American doctors as the first step forward socialized medicine.

The new British program will attract much attention from this country.

In the United States, the American Medical Association favors direct billing for services rendered citizens over 65, leaving it up to those patients to collect from the company handling the medical provisions of Medicare.

We have no criticism to make of the nation's doctors. Their services are to their patients and they have every right to bill those patients direct. We hope all of the doctors will render every assistance possible to their older patients in helping them to make out the necessary forms.

Looking at the Medicare picture as a whole, we must realize that our country has entered a new era.

We hope everything in our country works out for the best.

Medicare Begins Smoothly In Area

Nurses Problem Looms

By SYLVIA MALTZMAN and ANNE KOLB
(Staff Writers)

Medicare got under way smoothly at hospitals in Broward County today but no agency yet has been certified to provide the home health services part of the hallmark program.

While the 13 Broward certified hospitals admitted a small number of first day medicare patients and converted their books on a larger number of pre-medicare over-65ers, the Social Security Administration looked toward certifying qualified agencies for providing home nursing and health care under the program.

Failure to certify agencies for home nursing care, therapeutic treatments and inhalation centers was not an oversight but due to "the pressure and great importance in certifying hospitals," explained James Clemmons, assistant district manager for the SSA.

RETROACTIVE PLAN

Clemmons expected that home nursing and health care agencies would be certified in the next few days and made retroactive to today's start of the massive medicare program.

One of the most important provisions of the program, extended care in nursing homes, won't go into effect until Jan. 1.

The two programs started at 12:01 a.m. today in one of the biggest operations in medical history despite continued objections of many doctors.

Despite the significant benefits accruing to most senior citizens, in Broward County semi-indigent patients receiving home nursing care were seen as not faring as well under medicare as they did under the Kerr-Mills program.

K-M PROGRAM ENDS

The Kerr-Mills program, also called Medical Aid To The Aged, is being phased out at midnight today. It is being replaced by medicare.

Thelma Boring, director of the Visiting Nurses Assn., said the semi-indigent patients under Kerr-Mills were allowed as many home nursing visits as was necessary.

Under medicare, everyone over 65 regardless of financial status, is eligible for 100 visits a year if they have been hospitalized. Without hospitalization, she pointed out, they must pay a $50 yearly deductible plus 20 per cent of the cost of 100 visits.

While 100 home health visits may seem like a lot, Miss Boring said, some patients could use up that quota in a few months. As an example,

(Continued on Page 2C, Col. 1)

Medicare Under Way Smoothly

(Continued from Page 1C)

she said, her nurses visit stroke patients three times a week.

Advantages of medicare, as it applies to home health care, are the availability of speech and physical therapists. Kerr-Mills did not provide these services.

Miss Boring said she has about 20 patients who are receiving benefits from the Medical Aid to the Aged program. If home nursing care is continued to these patients under medicare, the bill will be paid by the Visiting Nurses Assn. until such time as the association is certified.

Certified in Broward County are the following hospitals: Broward General, North District, Doctors General, Ft. Lauderdale Beach, Hollywood Hospital, Holy Cross, Pompano Beach Hospital and Clinic, South Broward Hospital, South Florida State, West Broward, Memorial, Las Olas Hospital and Golden Isles Hospital.

Paper Reporter-News

Place Abilene, Tx

Date 7/1/66

Globe - Times
Amarillo - Texas - July 1, 196

86 Under Medicare In City's Hospitals

By ANNA C. THOMASON
Of Our Staff

"I don't know what I think of Medicare, but I'm a good Democrat. I knew Eleanor Roosevelt," Mrs. Maxine Aycock, 71, of Texhoma, Okla., said this morning from her bed at Northwest Texas Hospital.

Mrs. Aycock was one of 86 patients in three Amarillo hospitals this morning who automatically began receiving Medicare benefits.

Her opinion was not shared by one man who checked into Northwest Texas Hospital late Thursday. He said he wanted no part of Medicare.

"I'll pay my own bill," he informed hospital officials.

R. E. Rush, director of admissions for Northwest Texas Hospital, said Medicare business was much lighter than he had anticipated.

Northwest Texas Hospital reported a total of 272 patients this morning, of whom 35 were persons over 65. St. Anthony's Hospital had 46, and Amarillo Osteopathic had five persons eligible for Medicare.

Several persons checking into Northwest Texas Hospital under the Medicare program late Thursday said they forgot their claim numbers or had never received one, Rush said.

Reservations indicated the hospital was to receive 10 Medicare patients this afternoon.

Two were scheduled to check in Saturday and seven on July 4th.

Amarillo was running considerably lower in Medicare registration than cities of comparable size in South and Northeast Texas.

"They are pretty independent here," a spokesman said. "They voted Republican one time, didn't they?"

An Amarillo hospital official, who declined to be named, said: "I think you could headline your story 'Pride.'"

4 Hospitals Get Approval On Medicare

Full integration of all hospital facilities, one of the requirements for participation in the Medicare program, has recently been approved in four area hospitals.

The Department of Health, Education and Welfare has listed Northwest Texas Hospital and Underwood Psychiatric Hospital in Amarillo and Childress General Hospital in Childress and the Medical Center Hospital Annex in Plainview as among hospitals complying with Title VI of the Civil Rights Act of 1964.

J. H. Bond, regional director for HEW, said clearance under the civil rights legislation is one of the requirements for hospitals intending to participate in the Medicare program, scheduled to begin Friday.

F. S. Walters, administrator for the Amarillo Hospital District, said additional requirements for Medicare approval include full accreditation by the Joint Commission on Accreditation of Hospitals or a survey by the State Health Department and a utilization committee composed of staff doctors, which reviews Medicare cases and certifies need of hospitalization.

Compliance under the civil rights legislation requires that there be no discrimination of any kind in admitting patients, in the use of any facility and in hiring of personnel.

Walters added that no room assignment may be made on the basis of race, color or creed. He said, however, "We do give consideration on the basis of economic compatibility and diagnosis and condition."

No.
SSA-DO
Amarillo, Texas
Symbol
Medicare

Paper
Globe-Times

Place
Amarillo, Texas

Date
June 30, 1966

AMA Turns Militant On Medicare Policy

CHICAGO (UPI) —The American Medical Association wound up its dispute-riddled convention today with a Medicare policy more militant than AMA leaders had bargained for.

The association's House of Delegates today gathered up the loose ends of resolutions and were to decide whether the AMA should purchase radio and television time to explain to the public its Medicare policies.

The House of Delegates, in a shouting floor rebellion, Wednesday overruled study committees and urged the nation's healers to bill all their Medicare patients directly and to have nothing to do with forms that provide for doctor payments by government-designated insurance firms.

Doctors following the AMA policy—it is strictly voluntary—will leave it up to their elderly patients to get reimbursed under the federal health care program.

Dr. John H. Budd of Cleveland, Ohio, led the spirited floor fight that strengthened the AMA's stand for direct billing of patients. The 228 delegates representing 200,000 doctors shouted their approval.

The AMA Advisory Committee on Medicare reported Wednesday it was "disturbed" at the Health, Education and Welfare Department's submission of a new government regulation involving Medicare just six days before the new program went into effect.

The proposal, AMA spokesmen said, would limit fees of hospital-based specialists under Medicare. The AMA asked for, and received, a meeting Friday with HEW Secretary John Gardner to discuss the regulation.

The delegates also voted unanimously in favor of opposing any extension of Medicare into a national health plan.

The AMA also directed hospital-based doctors to boycott any hospital that did not allow its physicians to make separate charges for their services. Dr. Vincent W. Archer of Charlottesville, Va., led the fight for the resolution. A study committee had recommended the measure be delayed until the legality of the move could be determined.

Amarillo, Texas
Glove-Times
July 1, 1966



—Staff Photo

Medicare Pioneer

Among the earliest Northwest Texas Hospital Medicare patients is Miss Cassie Burris, 87, of Mountain View, Okla. Miss Burris checked into the hospital previously and was ready today to take advantage of Medicare benefits, which went into effect at midnight. Area hospitals also were receiving Medicare patients today. Dumas Memorial Hospital reported five by 8:30 a.m.

Reporter-News
Abilene, Texas

THE ABILENE REPORTER-NEWS
Abilene, Texas, Friday Evening, July 1, 1966

Medicare Effective Today; Johnson Calls It 'Blessing'

WASHINGTON (AP) — The massive medicare program providing hospital insurance for all 19 million of the nation's senior citizens went into effect today, hailed by President Johnson as "a blessing for older Americans."

Swinging into operation with the program was an optional doctor-bill insurance plan for which 17.3 million elected to pay $3 a month.

The two programs were brought into being at 12:01 a.m. in one of the biggest operations in medical history.

Doctors and patients reserved any prognosis, but the President pronounced it a success in advance. He called it "a test of our willingness to work together."

By Public Health Service count, 6,714 institutions — or 91 per cent of all the country's 7,374 general hospitals with roughly 93 per cent of the beds — opened their doors for the insured care of any American aged 65 or over.

The nonparticipating hospitals were mainly in the South. Most were barred from medicare payments by their failure to comply with the no racial discrimination provisions of the Rivil Rights Act.

To make extra sure that no one dies for want of access to a participating hospital, the government ruled Thursday night that federal hospitals — veterans', military and others — may be used for critically ill medicare patients in emergencies.

Previously it had been announced that any other non-participating hospital could be used — private or public, with medicare picking up the bill — if a bed in a participating hospital could not be found to avert the threat of death "or serious impairment of the health.

Despite the serious gaps in participation — only 25 per cent of Mississippi hospitals were in the pool — administration aides were jubilant over the generally high participation nationwide.

"We've done far better in the South than we had dared to hope a month or two ago," one Public Health Service official said.

"And more hospitals will be desegregating when they begin to feel the pressure from unhappy local residents, both white and black," he added.

Twenty-three states entered medicare with 100 per cent participation by their qualified hospitals, and some others came close to that.

In his medicare's-eve statement, President Johnson said he had no doubt of the success of the twin medicare programs if these three things happen:

"If hospitals accept their responsibility under the law not to discriminate against any patient because of race."

"If doctors treat their patients with fairness and compassion. I feel sure that most doctors do not plan to drive hard bargains with needy patients."

"If old patients cooperate in scheduling treatment and do not demand unnecessary hospital and medical services."

The Reporter
Sweetwater Texas
July 1, 1966

Difficulties Reported Minor With Medicare

By United Press International

The nation's hospitals began receiving the first Medicare patients today with no major difficulties reported.

Hospital administrators across the country indicated there was a light turnout of applicants for hospital space.

Simmons Memorial Hospital reported only one Medicare enrollee admitted Friday after the program went into effect.

The administrators said that was due to two factors: Friday is a light day for hospital admissions, and the July 4 holiday weekend is the lightest of the year.

Nevertheless, the trickle which could become a flood—19 million Americans over 65 are eligible for the federal health insurance program—made its mark in the history of social legislation.

Most Operating Routinely

A check by United Press International showed most hospitals operating routinely. Some hospitals in the San Francisco area, however, said there had been a significant increase in over-65 patients during June.

"I've been paying all these years for nothing," a new Medicare patient said. "I figure the company (private insurance) owes me something."

Most hospitals in the San Francisco area said the first real crush could come Tuesday, after the holiday.

Hospitals in Pittsburgh, Pa., and in Texas reported there were few new Medicare patients, and the transfer on the books of hundreds of thousands of persons already hospitalized to the status of Medicare patients went smoothly.

Basically, Medicare provides up to 60 days of hospital care with the patient paying the first $40 and, if additional hospital treatment is required. Medicare will cover the costs over $10 a day for another 30 days.

The second part of Medicare, which is optional, costs the oldster $3 a month and provides, after a $50 initial payment by the patient, the bulk of the money for doctor bills.

Civil rights also was an issue, principally in the South. The Department of Health, Education and Welfare said more than 600 hospitals had failed to comply with desegregation requirements in time to qualify for participation in Medicare on opening day.

"No hospital will be cleared for participation in Medicare unless the department has convincing evidence that the hospital is in fact in compliance," HEW Secretary John Gardner said, emphasizing that token pledges would not be enough.

The number of non-complying hospitals represent about 8 per cent of the nation's houses of healing and most are in the Deep South.

Rep. L. H. Fountain, D-N.C., charged the federal government with depriving elderly citizens, white and Negro, of Medicare benefits in an effort to impose "illegal" desegregation demands.

Individual physicians meeting in Chicago this week for the American Medical Association conventon had predicted that "bedlam" would break out when Medicare went into effect.

However, and American Hospital Association spokesman in Chicago said Thursday, "we expect no big rush in as far as in-patient hospitalization is concerned.

"Twenty-five per cent of the patients (in hospitals) today are 65 years or older. What happens is that they will be discharged, on paper, and will be readmitted tomorrow (Friday) as Medicare patients.

Medicare, Waiting Lists Begin Friday In Louisiana

By United Press International

Medicare and long waiting lists begin today in Louisiana.

Hospital administrators throughout the state predicted the immediate effect of Medicare will be longer waiting lists of people trying to get into already crowded institutions.

David Smith, administrator at West Jefferson Hospital, said "patients will still have to be admitted by doctors and they can't very well be admitted if there aren't any open hospital beds."

An official of the Health Insurance Bureau of Social Security said there are 275,000 persons over 65 years of age in Louisiana and of this number 243,000 have signed up for Medicare.

Jack Melane, regional representative of the bureau, said that room shortages will be greater in North Louisiana.

He said in Shreveport and Monroe, only one hospital in each city has signed up for the program.

Assistant Administrator Robert Debacker of Shepherd Hospital in Shreveport said he does not believe the hospital can handle the program in his city with only 342 beds.

"Shepherd Hospital cannot meet the demands of the more than 38,000 people who have signed up for Medicare in the Shreveport area. We will have to limit admittance to patients of doctors on our active and honorary lists," Debacker said.

An official of the Conway Hospital in Monroe, a charity hospital, said his institution will have to care for patients of the welfare rolls first since the hospital operates on state funds. Conway has 212 beds in the hospital.

Another fear expressed by several administrators was possible lowering of quality care because it appears Medicare may not equal actual hospital expenses.

Sister Mary James, administrator of Hotel Dieu in New Orleans, said "the government began Medicare on the right track with the principle of full reimbursements to the hospitals for their costs in treating Medicare patients.

"Since then the government has been cutting back on proposed benefits for hospitals. I don't look on this approach with much favor because it could affect the quality of care offered in our hospitals."



'HAPPY MEDICARE TO YOU' — That is the massage inscribed on a cake which radiology technicians at Hendrick Memorial Hospital treated the hospital's four radiologists with Friday morning during the first day of the Medicare program. Shown during the coffee are, left to right, Dr. Ed Haag, Mrs. Elaine Aycock, Eddie Bull, Mrs. Cathy Campbell and Dr. V. H. Shoultz. Mrs. Aycock and Mrs. Campbell are technicians, Bull is chief technician, and the two doctors are radiologists. (Staff Photo by Roy A. Jones II)

Medicare Turnout Starts Slowly, but Others Likely

Thousands of Abilenians were among the 886,000 Texans over 65 who came under coverage of the Medicare program at 12:01 a.m. Friday, but only four of them were admitted to hospitals Friday morning to partake of the benefits.

Hendrick Memorial Hospital reported three new admissions of persons under the program, while St. Ann Hospital reported one and Cox Memorial Hospital none.

All three hospitals, however, had patients already admitted who automatically came under the program Friday. Hendrick reported 58, St. Ann had eight, and Cox had 11.

"We expect to have some more come in, but it has been real light for the first day," said Mrs. Fred Daniell, admissions clerk at Hendrick hospital.

While clerks were admitting the new patients—the first Texan admitted under the historic measure is believed to have been 82-year-old widow admitted to Dallas' Parkland Memorial Hospital at 12:01 a.m. — employes in the radiology department at Hendrick hospital were having a "coffee" for four doctors who will be vitally affected by the new program.

Radiology technicians presented the four radiologists — Drs. Wayne Ramsey, Jack Ramsey, Ed Haag and V. H. Shoultz with a cake reading "Happy Medicare" because the new program will require that they send out bills themselves for the first time.

The white cake was patriotically — and tastefully decorated in red and blue icing.

Because of the separation of physicians and hospital charges written into the Medicare Law by Congress, patients receiving Social Security Medical Insurance payments for hospital X-rays will receive two bills, where they have received only one from the hospital in the past.

One bill will be from the hospital for making the X-ray film, the other from the doctors for reading and interpreting the film and for professional consultation, Dr. Shoultz explained.

"We are not opposed to the separation, but it will create a few problems at first," he said, citing as an example:

"Some people are likely to be awfully confused when they pay their X-ray bill to the hospital, then they get another X-ray bill from a doctor they may have never seen."

Doctors many times are busy reading films and never see the patients personally, he said, explaining that the technicians "shoot" the X-rays.

"Of course, we will try to see more of the patients now, so that they will know what they are paying for," he said.

"We're not anticipating any difficulty in collecting for our work because these elderly people are usually the best ones about paying their bills," he concluded.

"It's just a matter of getting these people to understand the reasons why they will get two bills."

Globe-Times

Amarillo, Texas

July 1, 1966

Drugs Are Paid Only in Hospital

WASHINGTON (UPI) —The Medicare insurance program which takes effect July 1 does not cover medicines or drugs unless they are administered while a patient is hospitalized.

Also excluded from coverage are routine physical examinations, dentist bills, eyeglasses, hearing aids, cosmetic surgery and orthopedic shoes.

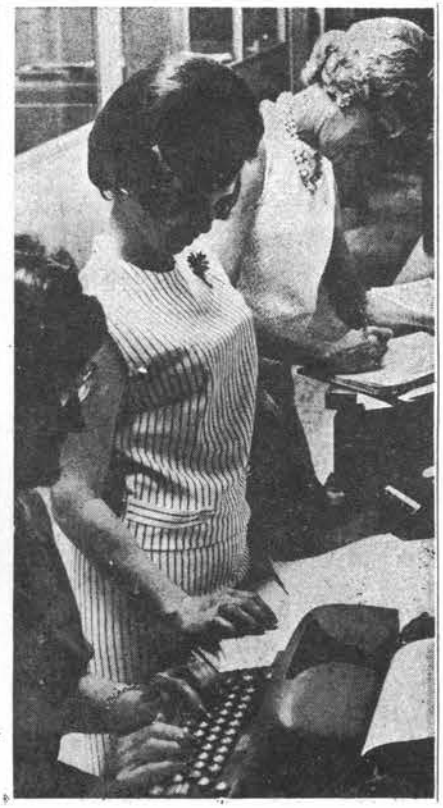
Some Blue Cross plans and other private insurance carriers are offering special policies to persons over 65 to cover these and other gaps in Medicare coverage.

WASHINGTON (UPI) —The Medicare handbook which the Social Security Administration is mailing out to 19 million old folks is printed in unusually large type.

Questioned about it, a Social Security spokesman said:

"We explained to the government printing office that this booklet was intended solely for people over 65, many of whom have trouble reading small print. So they printed it in 14-point type instead of the 10-point type customarily used in government pamphlets."





—*World Staff Photos*

Where Is the Flood of Medicare Paperwork?

Paperwork transferring records of patients already in the hospital who went under the Medicare program Friday involved the bulk of the program's opening day in Tulsa rather than a rash of new patients. Above, Helen Reed, left, claims examiner, and Merlene Heginbotham, Medicare section supervisor of Blue Cross, go over forms. At right, work in the St. John's Hospital admissions office is handled by, from left, Pauline James, Miki Compeau and Florabel Masoner.

WEST HELENA WORLD
NEWSPAPERS
HELENA, ARKANSAS
JULY 1, 1966

All but 23 of states hospitals are under Medicare

By THE ASSOCIATED PRESS

The federal Medicare program started today in Arkansas with all but 23 of the state's 109 hospitals qualified for participation.

Seven hospitals received contracts from the Social Security Administration just before the program got under way.

They are the Arkansas State Hospital at Benton, Harris Hospital and Clinic at Newport, Howard County Hospital at Nashville, Pike County Memirial Hospital at Murfreesboro, Ouachita Memorial Hospital at Hot Springs, Branch General Hospital at Hope and the Verser Clinic and Hospital at Harrisburg.

Meanwhile, a hospital administrator said the Health, Education and Welfare Department had said that hospitals must assign all their patients to rooms without regard to race and can't allow a patient to transfer to another room on racial grounds.

This comes under the 1964 Civil Rights Act, which hospitals had to agree to comply with to be eligible for Medicare participation.

John Gilbreath, Baptist Medical Center administrator, said the Little Rock hospital had been assigning patients to rooms without regard to race since April 1965, but had been permitting transfers if a patient objected to sharing a room with a person of another race.

HEW will allow transfer from a semi-private to a private room.

Helena Hospital is still wating word; patients also wait

Early this afternoon the Helena Hospital was still awaiting word from Dallas as to whether it had been approved for Medicare.

Meanwhile, at least a dozen prospective patients, mostly colored, were still waiting for the hospital to get the word so they could be admitted.

One hospital official said that Negro patients started showing up at 7 o'clock this morning with their Medicare Card in hand, seeking admittance. At one time the waiting group numbered about 20 but some left to return home when they learned of the situation.

The hospital has been informe unofficially that it had been approved but must wait for written word, by wire or letter.

There are 15 Medicare patient already in the hospital who were carried as welfare patients before the new Federal program went into effect at 12:01 this morning.

23 St. Bernard Patients Transfer To Medicare

Almost 20 per cent of the patients in St. Bernard's Hospital—excluding pediatrics and maternity—are being treated under the new Medicare provisions of the Social Security law today, Administrator John Foley said.

But no new patients have been admitted under the law—which went into force this morning at 12:01.

Foley explained that patients already being treated at St. Bernard's, who were over 65 and eligible for Medicare, were transferred over to Medicare as soon as the law went into force. Altogether 23 patients at St. Bernard's transferred over. Census at the hospital—exclusive of pediatrics and maternity—is about 100.

No new patients were admitted under Medicare this morning, but some are expected within the next few days.

The first morning of the new law has created no problems, Foley said.

By STERLING F. GREEN

WASHINGTON (AP) — With little commotion or visible strain on facilities, more than 6,400 hospitals opened their doors today for the medicare-paid treatment of senior Americans—with a guarantee of no racial discrimination.

There was no immediate sign of a general rush—such as some doctors had predicted — in the early reports on the launching of medicare for 19 million Americans 65 and older.

Thousands of elderly patients already in hospitals across the land were automatically transferred to medicare status for bookkeeping purposes.

In Washington a spokesman for the Department of Health, Education and Welfare said Secretary John W. Gardner was "gratified that so many Southern hospitals have come into compliance" with the Civil Rights Act for participation in medicare.

HEW issued a new tally of participating hospitals, certified for civil rights compliance, showing that 6,414 out of the 6,978 which could be used for medicare patients had been certified, or 92 per cent, nationwide.

Both the figures were smaller than those earlier reported officially. HEW said the new count eliminated hospitals which had obtained civil rights clearance but were not of a type suitable for medicare use.

Jonesboro Sun
Jonesboro, Ark.
July 1, 196

Patients Are Ordered Out

CORINTH, N.Y. (AP)—Eight elderly patients were ordered evicted today from a tiny community hospital, because federal officials said the hospital did not meet standards for the new government medicare program.

The two other patients at the Adirondack Regional Hospital in this village near Saratoga Springs also were over 65 and covered by medicare but were permitted to remain because they are heart patients who cannot be moved, Dr. Bruce Scidmore, head of the hospital, said.

The eight were considered well enough to go home until other accommodations could be found, he said.

The health insurance agencies that had been paying their bills automatically dropped coverage, with the advent of medicare at midnight. Thus, the eight, aged 67 to 87, could not afford to remain. The medicare program will pay for the critical ones, aged 70 and 78, until they can be moved.

Dr. Scidmore told a reporter he hoped the people would approve a bond issue before the end of July for improvements in the 30-bed, wood and brick hospital.

Social Security officials decided that too many of the hospital beds were in the old, wood portion, which is not fire proof.

Saturday, July 2, 1966.

Jonesboro Sun
Jonesboro, Ark.
July 2, 1966

Mountains Of Paper Work But Medicare Debut Calm

EDITOR'S NOTE -- Members of a special AP task force kept a close watch throughout the first day of medicare in a group of hospitals around the country. The following account is based on their reports.

NEW YORK (AP)—Down the corridors of Miami's Jackson Memorial Hospital figures in white passed each other with a cheerful greeting: "Happy medicare!"

For the nation's hospitals Friday was indeed happy medicare —the first day of the Social Security hospital program for persons 65 years and older had gone smoother than anyone had dared hope.

Still, there were problems: mountains of paper work, missing forms, bewildered patients, lost medicare cards, and one woman who got mad and swung her purse at a hospital worker.

By midafternoon, in the usually frantic emergency room at Jackson Memorial, interns sat with their feet propped on a table.

"It's the quietest day we've had," said Dr. James Connaughton, who joined the Miami hospital last month after graduation from the University of Indiana.

The situation was virtually the same in hospital after hospital across the United States. Fear expressed by some that medical facilities would be swamped by elderly people evaporated as the day wore on like any other before a July 4 holiday.

Northwest Hospital in Seattle, the first in the nation to be certified for medicare, admitted not a single medicare patient. Six elderly patients already in the hospital, however, were automatically switched over to medicare at its start, 12:01 a.m. Friday.

"Heaven help us when Tuesday comes," said Alfred E. Riley, business manager of St. Elizabeth's Hospital in Chicago. Riley said he looks for a big inflow of patients then because of the people who wanted to be home for the holiday or delayed entry because so many doctors woud be away for the weekend.

At 9 a.m. on the fist day, Anna Winston, 71, of New York City, showed up in the emegency room at mammoth Mt. Sinai Hospital complaining of "aches and pains." Within an hou she became one of the hospital's 19 patients.

"I knew I'd wind up in the hospital because I was very sick," Mrs. Winston said. "I should have been here a month ago, but I couldn't get into this or any other place."

The biggest problem faced by the hospitals is the increased load of paper work. Mt. Sinai added 41 clerks just to handle all the new forms and extra bookkeeping. Other hospitals are also taking on new help.

At St. Joseph's Infirmary in Atlanta, business manager David Messinger recalled that he had spent 20 years in the Air Force as a medical budget officer. He shuffled the forms piled high on his desk and said, "I'm right back home again. I haven't had much sleep in three days. I can't sleep any more, trying to figure out what to do about medicare."

An information desk was set up on the main floor at Detroits' Henry Ford Hospital, where more than 200 elderly persons came with questions about the program.

One elderly woman insisted a girl behind the counter was wrong when she explained that medicare doesn't cover all expenses. "You're trying to line your pockets with my medicare money," the woman shouted, and swung her purse at the girl

The girl ducked and the blow glanced off her hairdo. She retreated into a nearby office and the woman stomped out.

"They're generally surprised to learn that everything isn't paid for," said Thelma Cogswell, clinics admitting officer at Massachusetts General Hospital in Boston.

She said the clinic patients were used to being "whisked through" the formalities of being checked in. But Friday there were delays because of the medicare forms to be filled out. Miss Cogswell added: "The hardest part at this point is that nothing is cut and dried. If we had been given a few simple rules to follow it would be a lot easier."

By the end of the first day at Massachusetts General the hospital had 941 patients, of whom 260 were over 65 years. During the day the hospital admitted 67 new patients, 18 of them under medicare.

Queen of Angels Hospital in Los Angeles didn't have a single medicare admission until midafternoon, when a doctor called to advise he was sending in a male heart patient.

"The hospital census always goes down to rock bottom on July 4," said a hospital spokesman.

Also affecting admissions, he said, was the fact that California put into effect its own program March 1, absorbing early the influx of patients.

Some hospitals reported that a few elderly persons had shown up to "get their medicare." They weren't sick, but they mistakenly thought they had to report to the hospital.

"The people who come in under medicare often are too old and too sick to know about the program," said Alan Transue, credit manager of Research Hospital and Medical Center in Kansas City.

"They don't have cards, they can't find cards, they don't know what we are talking about," he said.

At the Boston Hospital one woman outpatient refused to produce her red, white and blue card—until she had a chance to go to the ladies room and unpin it from her underwear.

At Ochsner Foundation Hospital in New Orleans, Herbert Leonard, an oil jobber from Ponchatoula, La., said he objected to medicare and wouldn't have signed up if his private insurance company hadn't reduced his hospital coverage due to the federal program. "I still think an American would rather pay his own way," he said.

When medicare went into effect St. Joseph's in Atlanta transferred 50 age-eligible patients to the program. During the day six checked out and three more were admitted.

E.D. Rivers, 70, of Lakeland, Ga., Georgia governor from 1937-40, entered the hospital for a periodic checkup. His admission form bore the green-ink stamp "Medicare 65."

"I've been in Social Security for some little bit now," Rivers said. "I paid in a lot of money. They don't put it on the basis of need, but on the basis of right."

Madge English, 72, of Dallas, admitted to Parkland Memorial Hospital at midmorning for treatment of a broken hip, said of medicare: "It's a wonderful thing. It's God's blessing to the old people."

Dr. Fred Bonte, chief of radiology at Parkland, said, "It's a lot easier than we thought it would be." Five medicare patients were admitted Friday and 82 others in the hospital were automatically transferred.

Said administrator Jack Price: "I'm not surprised at the small number of medicare admissions. After all, old folks don't like to go to the hospital any more than anyone else."



Democrat/O. D. Gunter

GLENDA RAMSEY CHECKS PATIENT'S PULSE . . . Virgil E. Paul, one of the state's first Medicare beneficiaries

As Medicare Begins

Ark Democrat July 2, 66

No Rush Reported At LR Hospitals

By MARTHA ANN RILEY
Democrat Staff Writer

An early check of Little Rock's three largest hospitals revealed no large influx of patients 65 or over as the Medicare program entered its second full day.

For most hospitals, it was merely a matter of switching elderly patients already hospitalized over to the program.

Hospital spokesmen indicated, however, that the big rush may occur on Tuesday following the holiday weekend.

St. Vincent Infirmary reported only four admissions Friday, none early today and three scheduled for Sunday.

In addition, 53 patients 65 or over were transferred over to the program.

Five Medicare patients had been admitted at University Medical Center as of today, with 25 transferred to Medicare, representing about 9 per cent of the over-all patient load.

The number of patients at Arkansas Baptist Medical Center transferred to Medicare totaled 66 in addition to 9 admissions Friday and 1 today.

A 71-year-old North Little Rock man, who had been hospitalized only once before in his life, became one of the first Medicare beneficiaries admitted to a hospital here Friday.

The dubious distinction of being one of the first patients under the new federal government program went to Virgil Edward Paul, 302 Redwood, North Little Rock, who checked into Arkansas Baptist Medical Center at 9:50 a.m.

Paul, a retired carpenter, said he began experiencing severe abdominal pains between 8 and 8:30 a.m.

Upon his arrival at the hospital some 90 minutes later, tests were administered to determine the cause of pain, which had subsided by the time members of the press were admitted to his hospital room about 1:30 p.m. No determination of the ailment had been made at that time.

Resting comfortably, Paul said he planned "to get out of here just as soon as possible."

The only other time he has ever been admitted to a hospital was for an appendectomy about five or six years ago.

Paul said he began receiving information in the mail several months ago concerning the program.

"After I had gotten several letters, I decided that maybe I ought to try this thing because you never know when you might need it."

His wife, to whom he has been married 55 years, also is enrolled under the Medicare program.

Both had previously been under health insurance plans, he said.

Paul and his wife are parents of two children. They also have four grandchildren and eight great-grandchildren.

A native of Arkansas, Paul, whose hobby is fishing, has never been out of the state even on a visit. He and his wife are members of Grace Baptist Church in North Little Rock.

Today's Bible Verse

Thanks be to God, which giveth us the victory through our Lord Jesus Christ. — I Corinthians 15:57.

Medicare's 1st Day Quiet, Just Changes In Patients' Status

By the Associated Press

In most hospitals in Arkansas, Medicare began as a routine matter of switching elderly patients already in the hospital from welfare status to Medicare status. Scattered reports from around the state indicated that about 20 per cent of the hospital population was switched to Medicare.

The number switched at St. Bernard's Hospital, Jonesboro, amounted to 20 per cent of the adult patients outside the maternity ward.

At Levy Hospital in Hot Springs, the total was 25 per cent of the total number of patients.

On a statewide basis, more than 1,000 patients probably were switched into the Medicare program.

The number was 23 at St. Bernard's, 25 at Ouachita Hospital in Hot Springs, between 50 and 60 at St. Joseph's Hospital in Hot Springs, 15 at Helena Hospital, and 50 or so at each of the three major Little Rock hospitals.

At Helena, the hospital had a small rush of patients — 20 or so elderly Negroes — but delayed admitting them because it had not been officially notified of approval for participation. Controller Bill Boetler said the hospital had been notified by telephone of approval but wanted to await receipt of the telegram confirming it.

Medicare bans discriminatory practices in the treatment or room assignments of patients.

In Garland County, a retirement mecca, Social Security Administration officials said that 5,867 of the county's 38,107 residents were eligible for Medicare. The County's three hospitals have a total bed capacity of 348.

Charles Hodge of the Social Security Administration office in Little Rock said a staff member would remain on duty through the July 4 week end to assist hospitals who might need to call on the office for assistance in connection with the Medicare program.

No problems were anticipated and none were reported the first day, Hodge said.

'Not Bad,' LR Hospitals Say Of Much-heralded First Day

"We've had more calls from newspapers than we've had patients."

Edward Rensch, assistant administrator of St. Vincent Infirmary, thus summarized the much-heralded first day of Medicare. "It wasn't bad at all," he said.

Both Rensch and R. H. Hagaman, administrative assistant at Arkansas Baptist Medical Center, agreed that the Fourth of July holiday week end probably had some bearing on admissions. Fewer are admitted preceding holidays and more are released.

Neither hospital had anticipated being inundated with Medicare patients the first day, but it turned out to be even lighter, apparently, than they had expected.

Admissions at Baptist were off 6 per cent from the average Friday. Of 40 admitted during the day, only seven were Medicare patients. Sixty already in the hospital were eligible for Medicare assistance and their records were changed accordingly.

Rensch said admissions at St. Vincent also were down and only "three or four" were admitted under Medicare. However, 53 patients already in the hospital were eligible and were transferred over to Medicare records.

The first Medicare patient admitted Friday to either hospital was Virgil Edward Paul, 71, of 302 Redwood Street, North Little Rock, a carpenter retired under social security, who entered Baptist shortly after 8 a.m. — without his Medicare card. He had to send home for it.

Paul, who never has been outside Arkansas even for a visit, was making his second trip to the hospital. He underwent an appendectomy at Baptist about five years ago.

"I had to stay 16 days the last time and I said then, 'I hope to God I never have to come back again,'" he said.

Paul and his wife, Mrs. Lela Stivers Paul, will have been married 55 years in September. They have two children, four grandchildren and eight great-grandchildren.

St. Vincent's first Medicare admission Friday was Mrs. Laura Johnson of Conway, who entered about 1:25 p.m.

ARK GAZETTE July 2, 66

Medicare List Reaches 88

Three more Arkansas hospitals were issued Medicare contracts Friday by the Social Security Administration. They are the Leo N. Levi Hospital at Hot Springs, Jefferson County Hospital at Pine Bluff and Saline Memorial Hospital at Benton.

This makes 88 out of 109 hospitals in the state that are eligible to accept Medicare patients.

The total would have been 89 except that the Arkansas Children's Hospital, which was on a list released earlier in the week of hospitals approved for contracts, decided it wouldn't need one. It doesn't plan to accept any elderly patients.

Hospitals must meet the health and safety standards of the Medicare law and the nondiscrimination requirements of the 1964 Civil Rights Act to get a Medicare contract. Several more hospitals have qualified under the health and safety standards but not under the Civil Rights Act.

Several of the 109 hospitals are not seeking a Medicare contract for one reason or another.

ARKANSAS GAZETTE July 2, 66

Hays Calls Medicare Good, Says It Will Bring Problems

The beginning of Medicare Friday will mean better care for many elderly citizens, Brooks Hays said in a radio talk at Forrest City, but it also will present urgent problems that demand statewide solutions.

Hays, a candidate for the Democratic nomination for governor, outlined some of the problems and how he would approach them if elected.

"We already have a shortage of nurses and hospital beds, which we expect will get more acute as the demand from Medicare patients increases," he said. "The rising cost of medical care is of concern to all of us. As was pointed out last week by a group of hospital officials, the paying hospital patient cannot be expected to pick up the tab on the difference in cost between the $30 a day which the Welfare Department now pays and the $45 a day which is the actual cost of many hospitals. This places the burden on the small segment of the public who are patients themselves, when it should be covered instead by the Welfare Department."

He proposed to establish a Medical Advisory Committee made up of professionals and laymen to work on solutions for these and related problems.

He would recommend that the Committee study the use in Arkansas of Title 19 of the Medicare program. Some other states are using it but not Arkansas. Hays said Title 19 is to provide medical care for those who have enough income as long as they stay well but nothing left over for serious or long-term medical bills. It also extends medical help to welfare clients other than the elderly, that is, the blind, the disabled and others.

The federal government furnishes 83 per cent of the cost under Title 19, Hays said, but the best provision is that the program is administered and the decisions made in the state that uses it.

Arkansas Democrat
Little Rock, Ark.
July 1, 1966

In Over 6,400 Hospitals

No General Rush Reported As Medicare Takes Effect

WASHINGTON (AP) — With little commotion or visible strain on facilities, more than 6,400 hospitals opened their doors today for the medicare-paid treatment of senior Americans —with a guarantee of no racial discrimination.

There was no imediate sign of a general rush—such as some doctors had predicted—in the early reports on the launching of medicare for 19 million Americans 65 and older.

Cook County Hospital in Chicago—one of the country's largest, with more than 2,700 beds—reported fewer patients entering than usual. Some other Chicago hospitals said today's admissions were like Thursday's.

Six Oklahoma City institutions said that 255 patients who already were in the hospitals when the insurance benefits began at midnight became medicare patients at that moment—and only four more had entered up to noon.

Spot checks in Florida showed relatively few admissions, but hospital administrators said they expected the real impact on July 5, after the Independence Day holiday. Some said they were besieged by telephone calls.

One of the first medicare admissions—if not the first in the country—was Eugene Schneider, 65.

Schneider, an embroidery worker of 6302 Polk St., West New York, N.J., entered Polyclinic Hospital, New York City, at 12:01 a.m. for treatment of an eye problem.

Miami's Jackson Memorial Hospital, largest in the southeast, had its first medicare patient—Mode Lewis, 78, who suffered a stroke— at 12:20 a.m. There were no others at Jackson for the next 10 hours.

But thousands of elderly patients already in hospitals across the land were automatically transferred to medicare status for bookkeeping purposes.

In Georgia—where the latest figures showed 107 out of 182 hospitals in compliance with the civil rights law and thus eligible to take medicare patients—medicare took effect quietly Forty-two patients at Atlanta's Piedmont Hospital became medicare patients automatically.

In Washington, a spokesman for the Department of Health, Education and Welfare said Secretary John W. Gardner was "gratified that so many Southern hospitals have come into compliance" with the Civil Rights Act for participation in medicare.

HEW issued a new tally of participating hospitals, certified for civil rights compliance, showing that 6,414 out of the 6,978 which could be used for medicare patients had been certified, or 92 per cent, nationwide.

Both the figures were smaller than those earlier reported officially. HEW said the new count eliminated hospitals which had obtained civil rights clearance but were not of a type suitable for medicare use.

The nonparticipating hospitals were mainly in the South. Most were barred from medicare payments by their failure to comply with the no racial dis-

See MEDICARE on Page 2

State's Medicare Off to Slow Start

By MARTHA ANN RILEY
Democrat Staff Writer

Three of Little Rock's largest hospitals reported no influx of 65 and over patients as the Medicare program got under way today.

A check with officials at Arkansas Baptist Medical Center, which admits all patients other than emergency cases from 1 to 3 p.m. only, revealed 15 Medicare benficiaries on the waiting list in addition to 84 who already were hospitalized preceding opening of the program.

Noting that the patient load is up slightly for this time of year, a spokesman for the hospital said the number of patients 65 or over is running about normal, however.

University Medical Center had no admissions scheduled for the weekend due to a changeover of interns and residents in addition to many staff members being off for the July 4 holiday.

At St. Vincent Infirmary, a spokesman reported only two Medicare beneficiaries scheduled for admission later today with about 50 patients 65 or over having been admitted prior to start of the program.

Already operating at 90 per cent occupancy, St. Vincent anticipated no changes as a result of the program going into effect other than the possibility that waiting lists may become longer.

No noticeable changes were expected at Baptist Medical Center, operating at just above 80 per cent occupancy, provided the increase of patients does not go above the five per cent level forecast earlier.

As of today, 86 of the state's 109 hospitals had been certified for participating in the Medicare program including seven hospitals in the Greater Little Rock area with a bed capacity of $2,676.

Home health agencies approved for the program are the Visiting Nurses Association of Pulaski County and the State Health Department Home Health Service.

Hospitals which have received contracts from the Social Security Administration qualifying them for participation include:

Little River Memorial, Ashdown; North Arkansas Clinic and Dr. Gray's Hospital, Batesville; Bates Memorial Hospital, Bentonville; Booneville City Hospital, Booneville; Smith Hospital, Bradford; Mercy Hospital, Brinkley; Medical Center of Calico Rock, Calico Rock; Ouachita County Hospital, Camden, Clarksville Hospital, Clarksville.

Conway Memorial Hospital, Conway; Crossett Health Center, Crossett; Yell County Hospital, Danville; Dardanelle Hospital, Dardanelle; DeQueen General Hospital and Dickinson Clinic, DeQueen; St. Mary's, Dermott; Desha County Hospital, Dumas; Eureka Springs Memorial Hospital, Eureka Springs, Fayetteville City Hospital and Washington General Hospital, Fayetteville; Forrest Memorial Hospital and Hall Enterprise, Forrest City, Sparks Memorial Hospital and St. Edwards, Fort Smith; Boone County Hospital, Harrison; Heber Springs Hospital, Heber Springs, St. Joseph's Hospital and Ouachita Memorial Hospital, Hot Springs; Madison County Hospital, Huntsville.

St. Bernards, Jonesboro; Arkansas State Hospital, Arkansas Children's Hospital, St. Louis-Little Rock Hospital; St. Vincent's Infirmary, Gray Memorial Hospital and University Hospital, Little Rock; Polk County Memorial Hospital, Mena; Shaneyfelt Hospital, Manila; Drew County Hospital, Monticello.

St. Anthony's, Morrilton; Baxter General Hospital, Mountain Home; Mountain View General Hospital, Inc., Mountain View; Newport Hospital and Clinic and Harris Hospital and Clinic, Newport; Memorial Hospital, North Little Rock; Community Hospital, Paragould; Piggott Hospital Association, Piggott; Randolph County Hospital, Pocahontas, Rogers Memorial Hos-

STATE

(Continued from Page 1)

pital, Rogers; St. Mary's Hospital, Russellville.

Fulton County Hospital, Salem; Porter Rodgers Hospital, Searcy; Siloam Springs Memorial Hospital, Siloam Springs; Springdale Memorial Hospital, Springdale; St. Louis-Southwest Ry. Hospital, Texarkana and St. Michael Hospital, Crawford County Hospital, Van Buren; Scott County Hospital, Waldron; Lawrence Memorial, Walnut Ridge; Crittenden Memorial Hospital, West Memphis; Cross County Hospital, Wynne; Marion County Hospital, Yellville; Clark County Hospital, Arkadelphia; Chickasawba Hospital, Blytheville.

Van Buren County Hospital, Clinton; DeWitt City Hospital, DeWitt; Hall Enterprise Hospital, Gravette; Gurdon Memorial Hospital; Leslie Community Hospital; Rebsamen Memorial Hospital, Jacksonville; Hot Springs County Memorial, Malvern; Magnolia Hospital; Lee Memorial Hospital, Marianna; Montgomery County Hospital, Mount Ida; Osceola Hospital, Osceola; Turner Memorial Hospital, Ozark; Cleveland County Hospital, Rison; Stuttgart Memorial Hospital, Stuttgart.

Bradley County Memorial, Warren; State Hospital, Benton; Howard County Hospital, Nashville; Pike County Memorial Hospital, Murfreesboro; Branch General Hospital, Hope, and Verser Hospital and Clinic, Harrisburg.

The Sentinel-Record

(AP) United Press International (UPI) Hot Springs National Park, Arkansas, Sunday, July 3, 1966 News Photo Service By NEA, Central Press, Associated Press

AMA Adopts Direct Billing Method For Medicare Patients' Treatment

By ROBERT GOLDENSTEIN
AP SCIENCE WRITER

CHICAGO (AP)—The medicare program is picking up steam with the nation's doctors free—if they choose—to charge whatever they wish for their services and to require elderly patients to handle the paperwork in seeking reimbursement from the government.

The American Medical Association, with 214,000 members, strongly urged doctors at their annual convention just ended to bill medicare patients directly, rather than collect their fees from the government.

Consideration of medicare and its ramifications was the highlight of the week-long convention attended by 15,000 doctors.

The AMA's House of Delegates, its policy-making body, overruled an AMA Advisory Committee when it adopted without dissent recommendations of the Board of Trustees and delegations from Florida, Iowa and Illinois.

The final action put the AMA on record as calling on "each and every member of this association" to submit his bill directly to the patient, rather than choose the assignment method.

Both methods are permissible under the medicare act.

But the AMA House of Delegates refused to take a stand on the issue at a special convention in October, stating: "The American Medical Association opposes any program of dictation, interference, or coercion, whether direct or indirect, affecting the freedom of choice of the physician to determine for himself the extent and manner of participation or financial arrangement under which he shall provide medical care to patients under Public Law 89-97.

In opposing an all-out AMA stand in favor of direct billing, the Reference Committee on Insurance and Medical Service contended such action would be "inconsistent."

The AMA not only came out for direct billing by all doctors, but adopted a Florida delegation resolution recommending that no special review or mediation committees be set up in hospitals solely to handle medicare cases. It recommended that the standard mediation or review mechanism of the county medical society be utilized.

Under direct billing, the doctor sends his bill to the patient and, after the patient has paid $50 in doctor bills within a year, he can seek reimbursement from the government of 80 per cent of the remainder of what is considered a reasonable fee.

For example, if a doctor charges $250 for a surgical operation where the reasonable fee" for that type of surgery is set at $150, the patient would pay the first $50 to qualify for reimbursement, 20 per cent of the next $100 (or $20), all charges above the allowable $150 reasonable fee (or $100)—for a total of $170. The government would pay the remaining $80 of the $250 bill. In addition, the patient pays $3 a month for his Part B medicare premium.

If the doctor's charge is below the reasonable fee rate, his charge is accepted as a reasonable fee.

The AMA Board of Trustees

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Billing

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in its report to the House of Delegates said this week: "The matter of fees for physicians' services should be the subject of agreement between physician and patient but the physician who accepts an assignment has no assurance as to the amount that the carrier will determine to be the reasonable charge for his services.

Under the assignment method the doctor collects 80 per cent of his "reasonable" fee from the government and 20 per cent from the patient, after the patient has paid $50 in doctor bills within a year.

The doctor also would be required to fill out forms under this method, to seek the government payments.

In another medicare action taken at the convention, the House of Delegates called for certain specialists to refuse to replace any hospitalized-based doctors who are barred from the institutions for billing patients directly.

The doctors involved are pathologist, radiologists, anesthesiologists and other specialists who practice inside a hospital.

The policy making body took the action despite warnings from the Board of Trustees that the move might cripple the AMA with lawsuits.

After the delegates completed their action on medicare, Dr. Milford Rouse of Dallas, the AMA president-elect, told newsmen he will continue to bill his patients directly.

But Dr. James Z. Appel of Lancester, Pa., the outgoing president, urged doctors to plan immediately to correct deficiencies in the program. He also urged doctors to refrain from raising their fees or from frustrating efforts of the elderly from gaining reimbursement under the plan.

And the new AMA president, Dr. Charles L. Hudson of Cleveland, made no mention in his inaugural speech of attempting to overturn medicare.

President Johnson sent a telegram to Dr. Appel at the convention saying, "I am positive that with your dedicated help and cooperation, we can and will succeed in benefiting the many Americans who are greatly in need of this service."

He said he will continue to seek the counsel of organized medicine in the months ahead.

Combined Features of The Sentinel-Record And

HOT SPRINGS NEW ERA

(AP) United Press International (UPI) - HOT SPRINGS, ARKANSAS, SATURDAY, JULY 2, 1966 News Photo Service By NEA, Central Press, Associated Press

Operation Running Smoothly

U.S. Medicare Program Starts; Full Impact Yet Undetermined

By STERLING F. GREEN

WASHINGTON (AP) — With hospital-like efficiency the nation's medical plant easily absorbed Friday the first-day impact of medicare — and, in many Southern cities — desegregated thousands of hospital beds.

City after city reported, "no rush," "everything normal," "no problems," "going smoothly." Some hospital officers predicted heavier admissions after the Fourth of July. Others cautioned that the full impact is still a month or more away.

"An auspicious start," commented the U.S. surgeon general William H. Stewart.

Stewart and Robert M. Ball, Social Security administrator, estimated that 94 per cent of the nation's general hospitals, representing 95.9 per cent of the beds, were prepared and qualified to participate in medicare.

They met reporters jointly in Social Security's Telecommunications Center in Baltimore, Md. There, a nationwide wire network will feed data on the 19 million medicare policyholders into and out of computers.

The totals given by Ball and Stewart were a bit higher than those from other federal offices, but all sources agreed on this: Hospital participation was far broader, especially in the South, than authorities had dared to hope for a month or two ago.

Most of the several hundred Southern hospitals outside the program had failed to comply with the no-racial-discrimination provisions of the Civi Rights Act. They are therefore ineligible for federal payments under medicare of any other federal program.

President Johnson — known to have been seriously concerned a few weeks ago at predictions that elderly patients would suddenly swamp understaffed hospital facilities — was notified by telephone of medicare's flying start and strong participation.

Thousands of patients 65 and older who were already in hospitals became the instant beneficiaries of medicare at 12:01 a.m., by a mere bookkeeping transaction. Medicare automatically picks up their bills from July 1 until their 90 days of benefits expire, except for a $40 "deductible."

At the same moment, Eugene Schneider, 65, an embroidery worker from West New York, N.J., showed up at New York's Polyclinic Hospital for eye treatment — and became the hospital's first new medicare admission.

★ ★ ★ ★ ★ ★

1st New Medicare Patients Check In At All 3 Hot Springs Hospitals

The first new patient admitted to a hospital here under the medicare program, which went into effect Thursday midnight across the nation, was a retired office secretary.

She was admitted to St. Joseph's hospital at 2:30 a. m. Friday.

She is Miss Elsie Borchers, who resides at Arkansas Rest Home, 314 Whittington.

At 7:10 a. m., Leo N. Levi Memorial hospital, treatment center for arthritis, admitted 70-year-old Edwin Farkas of Albany, Ga., and 20 minutes later William H. (Hill) Cocke, 67, Harlingen, Texas, checked in at Ouachita Memorial, the county's hospital.

All three patients report they have both Medicare packages—Plans A and B. Part A is hospital-bill insurance and Part B is the optional doctor-bill insurance.

Even though the Medicare program gives these eligible bargain rates it still costs the patient and doctors are concerned that confusion still exists among many who think all hospital and doctor bills are paid by the federal government.

The three Hot Springs hospitals, all approved under Medicare, have a total bed capacity of 348. They are not expecting any great influx of patients over the Fourth of July week-end and only a few had been admitted yesterday.

Social Security records show that some 5,867 are eligible in this county for the program.

Interviewed at St. Joseph's Friday morning, Miss Borchers under oxygen, said she was "felling fine" and hoped to be discharged soon.

"I didn't realize I was the first person to be admitted after Medicare went into effect," she told a reporter. She would admit to being only "over 65."

"I think Medicare is a fine thing," she said.

Miss Borchers, a sister of Mrs. Edna Mae Ryan, 122 Kayla, has made her home here for the past six years, residing at the rest home for the last three.

She has been hospitalized at St. Joseph's on previous occasions, she reported.

At Ouachita, Cocke told the reporter he and his wife were returning to their home after a trip to Kansas, when he became ill.

"We had never been to Hot Springs and had never seen the Ozarks except by air," he said, "so we decided to drive through here. I developed a kidney infection and the doctor advised hospitalization."

It is the second time he has ever been hospitalized, he reported.

Cocke, an officer of Valley Ready Mix Concrete Company of Harlingen, is a native of Floresville, Texas, and formerly a citrus grower in the Rio Grande Valley following graduation from the University of Texas.

"Medicare is a fine thing, especially wonderful for the older person who has either been unable to save or has had a lot of trouble," he said. "We have so many elderly people

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1st

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now who are dependent on others even for their food and clothing."

Farkas said in an interview at Levi that "Medicare is a blessing for me as I'm sure it will be for others. I've had three major operations in my life and no insurance to cover the cost of any of them."

He, as are other Levi patients, was admitted through B'Nai Brith, supporting organization of the hospital.

Although the three new admissions were the first since Medicare became effective, others already in the hospitals and eligible under the program, were checked out at 11:59 p.m. Thursday and re-admitted at 12:01 a. m. under Medicare. This was simply a formality.

At Ouachita, some 25 were transferred; between 50 and 60 at St. Joseph's, and Levi estimated 25 per cent of its patients were classified as Medicare eligibles.

In other areas throughot the state, Medicare—critized, praised and made the law of the land to accepting hospitals—went into effect without major incident.

All but 23 of the state's 109 hospitals applied for and were approved for participation in the program to provide federally financed health care for the aged.

The elderly patient under Medicare will have to pay, in most cases, only a small percentage of his own medical bills.

There was no rush of patients to enter hospitals, as some physicians had anticipated. Others said that any major influx of patients under Medicare would not come until after the Fourth of July weekend.

In most hospitals it was a routine matter of switching elderly patients already in the hospital from welfare status to Medicare status. Scattered reports from around the state indicated that about 20 per cent of the hospital population was switched to Medicare.

The number switched to Medicare at St. Bernard's Hospital, the only one in Jonesboro, amounted to 20 per cent of the adult patients outside the maternity ward.

On a statewide basis, more than a thousand patients probably were switched into the Medicare program.

The number was 23 at St. Bernard's 15 at Helena Hospital, and 50 or so at each of the three major Little Rock hospitals

At Helena, the hospital had a small rush of patients—20 or so elderly Negroes—but the hospital delayed admitting them under Medicare because it had not been officially notified of approval for participation in the program.

Controller Bill Boetler said the hospital had been notified by telephone of approval by federal officials, but wanted to await receipt of the telegram confirming it.

Medicare bans discriminatory practices in the treatment or keeping of patients of different races.

At Conway, 24 patients were switched to Medicare but no new Medicare patients appeared to be admitted to the hospital. The situation was similar in Arkansas. At Pine Bluff, Davis and Jefferson hospitals reported no surge of new patients.

Officials said slightly more than 20 per cent of the patients already in the hospitals were age 65 or older.

Charles Hodge of the Social Security Administration office in Little Rock said a staff member would remain on duty throughout the July 4th weekend to assist hospitals who might need to call on the office for assistance in connection with the Medicare program.

No problems were anticipated and none were reported the first day, Hodge said.

The Sentinel-Record

(AP) United Press International (UPI) Hot Springs National Park, Arkansas, Friday, July 1, 1966 News Photo Service By NEA, Central Press, Associated Press

All Three Hot Springs Hospitals Set to Begin Medicare Program

Hospitals in Hot Springs — St. Joseph's, Ouachita Memorial and Leo N. Levi Memorial — are braced for the influx of patients expected to receive treatment in the nation-wide Medicare program, which began at midnight Thursday.

All three hospitals have been approved for participation in the program

The institutions have a total bed capacity of 348, St. Joseph's being the largest with 207 at present. Ouachita Memorial, the Garland county hospital, has 87 beds and Levi, an arthritic treatment center only, has 54, but when an extensive expansion program is completed, will have 104.

Social Security records show that some 5,867 persons over 65 in Garland county are eligible for medicare. In the five-county area served by the Hot Springs SS office, approximately 10,000 are eligible.

County Judge Lon Warneke and G. L. Crutchfield, administrator of the Ouachita hospital, last of the three to win approval for participation in the medicare program, said Thursday such approval had come through.

Warneke said the hospital's board had talked by telephone with authorities in Washington earlier this week and were assured approval would be given. Crutchfield said he had spoken yesterday morning by telephone with Social Security officials in Dallas and informed that approval had been given and that the contract was enroute here by mail.

A telegram confirming the telephone conversation was received by Crutchfild later yesterday.

Under terms of the contracts, all participating hospitals, which already have patients who will come under the medicare program, checked out those patients at 11:59 p.m. last night and checked them back into the hospitals at 12:01 a.m. today, a mere formality.

There are approximately 25 at Ouachita who were transferred to medicare at midnight, Crutchfield said.

At St. Joseph's, Sister Mary

See MEDICARE On Page 7

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Medicare: Who? What? When?

By STERLING F. GREEN

WASHINGTON (AP) — Here's a medicare who-what-when for July 1 — the biggest day of 1966 for almost 20 million Americans — plus some of the answers on where and how:

—What?

The start of medicare, in two packages. Part A is hospital-bill insurance, like the familiar Blue Cross plan. Part B is an optional doctor-bill insurance, like a Blue Shield plan at bargain rates.

—When?

Friday, July 1 for both. Home health service benefits, under the visiting nurse program or others, start the same day. Nursing home care during convalescence begins next Jan. 1, under part A.

—Who?

Every 65 or older is eligible for hospital care under plan A. Your red-white-and-blue medicare card is your admission ticket. But you've got to be sick; medicare doesn't pay for checkups, or bed rest not prescribed by a doctor.

For the 17.3 million Americans who decided to pay $3 a month for the additional protection of the voluntary plan B, medicare also will take care of most doctor bills and other medical costs.

—Where?

Insured hospital care will be available at more than 90 per cent of the country's general hospitals. The others are not participating. Some were excluded, mostly in the South, for refusal to drop racial discrimination. Some did not meet other medicare standards. Some stayed out for their own reasons.

How do I get medicare help?

You do exactly as before. Pick your own doctor. You and he pick the hospital. He recommends your treatment and says how long you should stay in the hospital.

There's one big difference: You get help paying the bill.

—The whole bill?

No. You pay the first $40 of hospital charges in each "spell of illness." After you've been in the hospital for 60 days, you pay

See WHO? On Page 7

Who?

From Page One

$10 a day during the next 30 days, with medicare paying the rest. After those 90 days, you pay the whole cost.

The 90 days may be used up in one stay, two, or several, and for one, two or more different illnesses.

—When do I become eligible for a new "spell of illness?"

Sixty days after your hospital discharge.

—What does medicare cover?

A semi-private room — or a private one, if your doctor says your condition requires it; regular nursing care; drugs, crutches, wheelchairs, operating room costs, and the hospital's cost for diagnostic X-rays and laboratory tests.

—What about nursing home care?

After next Jan. 1, you may qualify for up to 100 days of recovery care in a nursing home. But this is provided only after your doctor has put you in a hospital for at least three days.

—How much of nursing-home costs will medicare pay?

All costs for the first 20 days. After that, you pay $5 a day and medicare pays the rest.

—And after that, home care by a visiting nurse?

Only if your doctor prescribes health serves while you convalesce at home. Medicare pays for up to 100 visits by nurses, therapists, medical social service workers, or home health aides in the year following your discharge.

What about doctor bills?

Medicare covers them, if you signed up for the optional part B and pay the $3 monthly premium.

—What does part B pay for?

Bills for doctors' services, X-rays and diagnostic tests inside or outside a hospital; an additional 100 home-health visits each year; x-ray, radium and radioactive therapy; rental of iron lung, wheelchair or other medical equipment when ordered by your doctor for home use; ambulance service if necessary; artificial limbs, braces, or other prosthetic devices.

—Does medicare pick up the whole tab?

Again, no. You pay the first $50 of all the bills you get in a year for the services listed, plus 20 per cent of the rest. Medicare's part B covers the remaining 80 per cent.

Medicare

From Page One

Carol, administrator, said approximately one-third of the patients now hospitalized there beween 50 and 60, were checked out and re-admitted at midnight.

Mrs. Fannie McLaughlin, adminstrator at the Levi, was unable to give an exact number of those affected by the switch-over but estimated that 25 per cent of patients there were in the over-65 group.

Plaques, signifying approval of the hospitals for medicare participation, have been hung in both St. Joseph's and the Levi, it was reported.

At the Hot Springs Social Security office, William H. Bell, manager, reported Thursday that four other hospitals in the five-couny area had been given approval. He listed them and the bed capacity of each as follows: Hot Spring County hospital, 80; Clark County Memorial, 63; Gurdon Municipal, 12; and Mountgomery county, 16.

Bell said, in discussing the program, that "we can only adopt a wait-and-see attitude," adding that "we do not know just what the situation will be or what the influx of patients will amount to, but I am sure that since patients have to be referred for admission to the hospitals by physicians that the doctors will use their best judgment in such admissions."

With the Fourth of July weekend coming up, Bell said he doubted there would be any great influx of patients with probably only those coming into hospitals who need emergency treatment or surgery. But, again he said, "we'll just have to wait and see."

Dr. Martin Eisele, president of the Hot Springs-Garland County Medical Society, said Thursday he believed most of the doctors are going to cooperate in the medicare program.

"Our principal concern is that the patients understand that they are still going to have to pay something," he said.

Despite all the material that has been sent those eligible for medicare and despite all the publicity that has been given the program, Dr. Eisele said he believed there is still a considerable amount of confusion on the part of many.

"We in the medical profession will do the very best we can with this program," he said.

He and other physicians are also adopting a wait-and-see attitude, not knowing at present whether there will be any great immediate demand for hospital services under the program.

The federal government foresaw a smooth start today despite some scattered forecasts of overcrowding, some Republican charges of negligent planning, and the decision of many Southern hospitals to discriminate rather than participate, The Associated Press reported.

President Johnson, in a statement taped for television and radio use, said Medicare will succeed if hospitals accept their responsibilities not to discriminate because of race, doctors continue to treat their patients with fairness and compassion, and patients cooperate and do not demand unnecessary services.

"This program is not just a blessing for older Americans," Johnson said, "it is a test for all Americans — a test of our willingness to work together."

Officials now scoff at fears that elderly men and women will swamp hospital facilities.

Kenneth Williamson, Washington director of the American Hospital Association, agreed. In an interview with The Associated Press he called that idea "just plain silly."

ARKANSAS GAZETTE
LITTLE ROCK, ARK.
7/1/66 & 7/2/66

Medicare's 1st Day Quiet, Just Changes In Patients' Status

By the Associated Press

In most hospitals in Arkansas, Medicare began as a routine matter of switching elderly patients already in the hospital from welfare status to Medicare status. Scattered reports from around the state indicated that about 20 per cent of the hospital population was switched to Medicare.

The number switched at St. Bernard's Hospital, Jonesboro, amounted to 20 per cent of the adult patients outside the maternity ward.

At Levy Hospital in Hot Springs, the total was 25 per cent of the total number of patients.

On a statewide basis, more than 1,000 patients probably were switched into the Medicare program.

The number was 23 at St. Bernard's, 25 at Ouachita Hospital in Hot Springs, between 50 and 60 at St. Joseph's Hospital in Hot Springs, 15 at Helena Hospital, and 50 or so at each of the three major Little Rock hospitals.

At Helena, the hospital had a small rush of patients — 20 or so elderly Negroes — but delayed admitting them because it had not been officially notified of approval for participation. Controller Bill Boetler said the hospital had been notified by telephone of approval but wanted to await receipt of the telegram confirming it.

Medicare bans discriminatory practices in the treatment or room assignments of patients.

In Garland County, a retirement mecca, Social Security Administration officials said that 5,867 of the county's 38,107 residents were eligible for Medicare. The County's three hospitals have a total bed capacity of 348.

Charles Hodge of the Social Security Administration office in Little Rock said a staff member would remain on duty through the July 4 week end to assist hospitals who might need to call on the office for assistance in connection with the Medicare program.

No problems were anticipated and none were reported the first day, Hodge said.

'Not Bad,' LR Hospitals Say Of Much-heralded First Day

"We've had more calls from newspapers than we've had patients."

Edward Rensch, assistant administrator of St. Vincent Infirmary, thus summarized the much-heralded first day of Medicare. "It wasn't bad at all," he said.

Both Rensch and R. H. Hagaman, administrative assistant at Arkansas Baptist Medical Center, agreed that the Fourth of July holiday week end probably had some bearing on admissions. Fewer are admitted preceding holidays and more are released.

Neither hospital had anticipated being inundated with Medicare patients the first day, but it turned out to be even lighter, apparently, than they had expected.

Admissions at Baptist were off 6 per cent from the average Friday. Of 40 admitted during the day, only seven were Medicare patients. Sixty already in the hospital were eligible for Medicare assistance and their records were changed accordingly.

Rensch said admissions at St. Vincent also were down and only "three or four" were admitted under Medicare. However, 53 patients already in the hospital were eligible and were transferred over to Medicare records.

The first Medicare patient admitted Friday to either hospital was Virgil Edward Paul, 71, of 302 Redwood Street, North Little Rock, a carpenter retired under social security, who entered Baptist shortly after 8 a.m. — without his Medicare card. He had to send home for it.

Paul, who never has been outside Arkansas even for a visit, was making his second trip to the hospital. He underwent an appendectomy at Baptist about five years ago.

"I had to stay 16 days the last time and I said then, 'I hope to God I never have to come back again,'" he said.

Paul and his wife, Mrs. Lela Stivers Paul, will have been married 55 years in September. They have two children, four grandchildren and eight great-grandchildren.

St. Vincent's first Medicare admission Friday was Mrs. Laura Johnson of Conway, who entered about 1:25 p.m.

Medicare Starts Today for Those Who Are Over 65

WASHINGTON (UPI) — Medicare, the biggest extension of Social Security since old-age pensions were provided 30 years ago, goes into effect today for 19 million Americans over the age of 65.

Passed by Congress last year after a long controversy, it provides for two supplementary types of coverage.

First, there is the basic hospitalization program, which is available free to men and women over 65, with a few exceptions. The exceptions are recently arrived aliens, convicted subversives and certain retired federal employes who have their own program.

The basic program provides up to 60 days of hospital care, with the patient paying the first $40. If additional hospital treatment is required, the patient must contribute $10 a day and Medicare will cover the rest of the cost for another 30 days.

Doctors' bills are not included in the basic program but insurance against them and certain other medical expenses is available under the second part of Medicare, which is optional. It costs $6 a month but the government pays half of the cost, so that the premium charge is only $3 a month. More than 90 per cent of the Americans over 65 have signed up for this.

When they get sick, they'll have to pay the first $50 of their doctors' bills in any calendar year. Thereafter, Medicare will pay 80 per cent of any doctor's bill that comes within the limits of what is determined to be a "reasonable charge" for the service performed. The determination of "reasonable charges" will be made in each community by the local Blue Shield or other private insurance carrier designated to handle Medicare claims.

Doctor Can Charge More If He Desires

If a doctor wants to charge more than the "reasonable charge," he is free to do so. The difference, however, will come out of the elderly patient's pocket.

A doctor may, if he chooses, bill the patient directly and leave the patient to collect from Medicare. The American Medical Association has recommended that doctors use this procedure, which leaves them free to charge as much as they please and also requires the patient to do the paperwork of filing a claim.

To file his own claim, a patient fills out a one-page form, attaches his receipted bill from the doctor and mails it to the insurance carrier handling Medicare claims for his area. He can get the name and address of the carrier from his doctor or from the nearest Social Security district office.

If the doctor elects to submit the claim himself, he must certify that his total bill will come within the limits of the "reasonable charge." He then receives direct payment from Medicare for 80 per cent of the bill. Doctors can use this method to collect from the government for care of indigent old folks who would otherwise have been charity patients.

In addition to doctors' bills, the optional insurance program covers 80 per cent of the cost of X-rays; radiation therapy; surgical dressings; splints, casts, and braces; artificial arms, legs and eyes; the use of iron lungs, oxygen tents or other special apparatus; and, in an emergency, ambulance service.

It does not cover routine physical examinations; ordinary dental work; eye examinations or eyeglasses; hearing aid examinations or hearing aids; immunizations; orthopedic shoes; cosmetic ("face-lifting") surgery, or any drugs except those administered by a physician or nurse.

Private Hospitals To Join Medicare

NEW YORK (AP) — The Federation of American Hospitals, which represents private, profit-making hospitals, announced Thursday that its 114 member hospitals throughout the nation would join the Medicare program.

Hays Calls Medicare Good, Says It Will Bring Problems

The beginning of Medicare Friday will mean better care for many elderly citizens, Brooks Hays said in a radio talk at Forrest City, but it also will present urgent problems that demand statewide solutions.

Hays, a candidate for the Democratic nomination for governor, outlined some of the problems and how he would approach them if elected.

"We already have a shortage of nurses and hospital beds, which we expect will get more acute as the demand from Medicare patients increases," he said. "The rising cost of medical care is of concern to all of us. As was pointed out last week by a group of hospital officials, the paying hospital patient cannot be expected to pick up the tab on the difference in cost between the $30 a day which the Welfare Department now pays and the $45 a day which is the actual cost of many hospitals. This places the burden on the small segment of the public who are patients themselves, when it should be covered instead by the Welfare Department."

He proposed to establish a Medical Advisory Committee made up of professionals and laymen to work on solutions for these and related problems.

He would recommend that the Committee study the use in Arkansas of Title 19 of the Medicare program. Some other states are using it but not Arkansas. Hays said Title 19 is to provide medical care for those who have enough income as long as they stay well but nothing left over for serious or long-term medical bills. It also extends medical help to welfare clients other than the elderly, that is, the blind, the disabled and others.

The federal government furnishes 83 per cent of the cost under Title 19, Hays said, but the best provision is that the program is administered and the decisions made in the state that uses it.

Medicare Lists More Hospitals

Seven more Arkansas hospitals have received contracts from Social Security qualifying them for participation in the Medicare program which begins today. This makes 86 out of 109 hospitals in the state qualified.

The seven new ones are: Arkansas State Hospital at Benton, Harris Hospital and Clinic at Newport, Howard County Hospital at Nashville, Pike County Memorial Hospital at Murfreesboro, Ouachita Memorial Hospital at Hot Springs, Branch General Hospital at Hope and the Versser Clinic and Hospital at Harrisburg.

Two home health agencies that have been cleared for Medicare are the Visiting Nurse Association of Pulaski County and state Health Department Home Health Service.

Former Slave, 112, Uses Medicare Plan

ORLANDO, Fla. (AP) — A 112-year-old former slave, Sara Edwards, was admitted to a hospital Friday under Medicare.

Officials at the Florida Sanitarium Hospital said they believed she was the oldest Medicare patient in the country. She was to be treated for "infirmities of old age," a hospital spokesman said.

Mrs. Edwards was born in Brownswood, Ga.

Medicare List Reaches 88

Three more Arkansas hospitals were issued Medicare contracts Friday by the Social Security Administration. They are the Leo N. Levi Hospital at Hot Springs, Jefferson County Hospital at Pine Bluff and Saline Memorial Hospital at Benton.

This makes 88 out of 109 hospitals in the state that are eligible to accept Medicare patients.

The total would have been 89 except that the Arkansas Children's Hospital, which was on a list released earlier in the week of hospitals approved for contracts, decided it wouldn't need one. It doesn't plan to accept any elderly patients.

Hospitals must meet the health and safety standards of the Medicare law and the nondiscrimination requirements of the 1964 Civil Rights Act to get a Medicare contract. Several more hospitals have qualified under the health and safety standards but not under the Civil Rights Act.

Several of the 109 hospitals are not seeking a Medicare contract for one reason or another.

WEST HELENA WORLD NEWSPAPER
HELENA, ARKANSAS
JULY 3, 1966

Answers to questions on Medicare

WASHINGTON (AP) — Here are answers to some of the questions most frequently asked about medicare, starting today for all Americans 65 and older:

Q. If the hospital I choose is overcrowded, does medicare guarantee me a bed?

A. No. Medicare just helps pay the bill.

Q. If I have to go back into the hospital two or more times, do I pay the $40 "deductible" each time?

A. No. You pay just the first $40 of hospital charges in each "spell of illness."

Q. What's a "spell of illness."

A. To medicare it's a period of time, not an ailment. It starts the day you enter a hospital. It ends 60 days after your discharge from the hospital. Or from a nursing home — after next Jan. 1, medicare will provide posthospital convalescent care in nursing homes for those needing it.

Q. Suppose I go back to the hospital for a different sickness?

A. To medicare it doesn't matter. It's all one "spell of illness" if the new admission comes within 60 days of the last discharge.

Q. Do I have to go back to the same hospital.

A. No. Your benefits follow you from hospital to hospital and from city to city. Just show your red, white and blue card. Any participating hospital can tell instantly, by check to a computer in Baltimore, Md., whether you have used up all your "benefit days."

Q. If I'm in a hospital when medicare starts, does medicare pick up the bill?

A. Not for past days. Medicare picks up as of July 1, and you'll still have to pay the $40 deductiole as well as the charges for the days preceding medicare.

Q. I've signed up to pay $3 a month for the voluntary doctor bill insurance. It has a $50 deductible; how often do I have to pay that?

A. Just once each year, regardless of how much your doctor bills add up to in a year.

Q. Should I cancel my old health insurance policy?

A. If you are 65 but your wife is not, she's not covered by medicare. You may want to keep her policy in force.

Q. We are both over 65. Should we buy the "supplemental" plans offered to over-65 persons by Blue Cross, Blue Shield and other private insurers for additional protection?

A. That depends on your own needs and inclinations. Some policies are designed to cover medicare's "deductibles" and provide benefits beyond the limits of medicare. Another type of policy pays off in cash benefits for each day of hospitalization; the money could be used for the inevitable costs of an illness, or for "extras," such as a bedside telephone or a private room instead of the semiprivate accommodations paid for by medicare.

Q. Medicare's doctor bill insurance covers 80 per cent of a doctor's "reasonable charges," after the $50 deductible. Does the doctor send his bill to medicare or to me?

A. Either one. He can send it to medicare's local "intermediary" agency — in most cities, the local Blue Shield organization — which will pay him 80 per cent of what it deems a "reasonable charge" for his treatment or operation; the other 20 per cent would come from you. Or he could send the whole bill directly to you.

Q. In the latter case what do I do?

A. Pay it, then apply for reimbursement to the "intermediary."

ADMISSION 50c
For Kiddies

Medicare has quiet start thruout Nation

EDITOR'S NOTE — Members of a special AP task force kept a close watch throughout the first day of medicare in a group of hospitals around the country. The following account is based on their reports.

NEW YORK (AP)—Down the corridors of Miami's Jackson Memorial Hospital figures in white passed each other with a cheerful greeting: "Happy medicare!"

For the nation's hospitals Friday was indeed happy medicare —the first day of the Social Security hospital program for persons 65 years and older had gone smoother than anyone had dared hope.

Still, there were problems: mountains of paper work, missing forms, bewildered patients, lost medicare cards, and one woman who got mad and swung her purse at a hospital worker.

By midafternoon, in the usually frantic emergency room at Jackson Memorial, interns sat with their feet propped on a table.

"It's the quietest day we've had," said Dr. James Connaughton, who joined het Miami hospital last month after graduation from th Ueniversity of Indiana.

The situation was virtually the same in hospital after hospital across the United States. Fear expressed by some that medical facilities would be swamped by elderly people evaporated as the day wore on like any other before a July 4 holiday.

sick," Mrs. Winston said. "I should have been here a month ago, but I couldn't get into this or any other place."

The biggest problem faced by the hospitals is the increased load of paper work. Mt. Sinai added 41 clerks just to handle all the new forms and extra bookkeeping. Other hospitals are also taking on new help

At St. Joseph's Infirmary in Atlanoa, business manager David Messinger recalled that he had spent 20 years in the Air Force as a medical budget officer. He shuffled the forms piled high on his desk and said, "I'm right back home again. I haven't had much sleep in three days. I can't sleep any more, trying to figure out what to do about medicare."

Northwest Hospital in Seattle, the first in the nation to be certified for medicare, admitted not a single medicare patient. Six elderly patients already in the hospital, however, were automatically switched over to medicare at its start, 12:01 a.m. Friday.

"Heaven help us when Tuesday comes," said Alfred E. Riley, business manager of St. Elizabeth's Hospital in Chicago. Riley said he looks for a big inflow of patients then because of the people who wanted to be home for the holiday or delayed enory because so many doctors would be away for the weekend.

At 9 a.m. on the first day, Anna Winston, 71, of New York City, showed up in the emergency room at mammoth Mt. Sinai Hospital complaining of "aches and pains." Within an hour she became one of the hospital's 19 first-day medicare admissions..

"I knew I'd wind up in the hospital because I was very

How Medicare in Arkansas worked the first two days of operation

By THE ASSOCIATED PRESS

One of the state's 89 hospitals which qualified to serve patients under Medicare — which started Friday — made a last minute decision to back out of the program.

The Arkansas Children's Hospital at Little Rock decided it wouldn't need a Medicare contract, since it doesn't plan to accept any elderly patients.

Some physicians and hospital administrators expected a rush of patients eager to take quick advantage of the federally financed health care.

But it didn't come.

There was still anticipation that the first big influx of patients would come next week, after the Fourth of July holidays.

Many people needing surgery may have decided to wait until then, they reasoned.

Three more hospitals were issued Medicare contracts Friday by the Social Security Administration. They were the Leo N. Levi Hospital at Hot Springs, Jefferson County Hospital at Pine Bluff and Saline Memorial Hospital at Benton.

All but 21 of the state's 109 hospitals are eligible ot accept Medicare patients.

For most of the Arkansas hospitals, it was a routine matter of switching elderly patients already in the hospital to Medicare status. About 20 per cent of the hospital population was switched to Medicare, scattered reports from around the state indicated.

Among the first Medicare patients to be admitted after the program went into effect was Virgil Edward Paul 71, of Little Rock.

Paul, a retired carpenter, arrived at Arkansas Baptist Medical Center about 8 a.m. Stomach cramps put him in the hospital for the second time in his life.

Paul, who forgot his Medicare card and had to send someone after it, said doctors hadn't told him what was wrong. "But you can bet I'll get out of here as quickly as I can."

Charles Hodge of the Social Security Administration office in Little Rock said a staff member would remain on duty throughout the July 4th weekend to assist hospitals which which might need to call on the office for assistance in connection with the Medicare program.

He said no problems were anticipated and none were reported the first day.

Edward Rensch, assistant administrator of St. Vincent Infirmary in Little Rock, said the first day of Medicare wasn't bad at all.

"We've had more calls from newspapers," he added, "than we've had patients."

Helena Hospital is given Medicare OK Friday afternoon

The Helena Hospital received official word at 4:55 p.m. Friday that it had been approved for Medicare and in the spac of the next 15 minutes five waiting patient were admitted under the new Federal Program.

A long-distance call to Dallas, made by local Social Security officials, produced the hospital's contract number and they were then permitted to start taking patients under the program

Fifteen patients already in the hospital under the state Welfare program were shifted over to Medicare earlier in the day.

At one time Friday there were a dozen or more elderly persons waiting at the hospital for admission but at that time the hospital has not received word of its approval and most of those people went home before the word came.

Hattiesburg, Miss.

Saturday, July 2, 1966 Hattiesburg AMERICAN

Some citizens show up to 'get their medicare'

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At 9 a.m. on the first day, Anna Winston, 71, of New York City, showed up in the emergency room at mammoth Mt. Sinai Hospital complaining of "aches and pains." Within an hour she became one of the hospital's 19 first-day medicare admissions.

"I knew I'd wind up in the hospital because I was very sick," Mrs. Winston said. "I should have been here a month ago, but I couldn't get into this or any other place."

An information desk was set up on the main floor at Detroit's Henry Ford Hospital, where more than 200 elderly persons came with questions about the program.

One elderly woman insisted a girl behind the counter was wrong when she epxlained that medicare doesn't cover all expenses. "You're trying to line your pockets with my medicare money," the woman shouted, and swung her purse at the girl.

The girl ducked and the blow glanced off her hairdo. She retreated into a nearby office and the woman stomped out.

"They're generally surprised to learn that everything isn't paid for," said Thelma Cogswell, clinics admitting officer at Massachusetts General Hospital in Boston.

Queen of Angels Hospital in Los Angeles didn't have a single medicare admission until midafternoon, when a doctor called to advise he was sending in a male heart patient.

"The hospital census always goes down to rock bottom on July 4," said a hospital spokesman.

Also affecting admissions, he said, was the fact that California put into effect its own program March 1, absorbing early the influx of patients.

Some hospitals reported that a few elderly persons had shown up to "get their medicare." They weren't sick, but they mistakenly thought they had to report to the hospital.

"The people who come in under medicare often are too old and too sick to know about the program," said Alan Transue, credit manager of Research Hospital and Medical Center in Kansas City.

"They don't have cards, they can't find cards, they don't know what we are talking about," he said.

At the Boston Hospital one woman outpatient refused to produce her red, white and blue card—until she had a chance to go to the ladies room and unpin it from her underwear.

At Ochsner Foundation Hospital in New Orleans, Herbert Leonard, an oil jobber from Ponchatoula, La., said he objected to medicare and wouldn't have signed up if his private insurance company hadn't reduced his hospital coverage due to the federal program. "I still think an American would rather pay his own way," he said.

Paper Hollywood Sun-Tattler

Place Hollywood, Fla.

Date 7/1/66

Here's Complete List

Of Medicare Services

All Medicare services went into effect at midnight Thursday, with the exception of post-hospital extended care which starts Jan. 1.

To qualify, you must be 65 or over, entitled to Social Security or to railroad retirement benefits, be a U. S. Citizen or a qualified alien.

A breakdown of services, time limits, patients' share of payments, Medicare's payments, requirements and items not covered under Hospital Insurance are as follows:

HOSPITAL IN-PATIENT

● Kind of service: Semi-private room accommodations, unless more expensive are required for medical reasons; includes general nursing and services; each spell of illness begins with the first day of hospital confinement and ends after 60 consecutive days of non-confinement.

● Time limit and payment: For the first 60 days, patient pays $40 maximum; for the next 30 days of continuous confinement, patient pays $10 a day; Medicare pays the balance in both situations.

● Requirements: Hospital must be certified by and registered with the U. S. secretary of health, education and welfare.

● Not covered: The first three pints of blood and all services covered under the Medical Insurance Plan.

POST HOSPITAL EXTENDED CARE

● Kind of service: Extended care facilities, such as a nursing home; each spell of illness begins with the first day of hospital confinement and ends after 60 consecutive days of non-confinement.

● Time limit and payment: First 20 days patient pays nothing; Medicare pays 100 per cent; next days continuous confinement, patient pays $5 a day; Medicare pays balance.

● Requirements: Must occur within 14 days of hospital confinement which lasted three days or more.

● Not covered: Same as hospital in-patient, plus nursing homes that do not have an agreement with a hospital; custodial care.

HOSPITAL OUT-PATIENT

● King of service: Diagnostic services.

● Time limit: Twenty days for each diagnostic study; patient pays $20 plus 20 per cent of the balance; Medicare pays the balance.

● Requirements: Services must be approved, performed or supervised by a hospital medical staff.

● Not covered: Same as hospital in-patient.

POST-HOSPITAL HOME HEALTH CARE

● Kind of service: Home health care performed by nurses, aides, technicians.

● Time limit and payments: 100 visits within a year of discharge; patient pays nothing; Medicare pays 100 per cent.

● Requirements: Same as post-hospital extended care; must be home confined.

● Not covered: Services of any agency primarily for mental disease.

IN-PATIENT PSYCHIATRIC SERVICES

This is the same as hospital in-patient data, but subject to a lifetime limit of 190 days of care.

The coverage under Medical Insurance is as follows:

HOME, HOSPITAL OR OFFICE

● Kind of service: Services of physicians and surgeons, and reimbursement for the cost of artificial limbs and eyes, rental of medical equipment, ambulance, x-ray, therapy, all drugs not self-administered, prosthetic devices, etc.

● Time limit and payment: There is no time limit; patient pays $50, plus 20 per cent of the reasonable charges during each calendar year, but may be reduced by the amount of expense incurred in the last three months of the preceding year and that portion of the first $20 you pay under hospital out-patient; Medicare pays balance of reasonable charges.

● Requirements: You must enroll and pay premium of $3 monthly.

● Not covered: Private duty nurses, routine check-ups, eye glasses, hearing aids, dental work, orthopedic shoes, cosmetic surgery, immunization injections, custodial care of charges made by a relative, etc.

HOME HEALTH SERVICES

● Kind of service: Nurses aides, technicians.

● Time limit and payments: 100 visits per year otherwise same as home, hospital or office.

● Requirements: You must enroll and pay premium of $3 a month; no prior hospital care required. quired.

● Not covered: Same as home, hospital or office.

OUT-PATIENT PSYCHIATRIC

● Kind of service: Psychiatric services.

● Time limit and payments: Calendar year patient pays $50; may be reduced by the amount of expense incurred in the last three months of the preceding year and by that portion of the first $20 you pay under hospital out-patient; Medicare pays 50 per cent of charges to a maximum of $250 of the balance.

● Requirements: You must enroll and pay monthly premium of $3 monthly.

North Carolina

GREENSBORO DAILY NEWS

Greensboro Hospitals Report Little Change

The Age of Medicare arrived in Greensboro Friday and nobody paid much attention.

If any of the city's four hospitals had expected a sudden influx of older patients who had been waiting for this day to get something fixed, it didn't develop.

As of late afternoon, just five patients had been admitted and certified as eligible for financial assistance under the Social Security Medicare program.

THE DURHAM SUN
PUBLISHED IN THE FRIENDLY CITY OF EDUCATION AND INDUSTRY
EST. 1889 VOL. LXXVIII, NO. 107 DURHAM, N. C., SATURDAY AFTERNOON, JULY 2, 1966

Fears Of Early Medicare Overload Evaporate

Elderly Fail To Swamp Hospitals Across U.S.

EDITOR'S NOTE — Members of a special AP task force kept a close watch throughout the first day of medicare in a group of hospitals around the country. The following account is based on their reports.

NEW YORK (AP)—Down the corridors of Miami's Jackson Memorial Hospital figures in white passed each other with a cheerful greeting: "Happy medicare!"

For the nation's hospitals Friday was indeed happy medicare —the first day of the Social Security hospital program for persons 65 years and older had gone smoother than anyone had dared hope.

Still, there were problems: mountains of paper work, missing forms, bewildered patients, lost medicare cards, and one woman who got mad and swung her purse at a hospital worker.

By midafternoon, in the usually frantic emergency room at Jackson Memorial, interns sat with their feet propped on a table.

"It's the quietest day we've had," said Dr. James Connaughton, who joined the Miami hospital last month after graduation from the University of Indiana.

The situation was virtually the same in hospital after hospital across the United States. Fear expressed by some that medical facilities would be swamped by elderly people evaporated as the day wore on like any other before a July 4 holiday.

Northwest Hospital in Seattle, the first in the nation to be certified for medicare, admitted not a single medicare patient. Six elderly patients already in the hospital, however, were automatically switched over to medicare at its start, 12:01 a.m. the people who wanted to be home for the holiday or delayed entry because so many doctors would be away for the weekend.

At 9 a.m. on the first day, Anna Winston, 71, of New York City, showed up in the emergency room at mammoth Mt. Sinai Hospital complaining of "aches and pains." Within an hour she became one of the hospital's 19 first-day medicare admissions.

"I knew I'd wind up in the hospital because I was very sick," Mrs. Winston said. "I should have been here a month ago, but I couldn't get into this or any other place."

The biggest problem faced by the hospitals is the increased load of paper work. Mt. Sinai added 41 clerks just to handle all the new forms and extra bookkeeping. Other hospitals are also taking on new help.

At St. Joseph's Infirmary in Atlanta, business manager David Messinger recalled that he had spent 20 years in the Air Force as a medical budget officer. He shuffled the forms piled high on his desk and said, "I'm right back home again. I haven't had much sleep in three days. I can't sleep any more, trying to figure out what to do about medicare."

An information desk was set up on the main floor at Detroit's Henry Ford Hospital, where more than 200 elderly persons came with questions about the program.

One elderly woman insisted a girl behind the counter was wrong when she explained that medicare doesn't cover all expenses. "You're trying to line your pockets with my medicare money," the woman shouted, and swung her purse at the girl.

The girl ducked and the blow glanced off her hairdo. She retreated into a nearby office and the woman stomped out.

"They're generally surprised to learn that everything isn't paid for," said Thelma Cogswell, clinics admitting officer at Massachusetts General Hospital in Boston.

She said the clinic patients were used to being "whisked through" the formalities of being checked in. But Friday there were delays because of the medicare forms to be filled out. Miss Cogswell added: "The hardest part at this point is that nothing is cut and dried. If we had been given a few simple rules to follow it would be a lot easier."

By the end of the first day at Massachusetts General the hospital had 941 patients, of whom 260 were over 65 years. During the day the hospital admitted 67 new patients, 18 of them under medicare.

Queen of Angels Hospital in Los Angeles didn't have a single medicare admission until midafternoon, when a doctor called to advise he was sending in a male heart patient.

"The hospital census always gdes down to rock bottom on July 4," said a hospital spokesman.

GREENSBORO DAILY NEWS

GREENSBORO, N. C., FRIDAY MORNING, JULY 1, 1966

N.C. Hospitals Differ On Medicare Impact

By United Press International

North Carolina hospital administrators expressed divergent opinions as to the impact of Friday's opening of the federal Medicare program.

Administrators in the eastern part of the state expressed doubt there would be a great influx of patients 65 and over during the period immediately following July 1, Medicare's opening day.

Some said an influx would be desirable because, during the summer months, they run well below capacity.

In the two major referral hospitals in the state—North Carolina Memorial and Duke—the directors of both hospitals said they expected little or no direct impact from Medicare, but say the proportion of patients 65 and older may increase slightly.

Administrators were generally united in their beliefs that most of the brunt of the Medicare program will be felt by private physicians, clinics, and nursing and rest homes.

Two administrators of large county hospitals, C. D. Ward of Pitt County Memorial and Louis Worsley of Beaufort County Hospital, said they would almost welcome an influx of patients.

WARD SAID his 200-bed hospital is now operating at an average of 142 beds filled per day. He said, "We don't expect an influx tomorrow by any means. We certainly are ready if an influx comes immediately. We're not panicked. We'll take it as it comes."

Worsley said, "We feel that in the past older persons in the eastern part of the state have had care either through hospitalization benefits or disability insurance. Therefore, we do not anticipate a rush."

Neither Duke nor N.C. Memorial expect a major influx of elderly patients.

Eugene Crawford, director of N.C. Memorial, says, "Unless there are emergencies, people over 65 will have to wait, just like anyone else. We are not going to change our ways of doing things just because of Medicare."

Charles H. Frenzel, director at Duke, said, "We expect some increase in demand for admission. But, we are a referral hospital where the most serious cases come. We expect the community hospitals to feel the impact more than we."

Among the large city hospitals, opinions are somewhat divided. John F. Moulton, administrator of Durham's Watts Hospital, said, "I don't expect any big rush because all my beds are full and I have a waiting list." Moulton says his 350-bed hospital usually has about 60 patients who are over 65. This percentage, he said, is not likely to change markedly.

Reid Holmes, of Winston-Salem's Baptist Hospital, said he expected a temporary increase in the number of patients over 65—"but nothing special and nothing we cannot handle . . ."

And in Charlotte, Harold C. Green, administrator of Charlotte Memorial, said, "There is no way of telling. We will probably have some delayed operations on gall stones and hernias to await the deadline, but rehabilitation and long-term facilities like nursing homes will probably get more of an impact."

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Puzzler: 'Medicare Reaction'

DURHAM (AP) — Claims processors at Hospital Care Association did a double take Thursday when a hospital claim turned up for a 65-year-old resident of Greensboro with this diagnosis: "reaction to Medicare."

Overworked themselves, getting ready for the government's new health program for the aged, which begins Friday, the Blue Cross workers called the Moses H. Cone Hospital to confirm the diagnosis and express their sympathy to the patient.

They were a little disappointed when told by the hospital's records department that the diagnosis was a typographical error.

It should have read, "reaction to medicine."

Smooth Start Foreseen For Medicare Today

WASHINGTON, (AP)—Hospitals throughout the land brace themselves for the opening today of a new era of old age security for Americans—Medicare.

The government foresaw a smooth start today despite some scattered forecasts of overcrowding, some Republican charges of negligent planning and the decision of many Southern hospitals to discriminate rather than participate.

Starting at midnight the first of 19 million Americans 65 and older who now hold red, white and blue Medicare cards will be admitted for government-insured hospital care at any of 6,704 hospitals. Some 17.3 million of them also have signed up voluntarily for doctor-bill insurance under Medicare.

In a surprise statement Thursday, Social Security Administrator Robert M. Ball announced that Veterans Administration, military and other federal hospitals — generally barred from Medicare — may take Medicare patients in emergency cases of critical illness.

This provided some extra assurance of care for elderly persons in areas where a high percentage of hospitals are barred from Medicare participation because of racial discrimination.

N.C. hospitals doubt immediate pressure from Medicare, Page A-11.

Waukesha Freeman 7/2/66

Medicare in County Is Running Smoothly

The federal government's medicare program at Waukesha for elderly went into operation yesterday and Waukesha county hospitals had little or no problems adjusting to the change.

Two new patients were admitted yesterday under the medicare programat Waukesha Memorial hospital. Of the 66 medicare patients at the hospital, only two had not signed up for the plan. One of these two did sign up yesterday and the other did not want to take advantage of it.

At Oconomowoc Memorial hospital, where 19 patients are eligible for coverage, all patients had applied for benefits and only one had forgotten a card.

Community Memorial hospital in Menomonee Falls reported no great problems. One of the two new medicare admissions yesterday had forgotten his card, and one of the 10 patients eligible for coverage declined it.

Officials at all three hospitals agreed that there was no flood of patients seeking medical care with the first day of the program. Some national officials had feared such a sudden onrush.

There is speculation that the first wave of patients will enter hospitals Tuesday, after the July 4 holiday.

Section B–10 Pages
Saturday, July 2, 1966
Durham Morning Herald

Admissions Increase Light As Medicare Plan Effected



(Staff Photo by Harold Moore)

First Watts Medicare Patient

Miss Doris Jones, right, senior nursing student, greets Mrs. Martha Lasater Britt as the first medicare patient to be admitted to Watts Hospital Friday.

Most Are 'Holdover' Patients

The first day of medicare brought only slight increases in hospital admissions in Durham, spokesmen for the various local institutions revealed Friday.

At Watts Hospital, the first medicare patient, Mrs. Martha Lasater Britt, was admitted shortly after noon.

Mrs. Britt, 85 years old, was one of the first patients to be admitted to Watts when the hospital was located on Main Street, 71 years ago.

She has seen many changes in hospitals and medical care. She said she thinks the medicare program is a fine thing though she had not planned to take advantage of medicare benefits on the very first day of operation.

Duke Hospital reported the most activity Friday.

The first person treated in the outpatient clinic was a medicare patient. The clinic was described as being "pretty chaotic —just mobbed," Friday morning.

A spokesman said this was not directly attributable to medicare, since only five medicare patients were included. He said the first day of each month brings a swarm of welfare patients to the clinic.

Lincoln Hospital Director Frank Scott reported 15 medicare patients, but all had been in the hospital Thursday and were brought under the medicare program Friday.

"We really hadn't anticipated a large increase," Scott said.

"We were so late getting certified. We have to depend on doctors sending medicare patients in and the certification came so late the doctors either didn't get the word or went on vacation."

A spokesman for McPherson Hospital reported only six medicare patients Friday.

McPherson's director, Tom Peyton, said, "That's about what I expected. Since we're operating under a full occupancy, we can't take too many patients of any kind and we adm' these on the basis of need."

Stroke Of Pen: How Much Care Is Used?

Related Story On 1A

By CHARLES BARBOUR
Herald Managing Editor

How efficiently are investigations being conducted by federal officials who can take and give medicare certifications with the stroke of a pen?

This was the question raised in North Carolina this week when a certification for Watts Hospital of Durham was withdrawn and restored during a 24-hour period by a man who later admitted he acted on his own.

What made matters even more irksome to Watts officials were the truths and half-truths told in Washington about circumstances surrounding the withdrawal in the first place.

A Public Health Service official admitted after Watts was reinstated that the agency had "pulled a boner," and Robert Nash, head of the Office of Equal Health Opportunity, apparently pulled it.

Nash told the Durham Morning Herald's Washington correspondent on June 29 that Watts' certification had been withdrawn as a result of "new information" received. He indicated that the action was taken because white and Negro doctors on the Watts staff were referring all their Negro patients to Lincoln Hospital.

The statement raised the ire of George Watts Hill, grandson of the hospital founder, and a president of the board of trustees for 25 years. Hill sought to find out more about this "new information" which Nash and his associates had uncovered just 48 hours before medicare began.

Backgrounding The News

One Washington source first told Hill that the hospital's certification had been reinstated on the night of June 29 several hours after it had been withdrawn.

Nash first denied telling newsmen that Watts' certification had been withdrawn, but an administrative aide to U.S. Sen. B. Everett Jordan challenged the statement because he, too, had heard it.

When questioned by Hill, Nash never would reveal the source of his "new information" on Watts. He said at first that the decision was made on collateral information. Then he admitted to Hill: "I concluded that Watts discriminated."

Hill wanted to know how he came to this decision, and Nash told him that he based his conclusion on a report that Negro doctors at Lincoln were not referring patients to Watts.

Throughout the day Hill worked by telephone with Washington sources. First there was the statement of certification had been restored the same night it was withdrawn. Another said certification had been restored early the next morning and Watts would be notified by noon.

Washington and Hill again called. He urged that the telegram also carry an apology. Nash assured him there would be an apology.

But, the telegram received by the Watts Hospital administrator, probably sent prior to Nash's call to Hill, read:

"Assurance of compliance with Civil Rights Act Title VI for Watts Hospital accepted June 30 and social security administrator notified. Decision based on additional evidence regarding pattern of patient referral by physicians who admit patients to both Lincoln and Watts Hospital."

This was no apology.

Hill said the telegram had been sent from Baltimore, Md., at 5:55 p.m. — June 30 — some 10 minutes after Hill had spoken with Nash.

If the June 30 acceptance is to be believed, federal officials could not have been telling the truth when they said certification had been reinstated on June 29. And, no telegram was sent at noon June 30 as promised.

The run-around has caused North Carolinians to wonder if other hospitals in the state also are being judged unfairly — such as Rex Hospital in Raleigh, and Jubilee and Maria Parham in Henderson.

Senators Jordan and Sam Ervin have expressed their unhappiness with the decisions — particularly over Rex Hospital. Jordan said the move was a violation of an assurance which Nash himself had given North Carolina lawmakers concerning clearance. He said it was a "great disservice."

For the time being, Watts Hospital is in the clear. But, for the moment, a hospital with almost half the beds in the state's capital is ineligible for medicare patients.

Science & Medicine



By David S. Greene
Daily News Science Writer

Experts Offer Some 'Educated Guesses'

What Will Be The Impact Of Medicare?

Most provisions of Medicare went into effect Friday, but its too early to tell for sure just what impact the law will have on the United States. Some experts are taking a guess, however.

Among them is Ray E. Brown, director of Duke University's graduate program in hospital administration and former president of the American Hospital Association.

Brown, five physicians and a government official contributed "educated guesses" on the impact of Medicare to an article in Medical World News, the weekly news magazine for doctors.

* * *

BROWN SAID that although hospitals don't like everything about Medicare, "they see few extraordinary problems. Generally speaking, hospitals have been impressed with the manner in which the Social Security Administration has gone about the development of regulations, conditions and procedures for implementation of the Medicare program."

Brown and the five physicians helped write the regulations implementing Medicare. The government official, Wilbur Cohen, under secretary of Health, Education and Welfare, drew up the law.

Commenting on the views of Brown, Cohen and the doctors, the news magazine said one thing about Medicare is sure: "Despite an heroic effort by government and private agencies, there still are many people who envision nearly all their medical and hospital bills paid by Medicare."

* * *

SUCH PEOPLE face disappointment, the magazine said. "Many physicians fear that those who have dreams of pie in the sky and find only bread will vent their disappointment on the medical profession."

The doctors were asked to educate their patients to the facts of the law and to "remind them, when necessary, that you didn't write it." (Medicare will pay most but not all of the hospital and doctors bills for persons 65 and over who signed up for coverage earlier this year.)

Cohen described Medicare as an economic mechanism to help older Americans get the best care possible. He predicted it soon will be paying from 25 to 30 per cent of the operating expenses of the average hospital and will, in its first year, pay for about 10 per cent of the nation's total health bill.

Brown said Medicare regulations provide "local approaches" for the hospital's role in the program.

* * *

STATE AGENCIES, he said, certify hospitals for the program and help to coordinate local planning of health services and the fiscal agent through which Medicare fund payments are made. The fiscal agent, Brown said, "has very broad responsibilities for administration of the programs."

Two of the doctors said some difficulties might arise from the requirement that hospitals have review committee to determine the need for extending hospitalization of Medicare patients.

Dr. Willard Wright of Williston, N.D., said, "The physician is unlikely to enhance his standing with the patient (who prefers to remain in the hospital) and his family if he decides that the hospital care is no longer necessary. But if he decides in favor of the patient, he may be in bad odor with his colleagues or with the fiscal intermediary."

He also predicted that Medicare will reduce the number of welfare or charity cases, and that the program, along with the expanded Medical Assistance to the Needy Program, will result in charity and county hospitals becomming community hospitals.

Dr. Carl E. Anderson of San Francisco said many doctors will refuse to accept federal Medicare payment directly. The law allows but does not require doctors to bill Medicare for services rendered elderly patients.

* * *

DOCTORS who do not want to accept federal money directly will give their patients itemized receipts after the bills are paid. The patients will then submit the receipts with their claim forms to Medicare for reimbursement.

Dr. Anderson said the method can be used if the patient wants to pay his bill in installments.

Dr. Pierre Salmon of San Mateo, Calif., pointed out extended care phases of Medicare, including nursing home care, does not begin until Jan. 1, 1967, but predicted these services will "probably cause more difficulties proportionately than any other portion of the program."

Factors will be the doctor's unfamiliarity with different types of nursing homes, the three-day hospital stay requirement before admission to nursing homes, the need for transfer agreements between nursing homes and hospitals and the medical fact that typical long-term patients often have multiple problems that don't change appreciably within the 100-day limit of coverage, he said.

Idea Of Medicare Started With Franklin D. Roosevelt In 1935

By JERRY TILLOTSON
Staff Writer

Medicare originated in 1935 when a Report of the President's Committee on Economic Security was sent to Congress by President Franklin D. Roosevelt.

The report, which formed the basis of the Social Security Act passed that year, endorsed the principle of compulsory national health insurance. There were no specific program recommendations.

President Roosevelt did not recommend this medical program because "groups representing the medical profession are cooperating with the Federal Government in the further study of the subject."

He feared recommendation of national health insurance would have prevented enactment of the entire Social Security Act.

Medical facilities were also believed inadequate for a health insurance program.

Improvement and expansion of facilities through public health grants was given priority.

In 1943 Senators Robert F. Wagner of New York, James E. Murray of Montana, and Representative John D. Dingell Sr. of Michigan introduced the first "Wagner-Murray - Dingell" resolution (S. 1161— H. R. 2861). The resolution called for major changes in the Social Security Act including creation of a compulsory national health-insurance system for all people.

A payroll tax would have financed the program but Congress took no action on this proposal.

In a State of the Union Message, President Roosevelt, on Jan. 6, 1945, referred to "good medical care" but made no specific recommendations.

A comprehensive, prepaid medical insurance plan for all people, through the social security system was proposed by President Truman in a special message to Congress in November 1945.

This plan would have covered doctor, hospital, nursing, laboratory and dental services for people covered by the social security program.

Benefits would have also been provided from general federal revenues for needy people. Truman's proposal was immediately introduced by Senators Wagner and Murray as S. R. 1606 and by Representative Dingell as H. R. 4730.

Senator Robert A. Taft in 1946 opposed the President's proposal as a "socialistic measure". Taft introduced S. R. 2143, authorizing some $230 million a year in federal grants to the states for comprehensive medical care for people who could not otherwise afford it.

The proposal, which would have allowed states to pay part of private health insurance premiums for those who needed help in meeting the cost, was endorsed by the American Medical Association. No action was taken by Congress on these proposals.

President Truman twice proposed a bill for compulsory national health insurance for persons of all ages.

Controversy was aroused by Truman's last request. The American Medical Association was strongly opposed to a national health insurance program. Others testifying against it were the American Dental Association, Blue Cross-Blue Shield Commissions, Chamber of Commerce of the U. S., National Catholic Welfare Conference.

Those in favor included Mrs. Eleanor Roosevelt, Physicians Forum, American Veterans and others.

Dwight D. Eisenhower, in his 1952 campaign for presidency, opposed compulsory national health insurance as "socialized medicine," but promised to help needy persons meet the costs of health care.

In 1958, the Committee on Ways and Means of the House of Representatives held extensive public hearings on proposals for health insurance for the aged, but decided more information would be needed before legislation in this area could be recommended.

It requested the Secretary of Health, Education, and Welfare to study and report on possible ways of providing insurance against the cost of hospital and nursing home care for social security beneficiaries and on the benefit costs and administrative implications.

The Senate Committee on Labor and Public Welfare, in 1959, established a special Subcommittee on Problems of the Aged and Aging (the McNamara Subcommittee) to conduct a comprehensive study of the major problems of the aged. Public hearings were held throughout the country by the subcommittee, primarily on health needs of the aged.

This special Senate subcommittee stated in its first annual report that the number one problem of America's elderly citizens was meeting the costs of health.

After three months of consideration in 1960 the Committee on Ways and Means reported to the House H. R. 12580.

This bill, the Social Security Amendments of 1960, established a new title XIV of the Social Security Act, providing federal grants to the states to help pay the costs of medical services for aged people not on public assistance but unable to meet their medical expenses.

The late President Kennedy appointed a Task Force on Health and Social Security for the American People. Its purpose was to review from among the most pressing and significant health and welfare proposals those which should have priority in the initial phase of the new administration.

The first message ever devoted exclusively to the need for a health program was President Kennedy's Health Message

He recommended the addition of a health insurance program to the existing social security system to help meet the problem of financing the medical cost of old age.

In 1965, President Johnson's first legislative message to the 89th Congress, Advancing the Nation's Health, presented proposals for a broad health-care program that he termed "practical, prudent and patient."

The program included hospital insurance for the aged under social security and health care for needy children; top priority was given to his recommendation for a hospital insurance program for the aged, financed through the social security system.

After six weeks' consideration, the Committee on Ways and Means of the House of Representatives approved by a 17-8 vote a bill to replace the administration's proposal with an unprecedented package of health benefits and social security improvements—the first time the House Committee had acted favorably on a medical insurance bill for all older citizens.

A bill, which established two coordinated health insurance programs under the social security Act for people 65 or over, was introduced by representative Wilbur D. Mills, chairman of the Committee on Ways and Means. It proposed the following:

(1) A basic plan of hospital insurance and related care under the social security program, with financing through a separate payroll tax and trust fund; and (2) a voluntary supplementary plan providing for doctors' fees and other medical and health services, financed by $3 a month premium payments by each participant, matched by an equal amount from federal general revenues.

The bill was passed without amendment on April 8 by a vote of 313 to 115 by the House.

The bill contained 513 changes from the version approved by the House. The major features of the two versions were the same.

The bill was sent to a conference committee for reconciliation of difference between the two versions. The conference committee convened for its first negotiating session on July 14, 1965, and promptly settled a major point of disagreement: 60 days of hospitalization were provided with the patient paying a deductible fee of $40 and an additional 30 day with the patient paying $10 a day.

Agreement was also reached on the limits for nursing home or extended-care services and for home visits by nurses.

The compromise bill on July 21, 1965, conformed in all basic respects to the administration's specifications for a comprehensive medicare program.

It included: a hospital insurance program for persons 65 and over, administered by the Social Security system; an optional insurance plan for the elderly to help pay doctor bills and other medical costs; a even percent increase retroactive to Jan. 1, 1965; a general liberalization of social security benefits for retired persons and for widows children, the disabled, and othes.

The Conference Report was returned to both Houses for approval; the house ratified the Conference agrement on the bill by a vote of 307 to 116.

The Senate by a roll-call vote of 70 to 24 gave final Congressional approval to the administration's medicare-social security bill.

President Johnson signed H. R. 6675 in Independence-Mo., in the presence of former President Harry S Truman.



(SECO Photo)

MEDICARE CHAT — Mrs. Mary Stone (left) and Miss Alice Boatwright of the Catherine Kennedy home on 207 S. Third St. discuss the pros and cons of the Medicare program which went into effect Friday.

WILMINGTON MORNING STAR
WILMINGTON, NORTH CAROLINA
JUNE 30, 1966

Hospitals Optimistic About Program Of Medicare Creating Problems

By GENE MARLOWE
AND
JERRY TILLOTSON
Staff Writers

Although nearly eight per cent of southeastern North Carolina residents are over the 65-year-age, which qualifies most of them for Medicare, most hospital administrators expect no deluge of patients or change of hospital operations.

What they do expect is:

(1) Extra work for hospital staff, but not drastically so.

(2) Gradual construction of hospital facilities.

(3) More patients receiving medical attention than before.

Most SENCland hospitals are operating at full capacity. For example, Onslow Memorial Hospital is at 90 per cent capacity; Duplin General Hospital at 95 per cent; Columbus Memorial Hospital 90 per cent.

Construction of present hospital additions was generally underway before the Medicare bill was passed.

M. E. Bullard, administrator of Columbus Memorial Hospital stated: "A long term unit has been built into the hospital. Medicare was one of the factors but not the main one. We had planned this for some time."

Social security administrators describe Medicare as a program entirely between the patient, the hospital and the insurance company handling Medicare.

"This program is essentially a contract between themselves and the government," said Dr. W. M. Brady, of Morehead City.

Hospital administrators however, say that much of the program will be placed upon the individual doctor.

Unless a patient enters by way of the emergency room, he can get in only by way of the doctor.

When the hospitals begin to fill, the doctors will be faced with the decision of whom to admit and whom not to admit.

As a job none of them looks forward to, Hospital Administrator, Dr. Lawrence U. Chandler of Duplin General Hospital, says it will be similar to the "triage system" used in civil defense and war.

"The 'triage' is the man who stands outside the hospital door and decides who is going to live and who is going to die.

"The doctor sends the patient to the hospital and we take whoever the doctor decides," said Chandler, a Ph.D in public health.

"A doctor may see 25 people who need to go to the hospital, but he's going to have to decide who is going to go today.

"It's a terrible burden."

Most hospital administrators in this area feel they will not be hit by a great onslaught of patients who have been holding back treatment of their illnesses for Medicare coverage.

Earlier this week it was learned that 40 hospitals, most of them in Eastern North Carolina, were not eligible for Medicare.

Two of these hospitals were in this area, including Dosher Memorial in Southport and Duplin General Hospital in Kenansville.

Ernest Phillips, chief of the Health Benefits Section of the State Board of Health, stated the hospitals' records had been approved by Raleigh.

However, official recognition of their approval for federal funds has not yet passed through departmental channels.

Administrators of both hospitals are confident their institutions will be approved.

Dosher Memorial is in the process of hiring extra personnel. Most other hospitals are making similar increases, particularly in administrative capacities.

There are a few area hospitals, however, which admit that they expect trouble when Medicare goes into operation.

"We aren't prepared for the extra patients that may sign up," remarked M. H. Woodside, Sampson Memorial Hospital administrator in Clinton.

"Our hospital suffer now from a lack of space and personnel. We're wondering how we're going to meet the demand."

His hospital, which has 144 beds, is 90 per cent filled.

For the most part, Medicare will mean more paper work for doctors and hospitals alike, according to administrators.

Administrators are worried about persons over 65 being deluded that Medicare will give blanket coverage for their hospitalizations.

"I think a number of elderly people do not fully understand what Medicare is about," stated Dr. Caroline Callison, health director of the Sampson and Bladen Counties Health Departments.

She added: "If everyone works together, the program should work."

GREENSBORO RECORD
GREENSBORO, NORTH CAROLINA
JULY 1, 1966

Medicare's First Day Fairly Quiet

By THE ASSOCIATED PRESS

Texas hospitals encountered no particular problems Friday, the first day that persons over 65 were eligible to get treatment under the historic medicare program.

"We've been overcrowded right along and medicare seems to have caused no visible impact at this point," said a Fort Worth hospital spokesman.

Some observers had thought that hospitals might be swamped with elderly patients who had put off seeking treatment until the program started.

But such was not the case.

The great majority of over-65 patients in the state's hospitals by Friday night had already been admitted before medicare took effect at 12:01 a.m. Friday.

Such persons slept through it all but technically they were discharged and then re-admitted automatically, with their records changed in accordance with the program.

Some 886,000 elderly Texans became eligible under the program Friday.

The impact was apparently light all over the state.

Hospital spokesmen cautioned, however, that the Fourth of July weekend is traditionally a time of relatively light hospital activity, except for automobile accident victims.

They said the time to watch for a medicare impact would be about the middle of next week, when case loads might increase sharply. But still, no one really knew.

Only five medicare patients were admitted to Parkland Hospital in Dallas in the 18-hour period after the measure went into effect. Similar low figures were reported from other large hospitals around the state.

One of the patients was an 82-year-old widow who is thought to be the state's first medicare patient. She suffered a heart attack and was admitted to Parkland at 12:01 a.m.

Another was Mrs. Madge L. English, who was admitted to Parkland after she fell and broke her hip. Asked about medicare, she said:

"It's a wonderful thing. It's God's blessing to the old people."

MEDICARE REPORT

No Rush on First Day At 3 Victoria Hospitals

The first day of the year Medicare I produced little noticeable effect on local hospital activity, and administrators said this probably was due to the fact Friday was the eve of a long holiday weekend.

"It went very smoothly, there was no rush," said Mrs. Dorothy Swickheimer at Citizens Memorial Hospital. "There were some Medicare patients admit-

(Related story, Page 5)

ted, and there were some already in the hospital who became eligible for Medicare as of 12 midnight last night, but there certainly were no problems."

B. R. Pugh, administrator at De Tar, and Bourke Marxsen at Hohf Hospital and Clinic, both said that Friday was "nothing out of the ordinary" and expressed the view that the holiday weekend had some effect on the number of Medicare patients who might otherwise have entered the hospital.

They said this may have been particularly true of deferable surgery cases.

All three hospitals had announced earlier in the week that they had prepared in advance for the beginning of Medicare and expected no real problems.

[H]ospital Admits 4 on Medicare

Advocate News Service

PORT LAVACA — Two men and two women were admitted to Champ Traylor Memorial Hospital Friday under the Medicare program.

Three of the four local patients, who were already hospitalized were re-admitted under the special form on the recommendation of their doctors. The fourth was a former patient.

"I don't think it is going to affect us very much," said Business Manager Charles Draughon Friday afternoon. "At least, not for the present."

WILMINGTON MORNING STAR
WILMINGTON, NORTH CAROLINA
JUNE 30, 1966

Wilmington Hospitals

Ready, Waiting

By MARTI MARTIN
Staff Writer

No medicare problems are expected in New Hanover County hospitals, although business is expected to be better than usual during the next month.

At this point it is purely a matter of speculation as to what will happen when the more than 5,000 aged residents of this county begin receiving Medicare benefits July 1.

A controversial subject still, many authorities have maintained a number of hospitals will be overwhelmed and getting hospital beds and nursing services will be at a premium.

Others, as in New Hanover County, feel it is a problem that will work itself out during the first few weeks.

Only time can really tell.

Effects will not only be felt in the hospitals, but in the waiting rooms of doctors offices.

One local doctor locks his office doors at 5 p.m. and no other patients are admitted for the day. It is sometimes 7 p. m. before he finishes seeing the day's patients who had waited hours in his office.

The question is now how much of an impact will additional patients place on the physician's present burden?

Again, time will tell.

Leery about the situation in doctor's reception rooms is Dr. James Tidler, president of the medical staff at James Walker Memorial Hospital and an internal medicine specialist.

"It's going to be terrible all the way around. We have trouble keeping up with things today and July 1 may see it quadruple."

He said the public really didn't understand Medicare fully, and problems should arise over this. Tidler thinks there will be a problem in getting hospital beds, as well.

However, hospital administrators are not as worried over the provision for hospital beds for the expected influx.

Robert W. Martin, director of James Walker Memorial Hospital, said, "I feel we are ready to begin the Medicare program."

He said there are many unknown factors associated with this program, as in any new program, but "we will make every attempt to minimize them."

Martin said, "I expect some increased admission to the hospital of the over 65 patient group, however, I don't expect it to be anything that we will not be able to handle in providing their needs.

"It will probably make some higher demand on our facilities for all age groups as a result of Medicare coming in.

"As of today we have experienced a lighter census for the past 30 days. I presume there is a representative group who may be waiting for financial coverage for July 1.

"Our utilization of beds for this year has been at a maximum and there is expected to be a premium for an indefinate period following July.

He summed it up, "We don't see it as a problem we won't be able to handle satisfactorily in our own hospital."

Both James Walker and the Community hospitals will phase out when the new New Hanover Memorial Hospital is completed in the spring of next year. Available beds at the hospitals will jump from the present 355 to 404 when the new hospital opens.

E. M. Butler, director of Community Hospital, reports there should be no problem in providing beds at Community Hospital.

"Our census has not been as high this year as in previous years. There should be no premium for hospital beds.

"This is true here because of the loss of a house physicians. He accepted a position with the Veteran's Administration Hospital in Augusta, Ga., which caused the closing of the emergency room here.

"This will eliminate one-third of our patients.

"Unless there is a sudden accute development in our inpatient need, we can take care of the situation as of now. We are keeping our fingers crossed. We've planned for the worst and hope for the best."

R. J. McLeod, director of Cape Fear Memorial Hospital, reported there have been a few days when "we have had to put patients in the halls, but I expect this happens in every hospital.

"At times we are crowded, but not at the present time."

McLeod said he imagined there will be an influx for a period of time, as it is his opinion there were some people who have waited for Medicare to come in for elective surgery.

Emory Grubbs, administrator of the New Hanover Memorial Hospital which will open next year, said, "We will have a better opportunity to prepare of Medicare. I think as far as the medical staff is concerned we are in good shape.

"As far as nurses are concerned, this is a shortage for years to come. We are trying to look toward technical training programs to take care of a lot of work that has been done by RN's in the past.

"The shortage of RN's and LPN's is great. I think we will have to use paramedical personnel in the operating rooms and in other areas of the hospital."

Medicenter here, reported no difficulties are anticipated as Medicenter was built with Medicare in mind.

Opened in April 1966, Medicenter has already admitted some patients directly who refered because there were no hospital beds available in Wilmington.

"I will have to increase the work force to handle Medicare, but we have enough to handle the present situation."

Medicenter is geared to handle the convalescence type of patient as opposed to the long-term geriatric patient.

Ensminger added, "An impact may be felt here when there is a large demand for hospital beds because of Medicare and it would be necessary for them to transfer some of their convalescence type patients into this type of facility."

EAST CENTRAL STATES

Minnesota

Wisconsin

Michigan

Illinois

Ohio

Indiana

News Journal

An Independent Newspaper

Page Four Mansfield, Ohio Friday, July 1, 1966

Beginning Today It's Uncle Sam, M.D.

TODAY IS HISTORIC. The nation launches a program of socialized medicine. The federal government begins to assume responsibility for taking care of the citizens' health.

The opening phase of the program is Medicare.

It has been called a three-layer cake.

The bottom layer is hospital insurance for people over 65. This is paid for by social security taxes. It is not full coverage, however. The patient pays the first $40 of the bill and $10 a day on his bill after the 60th day until the 90th when coverage for one illness expires.

Second layer is the voluntary supplement to cover a portion of the patient's doctor bills. Persons over 65 pay $3 each month toward this insurance. The balance of the money comes from the U. S. Treasury and Congress has the last-minute jitters over how much this is going to cost.

The top layer on the medicare cake is known as Title 19. This permits enactment of state-federal programs which could extend health benefits to almost anybody regardless of age or financial need.

Seven states and Puerto Rico have set up such programs and the cost is already $262 million ahead of estimates.

New York state's program is being held up because it would cover almost a third of the state's population and the cost is almost incalculable.

★ ★ ★

THE ONE thing that alarmed everybody a few months ago—shortage of hospital space—no longer looks so troublesome. At least hospital officials and spokesmen for the Department of Health, Education, and Welfare in Washington say they don't think the scarcity will be serious.

Instead, two other worries loom suddenly: how to get Southern hospitals to desegregate and how to find money to pay the bills suddenly piling up on the federal government.

It would be a pretty safe guess that there will have to be additional taxes before long to help pay for medicare, that the federal debt will go up to help finance it, and that the program itself may have to be temporarily curtailed until the financial side of it can be put in focus.

But socialized health care is here, starting today.

It will stay. And it will grow to cover more and more people as time goes on.

An old German proverb seems applicable at the moment: "All beginnings are difficult."

EAST LIVERPOOL REVIEW
EAST LIVERPOOL, OHIO
JULY 2, 1966

We Need The Doctors

Medical doctors were given a choice in medicare legislation between billing their patients or billing the agents handling medicare payments.

There was a good reason for this. Doctors did not want their fees to be regulated. That would have been the essence of the "socialization" they accused backers of medicare of foisting on them.

It stood to reason that administrators of federal medicare funds could not tolerate wide differences in medical fees between individual doctors, or between geographic areas. The charge for the same medical procedure would have to be regularized under medicare the same as it is regularized now under private insurance coverage.

Private insurers, fortunately, have broken the trail for medicare in many directions, including direct billing. They have shown it is feasible to reimburse insurance beneficiaries for doctor bills submitted directly to patients. There is nothing new about it.

They also have revealed the tendency of doctors to use established fee schedules when making out their bills. They are not barred from charging more or less than the schedules, but being thoughtful of their patients' situation they charge what they feel will be acceptable.

In this and all other facets of this momentous move to compensate for improvements in medical skill that keep people alive longer and changes in modern industrialism that put them out of work when they reach a certain age, medical doctors are entitled to sympathetic understanding.

The greatest boon they could have at this sensitive juncture in the progress of their profession from an optional private service to a relief from paper work.

We need them for the practice of medicine. They should be freed from the practice of filling in quintiplicate forms.

Paper
Daily Pantagraph

Place
Bloomington, ILLINOIS

Date
July 2, 1966

Opinion Page

The Daily Pantagraph

Founded January 14, 1837 by Jesse W. Fell *Published Continuously Since 1846*

LORING MERWIN, *President and Publisher* DAVIS U. MERWIN, *Associate Publisher*

H. CLAY TATE, *Editor* CHARLES J. DRIVER, *Managing Editor*

Bloomington, Illinois, Saturday, July 2, 1966

By the Pantagraph

Medicare Should Get Fair Public Appraisal

To the committed enthusiast, July 1 was the dawning of a new era of health and happiness for the aged.

To the die-hard opponent, July 1 was the signal for socialistic chaos and the opening chapter of the decay of medical science in America.

Medicare has been so greeted by both extremes.

In fact, it is neither a panacea nor a poison.

On the eve of its effective date, Richard Nixon, once vice president of the United States, could mount the platform at an American Medical Association convention and say, to enthusiastic applause:

"I want a doctor who is working for me, not one who is working for the government."

Later in the session AMA delegates washed their hands of any claim forms connected with Medicare. Patients will be billed directly.

So it is clear that acceptance of Medicare is far from complete on the part of the medical profession and those who have no inclination to join the Great Society.

As part of the rearguard action, Americans have been warned, in recent months, to anticipate slavering hordes of elderly persons descending upon doctors and hospitals in high dudgeon, demanding medication and surgery with only the most tenuous of reasons—that it's free.

Overnight, we are to believe, the elderly have cast aside a facet of their personality that medical men have sought to adjust for many years. That is, the basic reluctance of many of the elderly to seek medical advice even when it's clearly indicated.

Because of Medicare, then, will it be a misdemeanor for the elderly with one of the "seven danger signals" to be curious enough to ask a doctor if cancer is present?

And are we also to believe that hypochondria exists only in those elderly who now will be able to afford a trip to the hospital?

Doctors' offices already are crowded (if we are to believe their own journals) with men and women of moderate years and adequate means who suffer from little more than imaginary diseases.

Will the elderly be more inclined to misuse the medical arts and sciences than their juniors? We think not.

Now doctors we know are not ogres; quite the contrary, they're a pretty good bunch of fellows and competent to boot.

But if they've ever made a bum diagnosis (and even the best doctor should be allowed a few), it's of Medicare. The misjudgment is best put in the words of Dr. James Z. Appel, retiring president of the AMA:

"The health care of the people is no longer a personal matter between the patient and the physician. It is now a political issue, the merits of which will not be determined solely on scientific grounds, but also on vote getting appeal, by individuals not at all well informed on quality health care."

This statement was made by a qualified medical scientist who ruled on the evidence of Medicare before the first experiment was conducted.

The medical profession has it in its power to make Medicare fail. If it is misbegotten, they cannot make it a success. Most doctors have indicated they'll give it a fair trial.

Dr. Appel's position cannot be justified on the evidence now on hand. We would expect the medical profession to oppose broadening of the Medicare base. But we also would expect them to offer valid evidence of its failure. This evidence can be gained only by experience.

This newspaper supported Medicare as a reasonable partial answer to the cost of medical care for the aged. Six months from now you may read in this column that Medicare is a failure.

But we will not join the crepe hangers until we see the corpse.

The News-Gazette - July 1, 1966
Champaign, Ill.

Hospitals Asking Medicare Patients To Bring Card

By A. TOWNSEND BARLOW
News-Gazette Staff Writer

If you are over 65 years of age and must go to the hospital for an operation or other treatment, do take your new Medicare card with you, hospital administrators plead.

"They are entitled to Medicare benefits to pay, in part, their care, according to the rules stated at considerable length in the brochure the government sent those over 65. But for the hospital to get paid by Medicare rather than personal payment by the patient, we must see their card."

Of over 25 patients over 65 in one hospital, only half had brought their red, white and blue decorated card with their number, one admissions director said Friday morning, the opening day for Medicare benefits.

Only six patients out of 55 over 65 in one C-U hospital had their Medicare card, another administrator said.

"Now we must get their numbers from the Social Security office."

Some Already In

At another local hospital, they had 33 patients over 65 on June 30, and four more were scheduled for July 1 entrance for operations and treatment, with part of their bills from now on being paid under the Medicare law.

"It is too soon to make a judgment as to how the already crowded situation in our hospitals will soon be if everyone over 65 decides to come in at once," one hospital administrator said.

"People should remember that we still have to look after the population under 65, too!" he said.

Help is one of the major difficulties being faced by the local hospitals, with the more skilled workers especially needed. Some of the hospitals have been giving added training to those who previously served as nurses' aide, but not all the hospitals have training programs.

At some of the hospitals, they have already added additional workers in the business offices to take care of the necessary paper work the new system entails.

Add 9,000 Workers

And a report from Washington said 9,000 additional workers had been added in the Social Security offices to assist in answering questions and help with the reports on which payments will be based.

So besides the payments being made from the U.S. Treasury for hospitalization and other benefits, the addition of the 9,000 workers alone at an average salary of $5,000 will approximate $45,000,000 during Medicare's first year.

But don't lose or misplace that card which came to those over 65. Carry it with you at all times, the Social Securtiy administration urges.

"May I just say we are busy, busy, busy this morning answering phone queries and questions people bring to us in person," Tommy Franklin of the area SS office said. "But that's what we are for, to help, and we are glad to assist any who do not understand just how the system works. It is spelled out in detail in the brochure sent out to all eligible to participate.

William Guy Cole Thought First One

William Guy Cole, 74, St. Joseph, entered Mercy Hospital, Urbana, early Friday Morning, and is thought to be the first one to enter one at the five local hospitals after the July 1 start of Medicare available to all U.S. citizens over 65.

Those over 65 presently in the hospitals will have the balance of their hospital bills from July 1 cared for after the first $40 deductible is taken from the amount the government will owe.

Uncle Sam, Physician, Surgeon, Hospital

Uncle Sam will enter a new role July 1 when the nation-wide plan to care for 19 million or more people who are 65 or over and are eligible for free—well, almost free—hospital care.

Without much serious planning except to adopt the plan in a congressional year, Uncle Sam enters a new, costly and experimental role in which the health and care of millions of people become of serious concern to government, physicians, and surgeons and hospitals.

It will be interesting to see what happens in a nation where our hospitals now are jammed and inadequate to meet the needs and challenges of an expanding population.

More facilities will of necessity need to be provided and our present medical facilities as well as hospital and nursing homes are doing all they can to cope with a serious situation.

With such help being provided at a very small cost to 19 million people, it is reasonable to assume that many will take advantage of the situation and a few may abuse the privilege.

People are living longer, and with modern science this will increase in a nation where many people are dedicated to the problem of helping and saving people from the ravages of terrible disease and sickness.

Medicare is an interesting change in the American scene, and it is hoped that it will do everything for our citizens that its sponsors hoped to accomplish.

ARCHBOLD BUCKEYE

WEDNESDAY, JUNE 29, 1966

First Prizes in Five National Newspaper Contests: 1934—N.E.A. General Excellence
1934—N.E.A. Newspaper Production
1935—University of Illinois
1936—N.E.A. General Excellence
1944—N.E.A. National First in Editorial Page
Member Casey's '31 All-American Weeklies
Ohio's Best Weekly Newspaper 1930-'31-'32
1940—Ohio's Award "General Excellence"
1941—Ohio's "Advertising Composition"
1941—Ohio's "Local Illustrative Art"

Member: National Editorial Association
Ohio Newspaper Assn.; Buckeye Press Assn.

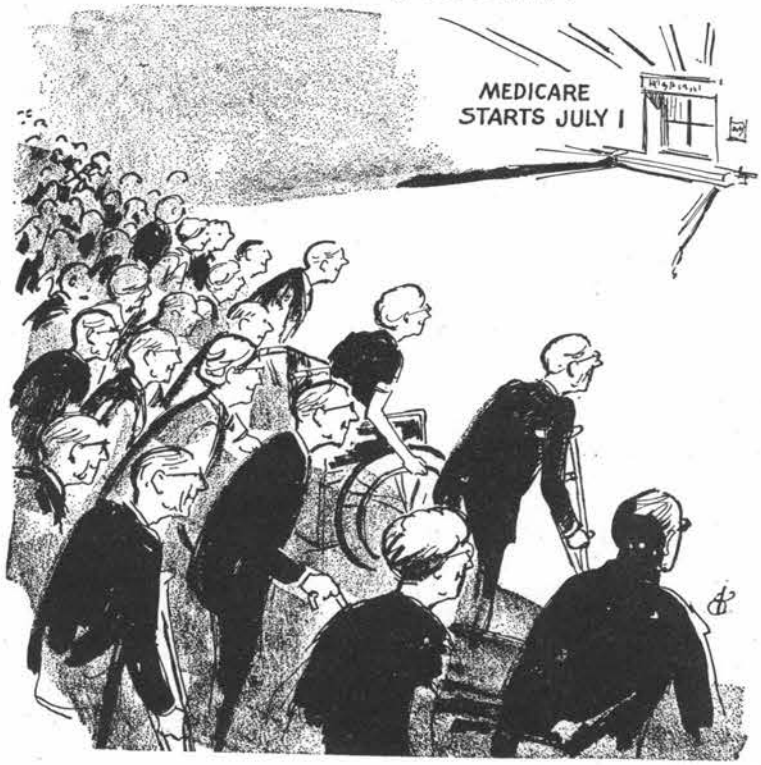
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On Your Mark, Get Set . . .



OHIO

July 1, 1966

A PAGE OF OPINION

The Dispatch

AN INDEPENDENT NEWSPAPER FOUNDED JULY 1, 1871—EVENING AND SUNDAY

Nation Poised for a View Of Medicare in Operation

MEDICARE, the nation's most controversial experiment in socialized health care, becomes a part of our way of life today. The nation's anticipation has been marked by a mixture of emotions, by hopeful expectation on the part of the eligible citizens and by various degrees of misgiving on the part of others who question our ability to support so comprehensive a program.

BY NOW all persons eligible for Medicare coverage have received a brochure from the government explaining how the system works. This does not guarantee that they all understand the operation completely.

For those who come under the program benefits it suffices to know what Medicare will do for them. For the others the question of how Medicare is to be made workable remains.

A QUESTION arises on whether our present hospital capacity can handle the increased burden of Medicare patients. The number of doctors in ratio to the rising population has fallen off sharply in recent years. Educators see the need of 20 new medical schools if the need is to be met.

There are supporters of Medicare who contend the feared rush of patients will not approach the taxing numbers first expected.

THE MEDICAL profession, at first militantly arrayed against what it maintained was the socialization of health care and hospitalization, has become somewhat more resigned to the idea as this opening day was approaching. A guarded optimism is sensed in some areas where there was an initial resistance to the Medicare concept.

While an uncertainty over Medicare's practicability persists, the experiment gets under way today with at least a sporting chance to prove itself.

Those of our ailing and indigent aged who may find a respite from sickness under Medicare are the first beneficiaries. This is the plus factor in Medicare with which all can find a common accord.

Ohio

THE CANTON REPOSITORY

For 151 Years a Dependable Institution

Published Daily and Sunday
Brush-Moore Newspapers, Inc.

Founded March 30, 1815
Member Associated Press

Sunday, July 3, 1966 Page 6

We Need The Doctors

Medical doctors were given a choice in medicare legislation between billing their patients, or billing the agents handling medicare payments.

There was a good reason for this. Doctors did not want their fees to be regulated. That would have been the essence of the "socialization" they accused backers of medicare of foisting on them.

It stood to reason that administrators of federal medicare funds could not tolerate wide differences in medical fees between individual doctors, or between geographic areas. The charge for the same medical procedure would have to be regularized under medicare the same as it is regularized now under private insurance coverage.

Private insurers, fortunately, have broken the trail for medicare in many directions, including direct billing. They have shown it is feasible to reimburse insurance beneficiaries for doctor bills submitted directly to patients. There is nothing new about it.

They also have revealed the tendency of doctors to use established fee schedules when making out their bills. They are not barred from charging more or less than the schedules, but being thoughtful of their patients' situation they charge what they feel will be acceptable.

In this and all other facets of this momentous move to compensate for improvements in medical skill that keep people alive longer and changes in modern industrialism that put them out of work when they reach a certain age, medical doctors are entitled to sympathetic understanding.

The greatest boon they could have at this sensitive juncture in the progress of their profession from an optional private service to a scientifically accredited public necessity is relief from paper work.

We need them for the practice of medicine. They should be freed from the practice of filling in quintiplicate forms.

DEPARTMENT OF
HEALTH, EDUCATION, AND WELFARE

PRESS CLIPPING LABEL

No. 52-417
East Liverpool D/O

Symbol

Paper The Salem News

Place Salem, Ohio

Date 7/1/66

Form HEW-123

A Goat Named 'Medicare'

Criticism of medicare already is under way and gaining momentum as the July 1 deadline arrives.

It is going to be an interesting thing to watch and listen to the critics in months to come.

Medicare is destined to be the scapegoat for all the problems of docter-patient-hospital relationships.

To hear its critics unburden themselves, hospitals never were overcrowded before, doctors never were overburdened and patients never had trouble paying bills and fees for the high cost of sickness.

The high cost of sickness wasn't a pressing problem, to hear the critics of medicare tell about it. People unable to meet it were entitled to unlimited free service,, or drew on relief funds. People able to meet it without a struggle were charged all the traffic would bear and never murmured. All others paid for the high cost of illness catch as catch can. Being wiped out by a dependent's lingering illness was part of the American way of life.

Men and women over 65 and living in forced retirement on fixed incomes had no problems, and if they did have problems their families underwrote their bills.

All in all, to hear the critics of medicare tell about it, everything was going fine until July 1, 1966—then everything turned sour.

Fortunately, critics of medicare are a minority.

Many were critics of pre-paid hospital care and medical costs when these now commonplace procedures were regarded as revolutionary.

It is unfortunate — this tendency to turn a controversial idea into a scapegoat. But is fundamental human nature to do it, and it will happen to medicare.

There will be times in the months ahead when critics of medicare will make it sound as if no problems existed before July 1, 1966. If they're not careful, they will make it sound as if sickness was unknown before medicare went into effect.

DEPARTMENT OF
HEALTH, EDUCATION, AND WELFARE

PRESS CLIPPING LABEL

THE PLAIN DEALER, FRIDAY, JULY 1, 1966

No. Cleveland Metro Chic

Symbol | SSA

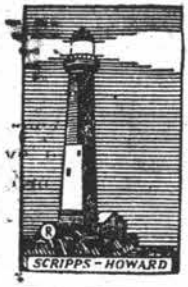
Paper Cleveland Plain Dealer

Place Cleveland Ohio

Date 7-1-66



GIVE LIGHT AND THE PEOPLE WILL FIND THEIR OWN WAY



The Cleveland Press

A Scripps-Howard Newspaper

THOMAS L. BOARDMAN, Editor GEORGE E. CARTER, Business Manager

Net Paid Circulation for Six Months Ending April 1, 1966

OHIO'S LARGEST DAILY NEWSPAPER 379,673

Friday, July 1, 1966 PAGE A 16

Don't Abuse Medicare

For the first time, starting today, the Federal Government will help pay hospital, doctor and other health bills for a large segment of the civilian population as a matter of right rather than need.

More than 19 million Americans past 65 are eligible for Medicare benefits.

The bill for Medicare will be a big one for the taxpayers to bear. Including benefits which states may extend to the medically indigent, cost of the Medicare package may exceed $4,000,000,000 in the first year. The cost is certain to keep rising as more and more people live longer and longer.

To keep Medicare's costs from soaring wholly out of reach, self-discipline will be essential.

Beneficiaries must refrain from seeking needless medical and hospital attention. Their families must refrain from encouraging older folks to use high-cost health facilities on the slightest pretext.

Doctors must refrain from sending patients unnecessarily to hospitals, ordering expensive tests not really required, prescribing needless drugs, performing unwarranted surgery, holding patients in hospitals longer than sound medical judgment dictates.

The will to make the program work must be supplied by all—the administrators of the law, the providers of the services, the beneficiaries of the program, and the taxpayers who supply most of the money.

●

The medical profession and the public are fortunate that a Cleveland doctor, Charles L. Hudson, has assumed the presidency of the American Medical Assn.

His term of office becomes a testing ground for Medicare. What Dr. Hudson does and says will be counted, criticized and consequential.

Already some extremist physicians have accused him of appeasement because this reasonable man feels it necessary for doctors to cooperate with Medicare, much as it may displease them.

Dr. Hudson's philosophy seems to be based on a primary concern for sick people, and only secondarily on concern for the medical profession. He displays courage and responsibility.

DEPARTMENT OF
HEALTH, EDUCATION, AND WELFARE

PRESS CLIPPING LABEL

No. Cleveland
South, Ohio

Symbol
SSA

Paper
Cleveland Plain
Dealer

Place
Cleveland Ohio

Date 6-30 '66



"I SUPPOSE THERE ARE TIMES WHEN WE MUST GO ALONG WITH THE INEVITABLE."

DEPARTMENT OF
HEALTH, EDUCATION, AND WELFARE

PRESS CLIPPING LABEL

No. Cleveland Downtown Ohio

Symbol
OSA

Paper The Plain Dealer

Place Cleveland Ohio

Date 7-1-66

Form HEW-123

the small society



THE PLAIN DEALER

Ohio's Largest Morning and Sunday Newspaper

HERMAN L. VAIL,
President

F. WILLIAM DUGAN,
Vice President and General Manager

THOMAS VAIL,
Publisher and Editor

PHILIP W. PORTER,
Executive Editor

Daily 376,813 Net paid circulation for six months ending March 31, 1966 Sunday 532,626

As filed with the Audit Bureau of Circulation, subject to audit

Page 18 Cleveland Ohio Monday, June 27, 1966

Friday, M-Day for Nation's Elderly

A little more than two decades ago, Nov. 19, 1945, the Wagner-Murray-Dingell bill embodying a proposal by President Harry S. Truman that costs of medical care for everyone be financed by the federal government was introduced in Congress. It failed.

On Friday, July 1, government health insurance becomes an operating law of the land.

Known familiarly as Medicare, it will apply only to a portion of the people, those over 65. It will have two divisions, one for hospitalization and nursing home care (the latter isn't effective until Jan. 1, 1967) and one for medical expense. It will be administered by the Social Security Administration.

As the country embarks on this new voyage into the field of social services, the watchword is "patience" and the slogan should be "wait and see."

No one can forecast accurately the impact of a gigantic health service program affecting an estimated 20 million people.

But the consensus of Social Security and private insurance experts—at least in the Greater Cleveland area—is that the physical inconvenience, the overcrowding of hospitals, will be less than originally expected.

Bugs in the administration at the outset understandably could be in the paper work operations although Blue Cross of Northeastern Ohio and Social Security leaders here have been working diligently with doctors, nurses, receptionists, hospital and insurance company personnel to straighten out possible bottlenecks.

For the first time in history, Social Security will be making payments to vendors (hospitals, doctors) on a large scale instead of paying the beneficiary directly.

Some confusion, therefore, will be expected from these sources:

- Doctor bills. Doctors have the option of billing patients directly or accepting an assignment of payment from a designated agent (Blue Cross for instance) and agreeing to a "reasonable cost, or charge" for the specific service set up usually by a local academy of medicine.
- Deductibles. Medicare carries specific deductible amounts to be assumed by the patient.
- Difference to a small degree in private health insurance company policies.

After considerable apprehension at the time, Medicare was approved by Congress. Now doctors, medical and hospital associations and private health insurance companies have seen fit to cooperate; at least there has been no overt expression of intended mass rebellion.

Insurance companies, Blue Cross is a good example, have tailored policies for people 65-and-over to fill in the financial chinks left by Medicare's two-part outline.

On Friday the great American experiment in compulsory health insurance at age 65 will open with an understandable feeling of cautious optimism and some uncertainty.

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Start Of New Era Of Medical Care

TODAY MARKS the beginning of a new era in medical care for the aged—the advent of medicare.

It is part of a new alliance for health that is taking shape to provide the nation's elder citizens more years, happier years and fuller years of life.

The other part of the alliance is the nation's hospital system, providers of the finest care in the world.

Now all our aged will be able to receive the excellent care developed in our hospitals since the close of World War II.

At the same time, this alliance for health removes from the shoulders of today's younger generation the burden that extensive illnesses of older family members can be. As President Johnson said in signing the medicare law:

"No longer will young families see their incomes, and their hopes eaten away simply because they are carrying out their deep moral obligations."

Today is indeed a significant day in the history of providing better and better medical care to the American people.

Paper BEMIDJI DAILY PIONEER

Place Bemidji, Minn.

Date 7/1/66

The Daily Pioneer

OPINION PAGE

Nothing Is Free

As the government and the medical profession seek to discharge their duties to older people under the medicare law, everyone should be reminded again and again that there is no such thing as a "free" service. Nothing in this world is free and nothing new has been created under medicare. By law, the taxpayers are paying some of the medical bills of a selected group of people. As time goes on, the law may be revised to include the care of other age groups. Medicare may eventually be extended until it becomes a national health service such as was adopted in Britain nearly 18 years ago.

The British plan of government medical care which was to provide free service to all is threatened with a disastrous breakdown. A British Medical Association reports that, "Unless vast new sums of money are made available — from some source or another — the present concept of a hospital service must be abandoned. . . . Half of the nation's hospitals are more than 80 years old, and only two new general hospitals have been built since 1939. The British Medical Association report concludes: 'If the public wishes to have an unrestricted health service, it must be prepared to pay for it. . . .'"

The medical profession in the United States is going to do everything possible to facilitate the operation of medicare. It will do its utmost to preserve the all-important, doctor-patient relationship that is so vital to the high medical standards to which we have become accustomed. It is the obligation of the people, all of us, to remember that medicare does not mean "free" medical care. The more that is demanded in the way of service from hospitals and doctors, the more it is going to cost unless we wish to end up with a bankrupt medical system as Great Britain appears to have done.

St. Paul Pioneer Press Fri., July 1, 1966

Editorials

A Sick Program

Vice-President Humphrey said last month that the federal government is moving into uncharted trails with its war on poverty and that "some things we try will not work out."

Indications are that the Job Corps has reached this stage and is in dire need of radical surgery or euthanasia.

The Job Corps program is eneffective and expensive, according to the Office of Economic Opportunity's own statistics.

The cost per trainee as reported by OEO is a ridiculously high $9,430—more than enough money to send a student through Harvard.

Furthermore, more than 25 per cent of the trainees drop out before they complete their training and less than half of the graduates are placed in jobs.

This failure has been recognized by the OEO and members of Congress and some changes will undoubtedly be made.

Unfortunately, most of the changes so far proposed will do little toward fulfilling the purpose of the program — to provide deprived youths with basic education, vocational training, and useful work experience which will prepare them to enter the civilian job market.

The OEO is tightening its entrance requirements by upgrading physical, mental or moral standards. It also proposes eliminating some duplications in training programs and plans to put trainees closer to their homes.

These changes would reduce the cost of training. They also would result in a significant reduction of the dropout rate and greater placement success.

But on the other hand, these changes will virtually exclude the youths for which the program was designed — the "hard core" products of generations of poverty in the slums of Harlem, Watts and Chicago.

It seems that the trainees who would remain after the OEO-proposed changes could just as well be trained in existing academic and vocational schools.

Medicare---It's Here

Now that medicare is in effect, after many years of bitter controversy, it probably will be found not quite as perfect as many expected, and not as bad as some opponents predicted. It will take a considerable shakedown period to get the administrative machinery running smoothly and to iron out the difficulties sure to arise in connection with such a far-reaching program.

Medicare is the law of the land, and as such deserves a fair trial and the cooperation of all those affected, including the medical profession. Obstructionism at this point would be unwise and unjustified.

Dr. Charles L. Hudson, new president of the American Medical association, assured his colleagues at the AMA house of delegates meeting in Chicago that doomsday is not at hand for the doctors. Most physicians will find their practice unchanged under medicare, he said, adding that it would be "wasteful of our professional energy to belabor the past."

The advice of Dr. Hudson and other moderates did not govern the Chicago meeting, however. Upsetting the recommendations of an AMA committee that had studied the matter, the delegates urged doctors to collect fees directly from their over-65 medicare patients instead of from the payment agencies designated by the Social Security administration. This would force the patients to collect from the government.

Such a course of action is not recommended by Social Security administrators, although it would be legal. It would be unpopular with many patients. It also might boomerang on the medical profession because direct billing would permit higher fee charges than could be collected from the government, and this could bring public reaction demanding more and tighter federal regulations.

Dr. Hudson warned of such a possibility when he told the delegates that emotional opposition to medicare might lead to far greater government controls, which is what the profession desires to avoid.

Medicare is now a fact of life for Americans. As experience is gained, weaknesses may be revealed and changes may be indicated. For the present, the plan deserves responsible attitudes from the beneficiaries and from all others involved.

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Medicare Real Blessing for Nation's Elderly

It took 31 years and many battles, but medicare—a massive program of medical care for America's 19 million senior citizens—finally went into effect Friday.

It was a long time coming. The principle of compulsory national health insurance was endorsed by a presidential commission in 1935, the year the social security act was born.

But the idea had to weather all these years of congressional debate and bitter opposition of physicians who have viewed the program as a step toward socialized medicine.

Medicare is the most important expansion of social security since the law was passed and it ushers in, for this country, a virtual revolution in medical and hospital administration.

It is more modest than revolutionary, however, in comparison with the health programs of other major governments. Britain's, for example. The national health service in that country does not pay those who provide the health services, as medicare does, but provides the services directly.

No one can forecast how great a burden medicare will place on this country's medical resources, personnel and hospitals. In fact, it may take several years to determine the full impact of the legislation.

Some fear hospital crowding. Most existing institutions, including 178 Wisconsin hospitals, have been certified for participation by the government.

One stumbling block in the offing is the stubborn determination of some doctors to impede rather than help the program which they opposed so long. Some patients will suffer hardships by being billed directly by their doctors, as was recommended the other day by the American Medical association. The law permits a physician to send his bills directly to his patients, requiring them to recover allowable costs from the government. This could result in problems for those with limited funds and could cost several hundred dollars more in doctor bills borne by the patient alone.

By direct billing doctors can charge as much as they think they can get. But patients, in turn, can collect from the government only what the private insurers consider "reasonable charges." The rest would come out of their own pockets.

The newly elected head of the AMA plans to go further than insistence upon direct billing. He says he will refuse to tell any patient the patient's rights under medicare—but will send him to the social security office. Further, if the patient wants indirect billing he will "send him down the hall" to another doctor. Such refusal to co-operate in a vital program is inhumane and unconscionable. Such hardheaded bucking of the program will hurt those who need help the most.

Medicare is, as President Johnson said Friday, a blessing. But he warned: "The program is not just a blessing for older Americans. It is a test for all Americans—a test of our willingness to work together."

Indiana

THE HAMMOND TIMES

Friday, July 1, 1966

TIMES WASHINGTON REPORT

Medicare's Impact Unknown Quantity

WASHINGTON — Medicare is ushering in a virtual revolution in medicine and hospital administration in the United States. The full effects may not be realized for several years.

The burden that will be placed upon hospitals is still a matter of conjecture.

Medicare comes, really, in two parts. The part that pays hospital



Richard Spong

bills is available without charge, starting today, to nearly everyone aged 65 or more.

The second part covers doctors bills and some other medical expenses for people 65 and more. This optional protection, which also starts today, costs $3 a month per person.

The Social Security administration as of June 3 had processed applications of 17,337,000 oldsters for the voluntary coverage. This service, incidentally, has the deductible feature familiar to most health insurance plans. Benefits start after the patient has paid $50 of his own money.

Still another service begins on Jan. 1, 1967. Medicare will then provide funds for up to 100 days in an extended care facility like a nursing home in each illness after a hospital stay of at least three days.

THE FEAR is widespread that the nation's medical, nursing, and hospital disciplines just won't be able to accommodate the upsurge of older persons seeking help under Medicare. This could cause political disturbances. Old people who have been told that their ills will be taken care of could be awfully cold to tales of doctor, nurse, and hospital bed shortages.

The Johnson administration already shivers at the memory of 1946, when voters who couldn't get meat expressed their indignation very pragmatically at the polls.

On the other hand, California, which implemented the federal Medicare program with special state legislation put into effect last April 1, reports no great hospital crush.

Dr. Ralph C. Teall, president of the California Medical Association, on April 27 said that the state's first month of experience with Medicare appeared to refute predictions that hospitals would become clogged when the program went into effect nationally.

"We should have seen a tremendous pressure on hospitals during the past month," Dr. Teall said, "but the pressure has been only relatively minor."

At the same time, Dr. Philip D. Bonnet, president of the American Hospital Association, predicted a "bulge" of about 5 per cent of new patients when Medicare became a reality. Dr. Teall said he believed that there would be a gradual decline rather than an increase in the number of hospitalized persons after the 5 per cent bulge.

IN ANY EVENT, a shortage of medical specialists already pinches, regardless of the pressures, however debatable, of Medicare. The Federal Nurses Training Act of 1964 is aimed at assuring a 1970 total of 680,000 registered nurses even though the Surgeon General's Consultant Group had forecast a need for at least 850,000 professional nurses by that time.

The ratio of physicians to civilian population has fast deteriorated in recent years. We should be turning out about 11,000 doctors of medicine a year, but we are falling far short of that number. In 1961 the dean of the Yale Medical School, Dr. Vernon M. Lippard, calculated that our needs could be met only by "the establishment of at least 20 new schools of medicine during the 1960s."

It's Hard To Tell From the Shadow–



Hospitals Here Report Quiet Start for Medicare

Medicare has arrived at Greater Cleveland hospitals without causing a ripple in admission volume, hospital authorities reported today.

This reflected the situation reported nationally: "It's business as usual."

There had been some fear expressed that the beginning of Medicare would bring a flood of hospital admissions of persons 65 or older who had been postponing treatment until the plan was in operation.

In Cleveland, as in the nation, part of the slow start is attributed to the fact that Medicare's inauguration day coincided with the beginning of the long July Fourth weekend.

"On holidays, everybody goes home who can go home, and nobody comes in until after the holiday is over," a Cleveland Clinic official said.

Officials questioned about what they expect Tuesday said that indications are that there will certainly be no flood of Medicare applicants for admission.

"AS WE HAVE ANALYZED the situation in our studies, we believe a very large portion of the Medicare age group in this area already has some sort of hospital protection," said Charles K. Arter Jr., president of St. Luke's Hospital.

"I think about 84% of that group has some sort of third party insurance. Overall, we think that only about 7% of the Medicare group would have had to pay their hospital bills themselves."

Arter said that there probably were other areas in the nation, where Blue Cross coverage was not so near complete as here, where Medicare will bring a gradual increase in hospital admissions.

"But we noticed nothing unusual at St. Luke's yesterday," Arter said. "We had about 60 patients already in the hospital who were shifted over to Medicare."

ADMISSIONS YESTERDAY at University Hospitals followed a "normal pattern," a hospital spokesman said. Yesterday's admissions were 34. Last Friday they were 24, but the Friday before that they were 35.

As for the clinics of University Hospitals, yesterday's 240 visits compared with a normal daily total of about 400. Of yesterday's 240 clinic visits, 44 were Medicare patients.

"That is about the usual percentage for that age group," the spokesman said.

"OUR STUDIES INDICATE we may have an over-all increase of hospital admissions of about 10%—but it will be a year before we can be certain of that.

"Most of this age group in the Cleveland area has been having hospital service. For a long time we have been underwriting care for a lot of these people now in Medicare."

Nationally, Social Security Administrator Robert M. Ball, the man in charge of the new health coverage for 19,000,000 Americans over 65, said a government check of 100 hospitals showed admissions running at normal rates.

There were 160,000 elderly Americans already hospitalized when Medicare went into effect at 12:01 a. m. Friday.

Next AMA President Has Skill, Sense

By WILLIAM J. CONWAY
Associated Press

CHICAGO (AP)—Dr. Milford O. Rouse combines professional skill with sharp business sense.

He made that clear in his first news conference since his selection as the president-elect of the American Medical Association (AMA).

He said he prefers, under Medicare, to give the 65-or-over patient an itemized account which the patient can take care of himself. Then the patient will be reimbursed, he said, under the new insurance system for the elderly.

"I'm not your insurance broker," he said in capsuling his attitude yesterday. "I'm your doctor. I'm trying to help you."

Dr. Rouse said he won't try to block Medicare.

But, he said, "I can see no way to do it (handle Medicare) except on a basis of direct billing."

Dr. Rouse is 63. He's of medium height, balding and tanned and has a rather slim silhouette.

"How do you keep so trim?" an interviewer inquired.

"I'm a gastroenterologist," he replied with a smile.

Careful of What He Eats

The implication, apparently, is that a doctor whose specialty includes the stomach and digestive tract is careful about what he eats.

Dr. Rouse dresses conservatively and wears spectacles rimmed in white gold. He speaks softly and a bit faster than a Texas drawl.

He was born in Jacksonville, Tex., son of a Baptist minister, teacher and author. He went to high school in Vernon and once worked for a newspaper there, the Vernon Record.

Baylor University

Dr. Rouse earned his M.D. at Baylor University in 1927 and went into practice in Dallas, Tex., a year later.

He will be installed as the AMA's 122nd president next June at the annual convention in Atlantic City.

But he long has been a familiar and influential figure in the organization of doctors. He has been a member of the policy-making house of delegates since 1953 and speaker since 1963.

Practical Conservative

AMA spokesmen say he is known as a "practical conservative." He is a member of the American Association of Physicians and Surgeons, a group that has been strongly opposed to Medicare.

Does he think physicians should run for public office, as had been suggested by speakers early in the AMA convention?

"In time they will," he said.

Increase Fees?

Dr. Rouse also was asked if many doctors will increase their fees in the medicare era.

"I don't think so," he replied.

"I'm going to charge what I charge now," he added.

He said no interest would be charged note signers unless a bill had been unpaid for 90 days.

Compliment to Work

Dr. Rouse termed the increasing number of elderly citizens "a compliment to our work."

He expressed the opinion that the average citizen over 65 has no conception of the Medicare law and the operation of the detailed law will give some of them "a rude awakening."

Rouse makes a hobby of taking movies. He is a deacon and a teacher of a men's Bible class at the Lakeside Baptist Church of Dallas.

He and his wife, the former Leaureame McDavid, a Baylor classmate, have one daughter, Mrs. Curtis L. Sawyer of Fort Smith, Ark.

Questions About Medicare Answered

JULY 1st 1966

WASHINGTON (AP)—Here are answers to some of the questions most frequently asked about the Medicare system, starting today for all 19 million Americans 65 and older:

Q. If the hospital I choose is overcrowded, does Medicare guarantee me a bed?

A. No. Medicare just helps pay the bill.

Q. If I have to go back into the hospital two or more times, do I pay the $40 "deductible" each time?

A. No. You pay just the first $40 of hospital charges in each "spell of illness."

Q. What's a "spell of illness."

A. To Medicare it's a period of time, not an ailment. It starts the day you enter a hospital. It ends 60 days after your discharge from the hospital (or from a nursing home—after next Jan. 1, Medicare will provide posthospital convalescent care in nursing homes for those needing it.)

Q. Suppose I go back to the hospital for a different sickness?

A. To Medicare it doesn't matter. It's all one "spell of illness" if the new admission comes within 60 days of the last discharge.

Q. What if I'm sent back later than 60 days from the discharge.

A. Then it's a new "spell of illness," with a new $40 charge and a whole new set of benefits—full coverage by Medicare for the first 60 days of hospitalization, then all but $10 a day for the next 30 days.

Q. Do I have to go back to the same hospital?

A. No. Your benefits follow you from hospital to hospital and from city to city. Just show your red-white-and-blue card. Any participating hospital can tell instantly, by teletype check to a computer in Baltimore, whether or not you have used up all your "benefit days."

Q. Suppose that I decide, when recovering from an operation, to use up my full benefits by staying in the hospital for some additional days of bed-rest. Does Medicare cover the extra days?

A. No. You must be sick to get Medicare benefits. You can enter a hospital and remain there only at the doctor's say so.

Q. Couldn't the doctor be persuaded to let me stay on, as a Medicare beneficiary?

A. He might give in to persuasion or pressure. But under Medicare rules, every hospital must have a "utilization review" committee controlling the use of beds. The committee can overrule doctors and order the discharge of patients who are able to go home or into nursing homes.

Q. If I'm in a hospital when Medicare starts, does Medicare pick up the bill?

A. Not for past days. Medicare picks up as of July 1, and you'll still have to pay the $40 deductible as well as the charges for the days preceding Medicare.

Q. I've signed up to pay $3 a month for the voluntary doctor-bill insurance. It has a $50 deductible; how often do I have to pay that?

A. Just once each year, regardless of how much your doctor bills add up to in a year.

Q. Should I cancel my old health insurance policy?

A. If you are 65 but your wife is not, she's not covered by Medicare. You may want to keep her policy in force.

Q. We are both over 65. Should we buy the "supplemental" plans offered to over-65 persons by Blue Cross, Blue Shield and other private insurers for additional protection?

A. That depends on your own needs and inclinations. Some policies are designed to cover Medicare's "deductibles" and provide benefits beyond the limits of Medicare. Another type of policy pays off in cash benefits for each day of hospitalization; the money could be used for the inevitable costs of an illness, or for "extras," such as a bedside telephone or a private room instead of the semiprivate accommodations paid for by Medicare.

Q. Medicare's doctor-bill insurance covers 80 per cent of a doctor's "reasonable charges," after the $50 deductible. Does the doctor send his bill to Medicare or to me?

A. Either one. He can send it to Medicare's local "intermediary" agency — in most cities, the local Blue Shield organization — which will pay him 80 per cent of what it deems a "reasonable charge" for his treatment or operation; the other 20 per cent would come from you. Or he could send the whole bill directly to you.

Q. In the latter case what do I do?

A. Pay it, then apply for reimbursement to the "intermediary."

Q. Which is the likeliest method?

A. Judging by statements at last week's meeting in Chicago of the American Medical Assn., most doctors will want to bill the patient directly.

Q. Will that cost me more?

A. It could. The doctor would not be bound by any "reasonable charge" limitation. He could charge any amount he felt entitled to. When you've paid his bill and applied for reimbursement, you get back only 80 per cent of the "reasonable charge," regardless of the actual size of the bill.

Q. Are medical costs going up?

A. They have been, regardless of Medicare, and may believe they will climb faster. President Johnson has appealed to the profession to resist "growing pressure toward higher prices for hospital and medical services." And a White House spokesman said this week: "The President feels sure doctors will not drive a hard bargain with needy patients by demanding direct, immediate reimbursement."

AMA Ignores Antitrust Suits; Urges Boycott of Some Hospitals

CHICAGO (UPI)—The American Medical Association (AMA) ignored the possibility of federal antitrust suits Thursday and urged boycotts of hospitals that didn't allow doctors to bill patients separately.

The AMA's stormy 115th annual convention came to a close on the eve of perhaps the biggest change ever to hit the U.S. medical profession, the advent of Medicare.

The AMA's new president, Charles L. Hudson of Cleveland, asked the AMA's policy-making house of delegates to reconsider its resolution calling for the boycotts which it passed Wednesday. A debate flared after Hudson warned that the AMA might be risking a federal antitrust suit.

Avert Costly Litigation

Joseph B. Copeland of Austin, Tex., a member of the AMA Board of Trustees, asked reconsideration to avert costly litigation.

The AMA is "getting about two suits a week" and a $19 million suit now is pending against the group, he said.

'Gentlemen, there are many people who want you wiped out as an organization," he said.

Stand Behind Resolution

Wendell G. Scott, a delegate from St. Louis, replied, "we should stand behind our resolution. It was made after ample debate.

"How long, oh Lord, how long will it be before this house makes its own decisions?"

In another action on the last of the five days of convention deliberation, the house resolved that doctors do not have to sign affidavits to prove that they are practicing in accordance with the civil rights act in Medicare matters.

* * *

Dr. Donald R. Hayes, chairman of a house reference committee, said such signed statements are not necessary under federally assisted programs.

Unacceptable

Further, he said, such a requirement 'is unacceptable to physicians who have traditionally treated patients regardless of color, creed or national origin.'

* * *

Expansion of other similar, government-finance programs was predicted by Hudson.

"New federal programs will continue to be born and will be left like foundlings on the doorstep of American medicine for sustenance and upbringing," Hudson said.

* * *

Milder Stand

The new AMA head repeatedly has taken a milder stand on Medicare than many house of delegates members. In a speech before the body Thursday, he recommended that the AMA take a position of leadership in the program.

The house acted on a number of other resolutions Thursday, including approval of a rise in AMA dues from $45 to $70, a program for sending medical aid to Viet Nam and strict control of drugs such as LSD.

The South Bend Tribune, Friday, July 1, 1966

4 ADMITTED TO HOSPITALS

Medicare Program Starts on Quiet Note

Medicare made its debut today apparently without any great rush on Northern Indiana hospitals.

Business managers and administrators of hospitals certified under the program, which offers nearly free hospitalization to persons 65 or over, generally made the same observations:

—No immediate influx expected of patients 65 or older.

—Mountains of paperwork involved transferring the elderly already in the hospital to the Medicare program.

—Virtually no waiting lists of applicants eligible under Medicare.

3 Admit Patients

Only three hospitals surveyed this morning reported Medicare patients admitted after midnight Thursday.

One patient each was admitted to St. Joseph's Hospital, Mishawaka, and the Murphy Medical Center, Warsaw, and two to Woodlawn Hospital at Rochester.

At Memorial Hospital, South Bend, officials noted that about 30 per cent of the present patients are eligible under the Medicare program. The hospital currently has been operating at about 98 per cent of total occupancy in the medical and surgical departments, according to Richard W. Trenkner, hospital administrator.

Although no great influx of elderly patients is anticipated immediately, Trenkner said that the next week or two probably would be more indicative of any trend.

Increase in Surgery

There was some evidence, he pointed out, of an increase in surgery anong the elderly preceding the onset of Medicare, apparently with the thought among the elderly being to "avoid any jam."

At the present time, the paperwork appears to be the heaviest load under Medicare, according to Trenkner.

St. Joseph's Hospital, Mishawaka, reports 12 patients under Medicare including the one patient admitted after midnight Thursday.

Hospital officials said they anticipate no immediate influx of elderly patients. As of the end of May, about 16.7 per cent of the total hospital occupancy represented patients 65 or over.

Heavy Paperwork Load

Officials at the Mishawaka hospital also cited paperwork and administrative procedures as the immediate heaviest load under Medicare.

Hugo Erickson, business manager for South Bend Osteopathic Hospital, reports 12 patients eligible for Medicare, none having been admitted after midnight Thursday.

He said that the hospital may experience an increase in the elderly patient load after the holiday weekend. Normally, the hospital census is down during holidays and comes back up after the holiday, he explained.

The hospital is prepared to handle, clerically, an elderly patient load of 12-15 per cent of total occupancy without adding any additional personnel, said Erickson, noting that if the load increases to 20 per cent, additional personnel will be needed to keep records and file claims.

Recertify Patients

Part of the paperwork involves the recertification of elderly patients after the first 14 days, and then every seven days up to a maximum of 60 days, he explained.

Officials at St. Joseph's Hospital, South Bend, declined to comment on Medicare until the release could come through the office of the hospital administrator.

The South Bend Tribune, Friday, July 1, 1966

Medicare Goes Into Effect For 19 Million Older Citizens

Other stories on pages 4, 5, 17 and 21

WASHINGTON (AP) — The Medicare program providing hospital insurance for all 19 million of the nation's senior citizens went into effect today, hailed by President Johnson as "a blessing for older Americans."

Swinging into operation with the program was an optional doctor-bill insurance plan for which 17.3 million elected to pay $3 a month.

The two programs were brought into being at 12:01 a.m. in one of the biggest operations in medical history.

Doctors and patients reserved any prognosis, but the President pronounced it a success in advance. He called it "a test of our willingness to work together."

By Public Health Service count, 6,714 intitutions, or 91 per cent of all the country's 7,374 general hospitals with roughly 93 per cent of the beds, opened their doors for the insured care of any American aged 65 or over.

Rule on Emergencies

The nonparticipating hospitals were mainly in the South. Most were barred from Medicare payments by their failure to comply with the no-racial-discrimination provisions of the Civil Rights Act.

To make extra sure that no one dies for want of access to a participating hospital, the government ruled last night that federal hospitals — veterans', military and others — may be used for critically ill Medicare patients in emergencies.

Previously it had been announced that any other nonparticipating hospital could be used, private or public, with Medicare picking up the bill, if a bed in a participating hospital could not be found to avert the threat of death "or serious impairment of the health."

Administration aides were jubilant over the generally high participation.

"We've done far better in the South than we had dared to hope a month or two ago," one Public Health Service official said.

Sees More Joining Plan

"And more hospitals will be desegregating when they begin to feel the pressure from unhappy local residents, both white and black," he added.

Twenty-three states entered Medicare with 100 per cent participation by their qualified hospitals, and some others came close to that.

In his Medicare-eve statement, President Johnson said he had no doubt of the success of the twin Medicare programs if these three things happen:

—"If hospitals accept their responsibility under the law not to discriminate against any patient because of race."

—"If doctors treat their patients with fairness and compassion. I feel sure that most doctors do not plan to drive hard bargains with needy patients."

—"If old patients co-operate in scheduling treatment and do not demand unnecessary hospital and medical services . . ."

He concluded: "I have no doubt for the future. I believe that July 1, 1966, marks a new day of freedom for our people."

The government has poohpoohed forecasts that a tide of elderly patients will swamp the hospitals.

The states which already had 100 per cent certification of hospitals for compliance as of midnight were Alaska, Arizona, Colorado, Connecticut, Hawaii, Idaho, Indiana, Iowa, Maine, Maryland, Massachusetts, Minnesota, Montana, Nebraska, Nevada, New Hampshire, New Jersey, North Dakota, Oregon, Rhode Island, South Dakota, Vermont

Continued on Page 3

LBJ PRAISES MEDICARE PLAN

19 Million Citizens Eligible for Aid In Hospitals

Continued from Page 1

and Wyoming. The territories of Guam, Samoa and the Virgin Islands also had full participation.

Mississippi Lags

At the other end of the scale were Mississippi with 33 of 133 hospitals certified for rights compliance, South Carolina with 46 out of 93, Louisiana with 78 out of 144 and Georgia with 107 out of 176.

Florida had 159 complying out of 188, Virginia 84 out of 119, North Carolina 138 out of 166 and Tennessee 138 out of 163.

If nonparticipating hospitals are used for emergency patients social security director Robert M. Ball has ruled, Medicare will pay such a hospital only for the period of emergency, but not for any care given after it becomes possible to discharge the patient or transfer him to a participating hospital.

And if an emergency admission to a federal government hospital is sought, Ball said, the decision is up to the medical officer in charge and is subject to the availability of beds.

Resolution Prompted

The presidential appeal to doctors not to "drive hard bargains with needy patients" apparently was prompted by a resolution passed Tuesday by the policymakers of the American Medical Assn. The AMA recommended that doctors should bill patients directly for services under Medicare.

This would permit doctors to set their charges at any amount they choose, leaving it to the patient to seek reimbursement from the government's Medicare "intermediary" agency — in most cases, the local Blue Shield plan. The "intermediary" would reimburse for only 80 per cent of what it considers a "reasonable charge" for the treatment given. The patient would have to absorb the difference, however large.

If, on the other hand, the doctor has sent his bill to the "intermediary" for payment, his compensation would be limited. He would get his 80 per cent of the specified reasonable charge, and could collect no more than the other 20 per cent from the patient.

The Milwaukee Journal

Medicare's Start Smooth in Nation, Officials Find

Baltimore, Md. — AP — Government officials operating the new medicare program said Friday that it started nationwide, without a major hitch, with no big rush to hospitals by elderly citizens.

The surgeon general Dr. William Stewart, said the plan to provide health care for the elderly made "an auspicious start."

"The fact that some hundreds of hospitals in reply to medicare requirements have now changed their practices and policies is particularly heartening," he said.

"It effectively demonstrates the desire of the American people to eliminate discrimination because of race, color or national origin from hospital and medical practice."

Social security Commisioner Robert M. Ball, sharing a news conference with Dr. Stewart in hailing the advent of medicare, reported that 6,600 hospitals had applied for participation in medicare and met the quality standards.

Some Not Cleared

"However, 327 of these institutions have not yet been cleared by the public health service as meeting the nondiscriminatory standards of the civil rights act," he said.

Dr. Stewart and Ball told newsmen that about 94% of the nation's general hospitals were qualified to participate in medicare. These included 95.9% of all the general hospital beds in the country.

Most of the holdouts or unqualified are in the south, they said. But Ball said he expected a "great forward movement in those areas in July."

Ball said a nation-wide telephone survey of 100 hospitals showed medicare "having little or no effect on hospital admissions or overcrowding."

No Stampede Reported

He said the random survey showed no stampede toward hospitals by 65 and over citizens who might have postponed treatment until after the start of medicare.

Only 10 of the 100 hospitals were filled, he said, "and none attribute overcrowding to new medicare admittances."

Asked about an American Medical association resolution calling on doctors to bill medicare patients directly, instead of through the medicare program, Ball said he anticipated no great problem.

"I would hope that doctors would use discretion when dealing with older people who might have difficulty in figuring these things out or who might have difficulty in meeting a particular bill at a particular time," he said.

Milwaukee Journal 7/1/66

He'll Fight Medicare, '67 AMA Head Vows

Milwaukee Journal
July 1, 1966

Journal Staff Correspondence

Chicago, Ill.—Dr. Milford O. Rouse, Dallas, Tex., the new president-elect of the American Medical association, made it clear Thursday afternoon that he would co-operate with medicare as little as possible. Medicare began Friday.

At a press conference, Dr. Rouse said he intended to bill patients directly, just as he does now. If a medicare patient should insist on his taking an assignment of the customary and reasonable fee from the government, Dr. Rouse said, he would ask the patient to seek care from another doctor.

Under the medicare's medical insurance program (part B), the doctor is permitted to bill directly or accept the patient's assignment. In the latter case, the doctor is paid by an insurance firm acting as agent for the social security administration.

Dr. Rouse's remarks were made at the end of the 115th annual meeting of the AMA, which earlier adopted a resolution urging all its members to restrict their participation in medicare to direct billing.

Spurns "Interpreter" Role

Dr. Rouse said he would leave it to his business manager to arrange with patients how they will pay what he charges.

"Why should I take my time serving as a collector, insurance broker or interpreter of this complicated law to them (the patients)?" Dr. Rouse said.

He said that the average citizen over 65 had "no conception of the medicare law" and thought that medical care would be "handed to him on a platter."

"He's going to have a rude awakening," Dr. Rouse said.

He said he wanted to make it clear to patients that this was not the fault of doctors. He said when they expressed confusion he would have to say:

"I'm not your collector or your insurance broker, I'm your doctor."

Dr. Rouse said that his business manager would not explain medicare to patients, either. The business manager will say, "I'm not your social security representative. You'd better see him," Dr. Rouse said.

In answer to a question, Dr. Rouse said the business manager did not explain now when patients asked about Blue Shield benefits, but referred them to the company or agency that provided the medical insurance.

Dr. Rouse said he never consulted with Blue Shield about customary and reasonable fees. He said he saw no reason to raise his fees.

Dr. Rouse said that instead of providing federal funds to finance medical care, the government should have undertaken an educational program designed to overcome what he called "the ignorance and apathy" of the public on health.

This, he said, would have motivated people needing care to seek it from private doctors. Such a program would have won the immediate approval of the AMA, Dr. Rouse said.

President a Moderate

Dr. Rouse, 63, is a specialist in digestive tract diseases. He is a member of the Association of American Physicians and Surgeons, which advocated nonparticipation in medicare.

Both the incoming AMA president, Dr. Charles L. Hudson, Cleveland, and the outgoing president, Dr. James Z. Appel, Lancaster, Pa., are moderates in their attitude toward medicare, urging doctors to co-operate to make the program work.

In a talk to the AMA Thursday, Dr. Hudson said this about medicare:

"We have been handed a challenge that is unlike any we have faced before. We must be tireless in our efforts to meet it, and meet it well, for the ultimate benefit of our profession and—more importantly—for the ultimate benefit of the patients we serve. . . ."

Before adjourning, the AMA's house of delegates voted overwhelmingly against reconsidering action taken the day before to back radiologists in their campaign to bill patients directly, instead of accepting a percentage of hospital radiology department receipts.

The delegates had voted to make it unethical for one radiologist to serve a hospital that displaced another radiologist because he demanded to bill patients directly.

In voting against reconsideration, the delegates ignored pleas by both Dr. Hudson and Dr. Gerald D. Dorman, New York city, a member of the board of trustees.

Dr. Dorman said the radiology resolution put the AMA "in a pretty risky spot" as far as antitrust suits were concerned.

OSHKOSH DAILY NORTHWESTERN
OSHKOSH, WISCONSIN
July 1, 1966

Historic Date

This is an historic date. Medicare begins on July 1, 1966. It is a program extending limited medical and hospital benefits to Americans who are over 65 years old. The scope of the program is not yet fully known. Proponents and opponents still express differing opinions.

Of the more than 195 million Americans, about one of every 11 will be eligible for Medicare benefits. Approximately 32 per cent of all families have an older person in need of medical attention. It has been said that more than half of these families are financially unable to provide the care needed.

Details of how Medicare will operate have been repeated a number of times. Still there will be questions. The demands to be made on the medical profession and on hospitals are not yet known. A plea to all physicians to cooperate fully to make the program work for the benefit of older persons has been voiced by Dr. Charles L. Hudson, incoming president of the American Medical Association.

Nearly a year ago (July 30, 1965), President Johnson signed the Medicare bill into law. He said then: "No longer will older Americans be denied the healing miracle of modern medicine." It will require the wise and responsible cooperation of physicians and those eligible for its benefits to make Medicare work.

Janesville Daily Gazette
Janesville, Wisconsin
July 2, 1966

Restraint, Cooperation

The heavy machinery of medicare is at long last getting into ponderous operation. President Johnson has made an appeal to prospective patients, to the medical-hospital organization and to citizens to cooperate. He noted that the spirit of restraint is needed—in demands for service, in charges and in acceptance of regulations.

It will be remarkable indeed if a program so revolutionary, so vast in scale and touching upon such delicately personal problems can be launched without massive troubles. The question is hardly whether there will be troubles, but rather the scale of them.

The beginning of medicare is the beginning of an era in more ways than one. Its friends see it as the means of bringing to the aged and aging the standards of medical care unavailable to most of them in the past.

Beyond that, however, it is also the beginning of a tremendous new field for taxing; the possibility of radical changes in traditional doctor - patient relationships; the impetus for possible far-reaching expansion in training of medical personnel, federal intervention in hospital construction, management, etc. and effects impossible to predict in the insurance industry.

One thing appears certain. That is, medicare as every other government program, will float on a sea of paper. There will be more blanks and forms and reports than can be counted, and everyone connected with the plan may well be resigned to standing in line, compiling endless records and submitting to the drudgery of official routine. It is a price inevitably paid in government programs, but will be especially irksome in a field where shortages of professional personnel exist and in which there is no cushion for lost time.

The Sheboygan Press

Sheboygan, Wis., Friday, July 1, 1966
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A Commendable Attitude

With the controversial Medicare law going into effect today, it is gratifying to note that the leadership of the important and influential American Medical Association —both retiring and newly installed presidents—are taking the new measure in stride and have pledged their cooperation. That kind of help is essential or a well-intentioned law might very well come to chaos and ruination.

Dr. Charles L. Hudson, 61, a Cleveland, Ohio, internist, is the new president of the organization. He pledged "a course of action, not a course of supine acceptance or of unproductive criticism." And, for the pessimistic, he added that while some were forecasting "doom on Thursday midnight, others, like myself, feel that is not a justified opinion." He elaborated as follows:

"With the advent of the government's health care program, we are not stepping off the brink into a bottomless pit of professional destruction and despair, but we are entering a new period in which we shall see some new problems develop and existing ones compounded." Already the AMA has encouraged its members to bill patients directly rather than through Medicare's administrative channels.

Naturally, as in the case with anything new, certain serious problems will arise in the administration of the law simply because of possible defects in the law itself. Hospitals in Mississippi and other southern segregation diehards already are boycotting Medicare, and, no doubt, some unalterably opposed physicians will continue to ignore it.

Few laws are perfect at the time of their inception. But, in this instance, who could be better qualified to rectify any mistakes and suggest improvements than the medical profession? For that reason, the present attitude of the AMA leadership is indeed encouraging for the future success of a measure to aid our ailing aged that has been long overdue.



Milwaukee Journal
July 1, 1966



Mrs. Milan Pudjak, 79, of 2575 N. 34th st., was helped into St. Joseph's hospital by her husband and by Sister Mary Jeanne, hospital administrator, as she arrived for an outpatient examination. She was the first patient admitted to the hospial after the official start of the medicare program Friday morning. —Journal Photo

No Stampede to Hospitals Marks Start of Medicare

Milwaukee hospital administrators anticipate neither a flood of elderly patients nor a major change in the cost of care as a result of medicare's beginning Friday, a spot check indicated.

Immediate effects of the new insurance program were obviously being cushioned by the holiday weekend — nobody wants to start an optional hospital stay at such a time—but most hospitals reported that their advance registrations also were near normal for the season.

The administrators expressed more fear of the increased paper work the government program will demand than of the possible increase in patients. Most hospitals said they had empty beds and were ready to care for anybody who needed them.

William Claypool, administrator of West Allis Memorial hospital and president of the Hospital Council of Greater Milwaukee, said:

"We're going to meet our obligation to society. We're going to take care of these people. But we really can't predict what the effects on hospital costs will be or even what will happen to the patient load over a long period."



Claypool



Knisely

On Friday morning, the 220 bed West Allis hospital was 80% occupied, Claypool said. It had 24 patients who went on medicare at midnight.

Claypol said that at a recent staff meeting doctors had been asked informally whether they had patients awaiting the advent of medicare before entering hospitals.

He said a third of the doctors had none waiting, a third had fewer than five patients waiting and a third had more than five. Not all planned to take their patients to West Allis Memorial—many doctors are on several hospital staffs.

If the percentage of older patients rises with the passing of time, hospital costs will increase, Claypool said.

One problem the hospitals face is that they do not know what medicare payments they will receive, he said.

The hospital will bill the government, which will pay according to a "cost reimbursable formula" which has not yet been established.

Still to be worked out is the amount of paper work which will be done by individual hospitals and the amount to be done by Blue Cross, the medicare administration contractor.

The administrators agreed that hospital costs would rise in the coming months, but were unable to say how much medicare might contribute to the rise.

S. K. Hummel, Columbia hos-

Turn to page 10, column 5

No Stampede Marks Start of Medicare

From page 1, column 8

pitail administrator, said bills had been going up 7 or 8% a year, and that as long as wages continued to rise the trend could not be halted. He said wages accounted for 65% of the cost of hospitalization.

Hospital employes are to come under minimum wage laws in February. Hummel said hospitals had to compete in the labor market now, and that the law would have minor effects. Columbia's 270 beds were occupied Friday morning, 70 of them by patients over 65, he said. Normally about 20% of the patients are in that age bracket, he said.

"We have no avalanche of reservations," he said.

Walter Harden, administrator of Doctors hospital, was the only source reached Friday who foresaw an increase in admissions resulting from medicare.

On Friday, the 150 bed hospital was 93% occupied, he said. There were 24 medicare patients.

He said preadmissions for next week were heavier than usual, and that a waiting list probably would be started on Wednesday or Thursday.

Elective Surgery

"This is mostly a result of elective surgery in patients of the medicare age group," he said. He estimated that the patient load would level out 7 to 12% above last year's as a result of the new insurance program.

Lutheran hospital's 311 patients Friday included about 50 in the medicare age bracket, said Neil Rittershaus, assistant director. The hospital was about 80% occupied.

"We don't anticipate any great immediate increase," he said.

Rittershaus said staff dectors had the impression that major medicare impact might fall on the outpatient department, but that there was no indication of it Friday.

Worry Over Increases

Merton Knisely, administrator of St. Luke's hospital, said 77 of about 400 patients there had gone on medicare at midnight.

He expressed worry over cost increases.

"There appears to me to be the factor that medicare is not going to cover all the expenses. We know of no alternative ex-

Area Hospitals Handle Medicare OK

Milwaukee Journal July 1, 1966

It was M day for Milwaukee area hospitals Friday as the first of the medicare patients trickled in.

There was no rush by the elderly who are now eligible for benefits under the health insurance amendment to the social security act.

In fact, as of Friday afternoon there were fewer than 100 medicare patients admitted, hospital officials reported.

However, the total number of patients 65 and over in area hospitals when the clock passed midnight Thursday totaled 841, according to a spokesman for the Hospital Council of Greater Milwaukee Area. This figure plus those medicare patients admitted during the day brought the total to around 920, the spokesman said.

Of the total number of patients in the 18 hospitals that are council members 24%, as of Friday afternoon, were under the medicare program. This percentage of elderly is about normal for this time of year, officials said.

Up to noon Friday, 80% of the beds in the 18 hospitals were occupied.

While there was no rush, medicare had an impact on the administration and clerical departments of hospitals.

"The paper work has been fantastic," said a spokesman for Mount Sinai hospital. "It quadrupled, at least, and will continue to multiply."

He said there was no question that more clerical help will have to be added to the hospital's staff.

About 10 medicare patients were admitted to the hospital during the day, bringing the total number of 65 and over patients to about 70. Ten more were treated in the outpatient department.

He said that Mount Sinai's surgery schedule was heavy, with a two week waiting period for elective procedures. The spokesman said, however, that he did not know if the load could be attributed to medicare.

It was clear to several hospital officials that most medicare patients had little understanding of the medicare program.

Sister Mary Paschalisa, administrator of St. Francis hospital, said that of the 42 medicare patients — plus two who were admitted during the day — most had only a vague idea of their benefits. She said that some did not have their claim numbers with them and had to call relatives. Others, the nun said, did not think they had received numbers.

St. Francis had a 74% occupancy rate in the 267 bed hospital Friday. 16% were medicare patients, Sister Paschalisa said.

Although July is usually considered a slow month for surgery, she said that 14 medicare patients had been scheduled for elective surgery Tuesday, about 15% above normal.

She and other administrators said that most patients who must be hospitalized at this time of year wait until after the holidays.

Of the 23 medicare patients at Misericordia hospital, "all had to be notified of the $40 deductible," said Sister Marie Albert, administrator.

The basic program—part A, or the hospital insurance program—provides up to 60 days of hospital care, with the patient paying the first $40. If additional hospital treatment is needed, the patient must pay $10 a day, and medicare will cover the rest of the cost for another 30 days.

Doctors' bills are included in part B of the program.

Sister Albert also mentioned that the hospital's accounting and admitting departments may have to add personnel to handle the expected increase in medicare patients.

Of the 388 beds at Lutheran hospital, 63 were filled with medicare patients, reported assistant administrator Earl A. Schiefelbein. The hospital had a total of 230 patients Friday, or about 85% of capacity, he said.

He said that three of the medicare patients were admitted as of noon Friday. The rest had been there as of midnight, he said.

At Doctors hospital 150 of its 160 beds were occupied, 27 of them under the medicare program, said Walter Harden, administrator. When the medicare program went into effect, 23 patients were put under the federally funded insurance. Only four were admitted after noon Friday, he said.

Harden said 30% of the hospital's surgery schedule would be covered by medicare and, he said, he expected this percentage to continue through the middle of September.

"We expect a waiting list to develop Wednesday or Thursday of next week," he said. "Due to advance registrations our schedules are running about 20% ahead of normal expectations."

William Claypool, administrator of West Allis Memorial hospital, said that while the normal elderly patient load was 12% of the hospital's census, as of Friday afternoon those over 65 totaled 17%.

The hospital had a total of 27 medicare patients, three being admitted during the day.

"This is certainly proof that everyone did not wait until July 1 to be admitted to a hospital," he said.

He said he expected hospital costs to rise because studies on treatment of the elderly show that it costs more to treat them.

"They take longer to register, longer to discharge, longer to prepare for surgery and longer to feed," Claypool said. "This all adds up to higher costs."

The story here appeared to be similar to that reported across the nation—no rush, but lots of book work.

"An auspicious start," commented the United States surgeon general, William H. Stewart.

Stewart and Robert M. Ball, social security administrator estimated that 94% of the nation's general hospitals, representing 95.9% of the beds, were prepared and qualified to participate in medicare.

The totals given by Ball and Stewart were a bit higher than those from other federal offices, but all sources agreed on this:

Hospital participation was far broader, especially in the south, than authorities had dared to hope for a month or two ago.

Most of the several hundred southern hospitals outside the program had failed to comply with the no-racial-discrimination provisions of the civil rights act. They are therefore ineligible for federal payments under medicare or any other federal program.

Free Press
Mankato, Minn.
July 2, 1966

Hospitals in City Report No Big Rush

Mankato hospitals reported today there has been no rush of persons over 65 waving their Medicare cards and seeking hospital care since the new federal health care program went into effect at 12:01 a. m. Friday.

According to spokesmen at St. Joseph's hospital, only three persons over 65 were admitted Friday, and one today, which they term is a normal number.

Immanuel hospital admitted no persons over 65 Friday, according to Robert Smith, assistant administrator.

Smith said "I suspect any rush we might have will be on Tuesday, because people generally stay out of the hospital over the 4th of July if they can."

Immanuel has enough beds available Tuesday to handle a "reasonable surge," he said.

St. Joseph's administrators do not expect a Tuesday rush. They said doctors usually call in for beds a few days in advance for their patients, and that there are no indications of an elderly surge for Tuesday.

Not Certified

Comfrey Hospital Can't Give Medicare Service

COMFREY — Medicare service will not be available at Comfrey's eight-bed hospital, Mrs. Karen Amdahl, administrator, said today.

"We weren't certified because we need an entirely new physical plant," she explained. "The examiners felt our present one was inadequate."

The hospital had been told by state authorities that unless an improvement in facilities is shown by Jan. 1, 1967, its license may not be renewed.

Presently the community is planning a fund drive to raise the $186,000 necessary for the new facility.

The patients will be housed in the new building. The present structure will be used for office space and storage.

"We feel the hospital provides the necessary services to the community. We will just have to refer persons who want Medicare to other hospitals," Mrs. Andahl stated.

At a recent public meeting 125 persons voted to continue the hospital. Five voted against it.

Pledges totaling $100,000 have been received toward the hospital.

"We are confident we can raise the money," Ervin Richter, publisher of the Comfrey Times, and member of the drive said. "The people here are enthusiastic about it. We will do everything in our power to get it."

The SUN-PRESS

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30 PAGES—TWO SECTIONS ...STAGE ...AND, OHIO JUNE 30, 1966

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AMA Chief Says Cleveland Ready to Handle Medicare

Enough Doctors, Too Few Nurses for Area Needs

By AL ORRICK

Cleveland area hospital officials and doctors need not reach for the panic button, in spite of widespread predictions that Medicare, starting tomorrow, will produce an overwhelming torrent of elderly patients.

This is the opinion of Dr. Charles L. Hudson of Beachwood, new president of the American Medical Association.



DR. CHARLES L. HUDSON

"I honestly believe it is futile to speculate on increased demands for services," said Dr. Hudson in a telephone interview from Chicago where he is atte ing the AMA convention.

While forecasts that ...dical facilities will be swamped may be fulfilled elsewhere, the ...veland area has several factors in its favor, Dr. Hudson suggests.

Blue Cross Helps

One of these is reportedly widespread local coverage under Blue Cross and private insurance of persons who have now signed up for Medicare. These patients or potential patients merely would be adopting a new method of payment.

"If this is the case, then there won't be a large number of people newly thrown onto medical service facilities," Dr. Hudson said.

Dr. Hudson also believes the Cleveland area is relatively well-supplied with physicians to handle any additional burden of patients resulting from Medicare.

As an outstanding medical university center, he said, the city tends to draw physicians, in contrast to some other areas lacking equivalent facilities for practice, research and study.

In another respect, however, he acknowledges that Cleveland shares one handicap with other cities.

Shortage of Nurses

This is a shortage of nurses.

But he sees a cure for this through supplementing the nursing corps with more special trainees.

"My approach," he said, "is to see what services of all kinds are needed and get people specially trained to perform these, that is, provide various gradations of training in nursing."

Turning to another aspect of Medicare's onset, Dr. Hudson upheld direct billing of Medicare patients.

This has been a subject of controversy at the AMA convention.

The Medicare law provides that the doctor may bill a patient directly and let the patient get reimbursement from the government, or the doctor may himself apply to the government for his fee.

The Sun-Press
June 30, 1966

Advocacy of direct billing has been equated with opposition to Medicare by some observers at the AMA convention. Dr. Hudson, who has philosophically accepted Medicare although not endorsing it, puts the case for direct billing as being "legal, ethical and most consistent with past practices."

'Revolt' Exaggerated

He was nettled by some published reports of a "revolt' against his leadership because of his stand on Medicare, which some physicians were reported to consider "appeasement" of Medicare officials.

Dr. Hudson admitted there are differences of opinion on the AMA's proper position on Medicare, but said calling opposition to his stand a "revolt" was a wild exaggeration.

Although he had opposed government medical programs, once Medicare was enacted Dr. Hudson was one of the first to accept an invitation to go to Washington to try to improve relations between the AMA and the government.

The Beachwood physician, recently featured on the cover of Modern Medicine, said in a statement to that leading medical journal:

"I do not fear contamination by association with those whose philosophies I do not embrace; rather, I believe it is important to be present if possible whenever decisions are being made.

"Our job is to act in good faith as a strong, independent organization and see to it that the quality of medical care remains high and that medical practice is disturbed as little as possible.

"We must assure the people that we, who know the medical field best, are looking after their welfare as medicine becomes increasingly complex."

Dr. Hudson, 61, who lives at 3333 Belvoir Blvd., is associate professor of medicine at Cleveland Clinic.

Born in Merrill, Mich., he was the son of a general practitioner. He has been president of county and state medical societies and member of many AMA committees and commissions.

COLUMBUS DISPATCH 7/1/66 FRONT PAGE

LBJ Hails Medicare As Program Begins

WASHINGTON (AP) — The massive Medicare program providing hospital insurance for all 19 million of the nation's senior citizens went into effect Friday, hailed by President Johnson as "a blessing for older Americans."

Swinging into operation with the program was an optional doctor-bill insurance plan for which 17.3 million elected to pay $3 a month.

THE TWO programs were brought into being at 12:01 a.m. in one of the biggest operations in medical history.

Doctors and patients reserved any prognosis, but the President pronounced it a success in advance. He called it "a test of our willingness to work together."

By Public Health Service count, 6714 institutions — or 91 per cent of all the country's 7374 general hospitals with roughly 93 per cent of the beds—opened their doors for the insured care of any American aged 65 or over.

THE NONPARTICIPATING hospitals were mainly in the South. Most were barred from Medicare payments by their failure to comply with the no-racial-discrimination provisions of the Civil Rights Act.

To make extra sure that no one dies for want of access to a participating hospital, the government ruled Thursday night that federal hospitals—veterans', military and others—may be used for critically ill Medicare patients in emergencies.

Previously it had been announced that any other nonparticipating hospital could be used—private or public, with Medicare picking up the bill—if a bed in a participating hospital could not be found to avert the threat of death "or serious impairment of the health.

DESPITE THE serious gaps in participation—only 25 per cent of Mississippi hospitals were in the pool—administration aides were jubilant over the generally high participation nationwide.

"We've done far better in the South than we had dared to hope a month or two ago," one Public Health Service official said.

"AND MORE hospitals will be desegregating when they begin to feel the pressure from unhappy local residents, both white and black," he added.

Twenty-three states entered Medicare with 100 per cent participation by their qualified hospitals, and some others came close to that.

IN HIS Medicare's-eve statement, President Johnson said he had no doubt of the success of the twin Medicare programs if these three things happen:

- "If hospitals accept their responsibility under the law not to discriminate against any patient because of race."
- "If doctors treat their patients with fairness and compassion. I feel sure that most doctors do not plan to drive hard bargains with needy patients."
- If old patients cooperate in scheduling treatment and do not demand unnecessary hospital and medical services . . ."

HE CONCLUDED: "I have no doubt for the future. I believe that July 1, 1966, marks a new day of freedom for our people."

The government has debunked forecasts that a tide of elderly patients will swamp the hospitals. Hospital administrators generally agree that there will be some difficult local situations but that they can handle the expected average increase of not more than 5 per cent in the patient load.

This judgment was reinforced as each recent day brought scores of new hospitals into compliance. Officials expect that many more will meet both the medical care standards and the civil rights test during July.



NO MAD RUSH—Medicare dawned in Columbus and across the nation Friday and as expected, there was no mad rush here by the elderly to hospital beds. The big ailment: headaches of administrators filling out voluminous forms necessitated by the new plan. Mrs. Basil Stafford, 1021 Carlisle Ave., a nurse at Riverside Hospital, assists John F. Oldfield, 68, of 28 Orchard Lane, with form filling. He already was a hospital patient before Medicare went into effect. Hospital administrators reported the inauguration smooth and with no onslaught of patients. "We were confident there would be no big rush, because people here have been receiving hospital care," one summed it up. (Dispatch Photo)

Cleveland Plain Dealer, Cleveland, Ohio
July 1, 1966

Medicare to Use Space-Age Aids

A network of telegraph lines and a vast system of computers are awaiting the signal for the start of the Medicare program Friday.

Arrangements for the new program of health insurance for the aged are just about complete, said Albert W. Boehringer, Social Security district manager in downtown Cleveland, at a press conference yesterday.

Use of the space-age electronic equipment will expedite handling and payment of claims.

"All steps possible have been taken to insure a smooth start," Boehringer told representatives of the Academy of Medicine of Cleveland, hospitals, Blue Cross and Blue Shield and the communications media.

INDICATIONS ARE that all hospitals in the Cleveland area, with a total of some 7,500 beds, will be certified as eligible to participate in Medicare.

"Admitting a Medicare beneficiary will be much like admitting a patient covered by Blue Cross or a private health insurance policy," Boehringer said. The patient will be asked to show the health insurance identification card sent to him in the mail.

All physicians in the area have received copies of the Physician's Reference Guide and copies of the Medicare handbook.

In Cuyahoga County, about 175,000 persons are eligible for the medical insurance benefits under Social Security.

FIRST CLAIMS for payment under the voluntary medical insurance plan are not expected until at least next week.

Medicare claim services for railroaders will be provided by the Travelers Insurance Co. through its seven claims offices in Ohio — in Cleveland at 1422 Euclid Avenue.

An expanded office force will have at its disposal the facilities of the largest data processing center in the insurance business; according to Richard Custer of the Cleveland office. The center is located in Hartford, Conn., the company's home office.

"Under normal circumstances, a check will be in the mail to a beneficiary or his assignee within 24 hours after the claim has been processed at one of our local offices," Custer said.

Cleveland Press
Cleveland, Ohio
July 1, 1966

First Patient of Medicare Had Waited for This Day

The arrival of Mrs. Dorothy Guest, 65, at Euclid-Glenville Hospital today marked the start of a new era in health care for the elderly.

Mrs. Guest was admitted as Cleveland's first Medicare patient.

Medicare is the new U. S. health insurance program which, beginning today, is expected to benefit about 19,000,000 older Americans, including 190,000 Greater Clevelanders who are 65 or older.

Mrs. Guest's two sisters, who accompanied her to the hospital, described Medicare as a blessing for her.

MRS. GUEST, a widow with no children, obtains her only income from roomers in her home at 37929 Third St., Willoughby. Previously she had no hospital insurance.

"She has been very ill for about a month," said Mrs. Nellie Banfield and Mrs. Jeanette Worrallo, also of Willuoghby.

"The Aid for Aged office said they would have to put a lien on her home to pay the hospital bill and she wouldn't do this.

"WE TOLD HER if she could just hold out until July 1 for Medicare, she would be all right."

Meanwhile Mrs. Guest enrolled in Blue Cross-Blue Shield which supplement the federal health program.

Although some, like Mrs. Guest, may have postponed their hospital entry until Medicare began, Jay Collins, hospital director, said:

"We are not expecting any big surge of admissions from older people," he said. "But the government forms, and the accounting and record-keeping, will put a bigger load on our office staff."

Mrs. Guest's physician, Dr. Michael Matteo, said he probably would send his bill directly to her, rather than to Medical Mutual which is the agency here for Medicare's Plan B covering physicians' services.

Direct billing is the official policy of the American Medical Assn.



FIRST MEDICARE PATIENT Mrs. Dorothy Guest, 65, entered Euclid-Glenville Hospital today. Shown with her are nurse Mrs. Helen Margheret, Dr. Michael Matteo, her physician, and Jay Collins, hospital director.

Cleveland Press
Cleveland, Ohio
June 29, 1966

AMA Chief Predicts Success in the Start of Medicare

By ED SEITZ
Press Medical Writer

CHICAGO—Dr. Charles L. Hudson of Cleveland, new president of the American Medical Assn., predicted here today that Medicare will get off to a smooth start at midnight tomorrow.

Pleased at the warm reception given his inaugural speech late yesterday, Dr. Hudson said he is confident that the nation's doctors will learn to live with Medicare.

But he warned that elderly persons themselves may upset the Medicare applecart in their eagerness to claim benefits.

"Elderly people should not flock to hospitals just because government financing has made it convenient for them," the Cleveland Clinic internal medicine specialist said.

"MEDICARE CALLS FOR responsibility not only on the part of physicians but also on the part of the people."

Dr. Hudson did not touch on direct billing in his inaugural speech. But he said today that he is not opposed to having doctors accept reimbursement from the Government, although he favors direct billing of most Medicare patients.

The AMA's policy making house of delegates is expected to approve, late today or at the convention's final session tomorrow, some form of Individual Responsibility Program.

SIMPLY DEFINED, IRP means that it is the doctor's responsibility to provide good medical care and the patient's responsibility to pay for it.

But in practice IRP would mean that Medicare patients—and perhaps all patients—would have to deal with the Government or a private health insurance company to obtain benefits.

Dr Hudson said he favors some form of IRP in principle, but does not believe that all or even most of the nation's physicians will apply it strictly in their office practices.

IN THE PALMER HOUSE'S packed and festive Grand Ballroom, he outlined this four-point course of action for AMA leaders and members.

DEMONSTRATE the competency of private medical practice to perform all necessary technical, professional and administrative services.

ARREST the trend toward dependency on government, especially for health care.

ENCOURAGE the Government to stimulate and support private enterprise, but to stop undertaking operational and directorial duties.

COOPERATE with government agencies, but act as a free, strong, independent group.

He said he will discuss his proposal in detail before the house of delegates tomorrow.

THE PLAIN DEALER
CLEVELAND, SUNDAY MORNING, JUNE 26, 1966



AID FOR THE AGED. Mrs. Mary Silver, a therapist, left, and Ken Perry, an orderly, help Mrs. Minnie Fisher walk on parallel bars in the physical therapy unit at Mount Sinai Hospital.

Photo by Richard J. Misch

The Medifact Guide

The following analysis of Medicare benefits and services not covered by Medicare was prepared by the American Society of Internal Medicine.

PART A–Hospital Insurance Benefits

HOSPITAL BENEFITS (BEGIN FRIDAY)

Medicare Pays

(1) Up to 90 days of care in a semiprivate accommodation (board and room in a 2- to 4-bed room) in an approved participating general hospital for each "spell of illness," certified as required and recertified if the stay is prolonged.

(2) Non-custodial care in an approved tuberculosis or psychiatric hospital provided the service is certified as medically required and is reasonably expected to improve the psychiatric condition or render the tuberculosis patient non-communicable.

(3) All hospital services and use of hospital equipment normally furnished to inpatients.

(4) Approved drugs used in the hospital.

(5) Blood, except the first three pints.

(6) Regular hospital nurses.

You Pay

(1) First $40 of the hospital bill for each "spell of illness."

(2) $10 per day from 60-90 days.

(3) All hospital charges after 90 days.

(4) Psychiatric hospital charges after the 190-day lifetime total.

(5) The first three pints of blood.

(6) Private duty nurses.

(7) Attending physician's bill for services rendered.

(8) Private room costs unless certified as medically indicated.

(9) Services provided for any "spell of illness" which is not certified as medically necessary.

HOSPITAL OUTPATIENT BENEFITS (BEGIN FRIDAY)

Medicare Pays

(1) Laboratory, X-ray and other diagnostic tests performed in any 20-day period.

You Pay

(1) First $20 and 20% of the balance of cost of tests performed in each 20-day period.

EXTENDED CARE SERVICES (BEGIN JAN. 1, 1967)

Medicare Pays

(1) Up to 100 days for each "spell of illness," certified as required.

(2) Admission must be preceded by three or more days of hospitalization and must occur within 14 days after discharge from hospital for same "spell of illness."

You Pay

(1) $5 per day from 20-100 days.

(2) Custodial care.

(3) Charges for same "spell of illness" after 100 days.

HOME HEALTH SERVICES (BEGIN JULY 1, 1966

Medicare Pays

(1) Up to 100 home health visits provided under a specific medical plan by an approved or qualified home health agency (such as the visiting nurse service) during one year.

(2) Care must follow a minimum three day hospital stay and not later than 14 days after and ending one year after discharge from the hospital or an extended care service for the same "spell of illness."

You Pay

(1) Cost of drugs.

(2) Services rendered without a physician-approved plan of treatment.

PART B–Supplemental Insurance Benefits

Medicare Pays

80% of "Reasonable Charges" including:

(1) Physicians services in home, office, and hospitals.

(2) Services and appliances incidental to treatment, including surgical dressings, splints and casts, and medications patient cannot take himself.

(3) X-ray, radium, and radioisotope therapy.

(4) X-ray, laboratory and other diagnostic tests.

(5) Rental of hospital beds, wheelchairs, oxygen tents, iron lungs for use at home.

(6) Ambulance service for critically ill patients only.

(7) Artificial eyes, arms, legs, braces and certain other prosthetic devices.

You Pay

(1) First $50 and 20% of the remainder on a calendar year basis. This deductible applies to all covered services under Part B.

(2) Routine dental services.

(3) Ordinary ambulance service.

(4) Plastic surgery costs unless required because of accident or disease.

(5) Medications patient can take himself.

(6) Routine physical examinations.

(7) Examinations for hearing aids or eye glasses.

(8) False teeth, eye glasses, hearing aids, orthopedic shoes.

(9) Personal comfort items including TV, phone.

HOME CARE SERVICES

Medicare Pays

(1) Home health care up to 100 visits by visiting nurses, home health aides and therapists, (prior hospitalization not required).

(2) One-half the cost of treatment of mental patients up to total of $250.

You Pay

(1) Custodial care without treatment in rest or nursing home.

(2) 50% of bill up to a total of $250 for psychiatric patients and 100% thereafter.

(3) Routine physical check-up.



A ROUTINE BLOOD PRESSURE TEST at Highland View Hospital. Frank Doleys, 80, is recovering from a stroke. The nurse is Mrs. Edythe O'Donnell.

Photo by T. Warren Strauss

The Plain Dealer
Cleveland, Ohio
June 26, 1966

MEDICARE MAKES DEBUT FRIDAY

By Josephine Robertson

Friday at 12:01 a.m. comes an historic moment in this country's social history.

In the Greater Cleveland area about 300,000 persons 65 or older will become entitled to federal health care payments; in Ohio 1 million and in the nation, 19.1 million. The payments will be made under Title 18 of amendments to the Social Security Act.

In general Part A deals with payments to hospitals and Part B with payments to doctors.

Whether the law making it possible is considered a noble act or a mistake, the impact of Medicare is expected to be enormous in the long run.

BUT IN THE Greater Cleveland area, at least, no immediate rush of people to hospitals and doctors' offices is anticipated.

Stanley A. Ferguson, director of University Hospitals, said he based his opinion in this regard on the fact that Blue Cross of Northeast Ohio has not discriminated against the elderly but has emphasized the community's obligation to carry them. As a result, thousands 65 or older are already covered by hospital insurance.

As to possible abuse of the program, Ferguson said: **"I don't expect any more abuse from Medicare patients than from any other age group of patients. I don't believe that people over 65 are any different from the rest of the community in seeking health care. We must assume that citizens and doctors will do the appropriate thing. There is no evidence that they will not."**

Sidney Lewine, director of Mount Sinai Hospital, based his opinion on the immediate reaction of people with Medicare, on a study of discharges of patients over 65 from Mount Sinai in 1964. Of 2,951 in this age group, with a total of 49,575 hospital days of care, 78.4% of the days of care were paid for by Blue Cross; 12.6% by Aid For Aged or in whole or part by Mount Sinai. Only 9% were paid by commercial insurance or by the patients.

"Only in the limited group of 9% can it be expected that some patients might pressure their doctors for more ready admission," Lewine said.

REFERRING TO the pattern of coverage of patients over 65 in other hospitals in Cuyahoga County, Lewine said it varied little from that at Mount Sinai. He anticipates no source of large numbers of Medicare patients who have not been receiving hospital care because of less liberal coverage than the Medicare law will permit.

Actually, present coverage of Blue Cross of Northeast Ohio is much more liberal than Medicare. Because of this, BCNO is offering a special policy called "Blue Cross 65" to fill in gaps in Medicare payments, such as those requiring a $40 deductible for each "spell of sickness" and $10 a day toward hospital care from the 61st to the 90th day.

John R. Mannix of BCNO has asked that subscribers who have not notified this agency that they have reached 65 should do so, in order that their policies may be changed to "Blue Cross 65," which costs only about 30% as much as they are now paying.

One immediate result of the advent of Medicare will be the great increase in paper work for both hospitals and physicians, and for BCNO, which will be the intermediary for Social Security in this area.

"It is a tremendous program," said Ferguson. "It will take time to find out the problems and solve them. We should be prepared for a certain amount of confusion. Everyone has to be patient."

Hospital personnel have been studying a 68-page manual on Medicare, recently issued. Persons over 65 can avoid misunderstandings and save time by studying the green Medicare handbook which has been or will be sent to them by the Social Security Administration.

ONE IMPACT of Medicare that is bound to cause misunderstanding and confusion, for a time, has to do with services of certain hospital-bound physicians that were formerly included in the hospital bill. These will now be billed directly to the patients.

"Making this (B) section of the law work will be a sticky problem," said Lewine.

"There will be problems of public misunderstanding when the number of bills increases, especially on top of an already complex set of provisions regarding deductibles and co-insurance in both the hospital bill and the doctor bill sections of the law."

Adding to the confusion about bills will be the fact some physicians will refuse to accept assignment of payment from the patient and to collect from Medicare the 80% of the reasonable fee that the law allows for his services. The patient in this case may have to pay the bill himself if he is able, and collect through Blue Cross as the intermediary for Social Security.

The involvement of people in section B of the law will be immense. Approximately 90% of the 19.1 million eligible have voluntarily subscribed.

Commented Commissioner Robert M. Ball of Social Security: "I doubt if ever in history nearly 17 million people in the course of seven months signed up to pay $3 a month for anything."

THE GREATEST impact of Medicare as hospitals and doctors attempt to carry out its provisions may be its emphasis on the nation's already acute shortage of personnel in the field of medicine and health.

Ferguson considers this manpower deficiency will become even worse as Title 19 of the Social Security amendments is implemented across the nation.

Save This Page

This page of Plain Dealer articles is designed as a handy reference on the Medicare program. Simply tear the page from the section and save it for future use.

Ohio Hospitals Set

On the first day of Medicare, 230 of Ohio's 255 hospitals will have approval for participation in the program, Fred B. Wolf, Chicago regional representative of the Social Security Administration (SSA), told The Plain Dealer.

"This means that about 75,000 beds have been approved," Wolf said. "The 25 remaining hospitals are still being processed. Or they are being helped by the Ohio Department of Health so that they can correct deficiencies that prevent their qualification."

AMONG THE 255 hospitals that asked for approval for participation are some tuberculosis and psychiatric hospitals. To qualify they must not be merely custodial institutions, as has been the case with some in the past, but must have active treatment programs. Medicare does not cover custodial care.

In the Cleveland area all hospitals are believed to qualify for Medicare, according to Albert Boehringer, Cleveland representative of the SSA.

To qualify, hospitals must meet the health standards set by the Joint Commission on Accreditation of Hospitals, or be certified by the Ohio Health Department and the SSA, after a survey. Participating hospitals must also qualify as meeting non-discriminating regulations of the Civil Rights Act. No Ohio hospital is known to have been barred from participation for reasons of civil rights.

The extended coverage part of Medicare will not begin until Jan. 1, 1967.

Vernon D. Seifert, executive director of the Regional Hospital Planing Board, believes there will soon be an excess of extended care facilities with skilled nursing care in this region.

"EXAMPLES OF such institutions are Benjamin Rose Hospital, Jewish Convalescent Home, or free standing proprietary homes of philanthropic homes with skilled nursing," Seifert said. "It is expected that about 2,000 qualifying extended care beds will be built within two or three years, making about 4,600 that will meet standards.

"The big question is what happens to the patient after the 100 days of extended care. There is no plan in Medicare to pay for custodial care after extended care. We are going to be out of resources of this kind and will need to devise a way to provide them. This is a gray area.

"Medicare will point up this need."

WEST CENTRAL STATES

Colorado

North Dakota

South Dakota

Nebraska

Kansas

Oklahoma

Iowa

Missouri

Paper Daily Globe

Place Dodge City, Kansas

Date July 2, 1966

Form HEW-123

Probably No Medicare 'Flood'

If medicare, as it gets started, does not degenerate into chaos, and it probably will not, it is probably the money the patient must pay as well as the government which will be largely responsible for this. Getting up the first $50 and paying 20 per cent of the rest is not a trivial detail to many, many persons.

It is ironic that the comparatively well heeled, whom the doctors wished to leave out of it entirely, are about the only ones to whom that money is a relative trifle to raise. So possibly we might see an inordinate percentage of these persons in the hospitals, although it is the poor persons the President said he wanted to help.

But much of this may not happen. Older folk are probably no more and no less grasping than the rest of the population. That may mean that 10 per cent will grab all they can get and as many as a third might be tempted to stray, in great or small degree, from the paths of true honesty, and that about two thirds will make no effort whatever to get more than they need.

Moreover, even an utterly grasping person can't just march up to a hospital and put himself in a bed there when he really doesn't need hospital care. He will have to work through a doctor and fool one or else find one as unscrupulous as he is — and these combinations are not always easy for a person to arrange. They aren't impossible but they are unlikely in big quantities.

A flood of patients might come closer to meaning that many persons have gone without medical care they needed because they could not pay for it, under the old system. Most of us have acknowledged that many not well heeled older persons have had medical needs which were being met only indifferently under the former system.

This does not mean that medicare is the only or necessarily the best means of meeting these needs. But it is the one the people seem to have chosen. We do hope, for the sake of older persons who really do need help, that it can be made to work and its flaws modified as they become apparent.

OKLAHOMA

TIMES FRIDAY FORUM

Think for yourself and let others enjoy the privilege of doing so, too - VOLTAIRE

Friday, July 1, 1966 17

Medicare Good Tonic For Patient

TO THE EDITOR:

I have a chronic illness and do not want to jeopardize my chances of treatment by local doctors. I have a good doctor here, but having been a chronic all my life, I have seen a lot of hospital administration. Frankly, there is a lot wrong with it.

Furthermore, doctors and hospitals seem to cater to themselves more and more and to the patients less and less. I am afraid to speak out about the profession because I am dependent on it.

But Medicare is justified, and the attitude of doctors is wrong. From my personal experiences, I know this to be true.

Mrs. KFM, Midwest City

Longer Life No Godsend

TO THE EDITOR:

There has been a lot of talk about discrimination and all it's horrors. There also has been a lot written in medical journals and newspapers about the joys discovered to increase man's lifespan. What for, may I ask?

After an individual reaches the golden age of 75 with all the health and knowledge of a 40-year-old, what does our society offer him? We offer the rocking chair, an air-conditioned room and Medicare.

What does the average individual really want? Independence. But, no. If he has been involved in an accident in which anyone of any age could have been involved, the insurance company with which he carried his policy for 15 years cancels his policy.

Because of his age, it is almost impossible for another policy to be secured. Should we take the keys away from him and tell him he can't drive anymore when he has good health and good eyesight and is much more capable of driving than a 50-year-old with a record of repeated heart attacks?

Why not develop a more tolerant attitude toward these honored senior citizens of ours, as do some of the other states? Why not require a driver's examaination of anyone over 45?

Or, require a doctor's examination of such aged individuals. But let's start at an early age because there are a lot of drivers in this city with bad hearts or bad eyesight.

THE SUNDAY OKLAHOMAN

E. K. GAYLORD, Editor

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Fewer Non-Urban Hospitals

ONE manifest result of Medicare will be fewer non-urban hospitals and correspondingly heavier demands on the already overcrowded hospitals in the larger cities.

The inability of some non-urban hospitals to cope with increasing federal regulation is causing them to close already. Two announced they were closing in Oklahoma on the day that Medicare became effective.

The difficulty is that the broad federal standards prescribed for hospitals in general are heedless of the practical limitations governing hospital operations in the smaller communities.

It stands to reason that a hospital or any other business operating in a small community can't afford the payroll, plant and equipment usually taken for granted in a big city where patronage and the general level of affluence is much higher.

Singularly short-sighted in this regard is the new federal wage legislation raising the present $1.25 hourly minimum to $1.60 and extending coverage to seven million additional workers including those employed by hospitals.

Even without Medicare and the prospective federal minimum wage, payroll costs were responsible principally for the steady rise long visible in hospital operating costs. The growth in labor costs is attributable partly to rising wages and partly to the fact that more employes are required now to provide the expanded services offered in modern hospitals.

All signs suggest a continued rise in staffing costs, particularly in view of the federal government's growing influence on hospital management through Medicare. An extremely sensitive aspect is the encouragement that federal intervention may lend to the possible unionization of hospital workers.

The traditionally low-paying hospitals are confronted with intensifying wage pressures, and the American Hospital Association's journal noted a few years ago that hospital administrators were becoming interested in modernizing personnel policies "in the hope of meeting employe needs and warding off further union activity."

But of course any improvement would be confined pretty largely to metropolitan hospitals which were in a position to be more generous. Federal intervention through Medicare will lead almost predictably to renewed efforts to remove voluntary hospitals from their favored position with respect to labor laws. Hospitals will lose a major advantage when they become subject to the minimum wage and unemployment compensation laws.

The growing complexity of medical procedures would indicate a continued rise in the costs of hospitalization even in the absence of continuing general inflation. The rises that have occurred already may seem relatively inconsequential in comparison to what the future holds.

But at some point it's altogether conceivable that hospital costs will get completely beyond the reach of patients not eligible for some form of medical subsidy. Thus the political exigencies point to the eventual extension of Medicare to the whole population.

DEPARTMENT OF
HEALTH, EDUCATION, AND WELFARE
PRESS CLIPPING LABEL

No.

Symbol SSA

Paper Denver Post

Place Denver, Colo.

Date 7/2/66

Form HEW-123

Who Will Pay?

ON JUNE 27, television and newspapers made a great deal of noise about the fact that doctors will not increase fees for Medicare patients. This is fine, but what about those of us who are not eligible for Medicare? No mention was made about whether our fees would be raised.

Also, what about hospital expenses? Persons eligible for Medicare will certainly put a strain on hospitals. This will mean a need for more personnel to staff them. The older patients will need more care and who will suffer? Not our respected elders, but me and thee. I have heard one hospital administrator say he estimates Medicare will increase costs $5 per bed per day.

And, who will pay for this added staff? Certainly Uncle Sam will pay part, but then Uncle Sam is me and thee. The other part of the expense won't be in the form of a tax, but it will come out of our pockets anyhow.

I don't know how others feel, but I believe I will be taxed to death before I ever get a chance to be eligible for Medicare.

Denver. J. H. JONES.

Paper Denver Post

Place Denver, Colo.

Date 7/3/66

Form HEW-123

MEDICARE OR MOUNTING COSTS?

Evidence Shows Some Doctors Raising Their Fees

By DAVID R. JONES

WASHINGTON — There is evidence that some doctors in the United States are raising their fees because of the arrival of Medicare. But the men who advise doctors on business matters assert that this is only true in a minority of cases. Government officials say it is too early to know how widespread the movement is.

A survey of medical fees among doctors and their financial advisers last week in several key cities confirmed recent government statistics indicating that doctor fees have been rising in the first five months of 196, roughly twice as fast as in previous months.

The reasons for the sharper increases are difficult to pinpoint. Most medical business advisers blame them on mounting costs. But there is a suspicion among some government experts that the arrival of Medicare is spurring the rise, and some medical business consultants agree.

The impact of the Medicare program, which began Friday upon medical costs is a sensitive question fraught with political implications. Doctors generally believe the program will raise costs and push up fees. But liberal forces are on the lookout for fee gouging under the law, which would lead them to call for federal fee controls that doctors fear.

The Medicare program is designed to help those aged 65 and above to defray the costs of medical care. The law provides for federal payments for 80 per cent of most annual doctors' bills, except for the first $50 in costs, and also pays some hospital bills.

The law, passed last year over strong opposition from the medical profession, speicifies that the government will reimburse doctors' "reasonable charges" for Medicare patients. What is "reasonable" is determined by insurance companies, who must base their finding on the "customary charges" made by the doctors for such services and the "prevailing charges" in the locality.

Medical financial experts surveyed last week said the arrival of Medicare had prompted a widespread re-examination of fee structures. Most of these experts said they had advised their doctor clients to make such studies to be sure their "customary charges" cited under Medicare were in line with costs and the fees levied elsewhere in the community.

The majority of financial advisers agreed with Lewis A. Miller, executive editor of Medical Economics magazine, who said that recent talks with perhaps 500 medical people had convinced him there was no widespread Medicare-inspired fee boosting.

Some advisers, however, indicated the increases were more widespread. William D. Huntington, northern division manager of Professional Management Midwest in Minneapolis, said Medicare "has been a very definite factor" influencing higher fees "pretty much across the board" in his region.

Morris C. Flanders, president of Black & Skaggs Associates in Battle Creek, Mich., said a "vas minority" of the company' s7,000 doctor clients had adjusted fees because of Medicare. This has produced "no drastic change" in fees but there have been some "minor adjustments" prompted by Medicare, he said.

John C. Post, president of Professional Business Management in Washington, said that with the start of Medicare, "doctors have paid much more attention to fees in the past few months than in the past several years. I don't mean they are unnecessarily raising them, but they are taking a hard look at items."

"Where they might be charging $5 for office fees for the past few years, they are raising it to $7," Post said.

These fee revisions are resulting, he explained, because "they're putting themselves on record now as to the fees they reasonably expect" and "if they are careless or indifferent enough to put out a 1955 cost in 1966, they're going to be out of luck."

A large number of those doctors who have been increasing fees appeared to be motivated by eliminating what they considered to be "substandard" charges that were below the prevailing level in the community.

"The doctors who know of low fee men in the area are trying to get these men up to an averqge fee," commented Edward F. Phelps, vice president of PM Florida East Coast in Miami. There are some general practitioners "who are volume low price guys," he explained, and the higher charging doctors want them to raise rates "because Uncle Sam will ask how come Joe Blow does it for $3 and you charge $5."

THE PUEBLO STAR-JOURNAL
and
THE PUEBLO CHIEFTAIN

PUEBLO (Colo.) STAR-JOURNAL Friday, July 1, 1966

THE SMALL SOCIETY



DEPARTMENT OF
HEALTH, EDUCATION, AND WELFARE
PRESS CLIPPING LABEL

No.

Symbol

Paper Des Moines Tribune

Place Des Moines, Iowa

Date 7/1/66

Form HEW-123

Doctor's Bills Under Medicare

The House of Delegates of the American Medical Association has recommended that doctors bill patients directly for services after Medicare goes into effect today.

It is not surprising that the A. M. A. takes this position, but if all doctors rigidly adhered to this policy, hardships to some patients would result and much ill will would be created for physicians. We would expect that most doctors, as they gain experience with the new program, will use common sense in applying the recommended policy.

The part of the Medicare plan which applies to doctor's services is the supplemental insurance plan. People over 65 are eligible for this insurance and pay $3 a month for it. This $3 is deducted from Social Security payments for those who receive Social Security benefits. The $3 is paid from welfare funds for most indigents.

The federal legislation permits doctors to bill patients directly or, with the patient's consent, to send the bill to Medicare for that part of the doctor's services covered by the insurance plan. The patient has to pay the first $50 in doctor bills in any one year and after that he has to pay 20 per cent of the charges for doctor's services.

So whatever method a doctor chooses in submitting his bills, he will have to bill the patient for part of the cost of his medical expenses, and it will be his problem to collect from the patient. The doctor may conclude that he can avoid some paper work by submitting the entire bill to the patient and letting the patient himself collect the part paid by Medicare.

But if the doctor will not deal with Medicare, the patient has to pay the doctor before he can get his reimbursement from Medicare. Some patients would find this a hardship and some might find it an impossibility if the doctor's fee was a large one for a major operation. We can see the possibility in some cases that the doctor won't be able to collect anything if he insists on the direct billing method. Direct billing also would present many complications if the patient were a confused elderly person.

The A. M. A. resolution, while recommending direct billing, leaves each physician free to make up his own mind about what method he will use. Direct billing, in our opinion, would not be the humane or sensible procedure in some cases. We also suspect that in the long run some doctors will find their problems simplified by doing business directly with Medicare for the major part of their fees.

Don't Expect Medicare To Be Free

By Gilbert Cranberg

(Of The Register's Editorial Page Staff)

Paper Des Moines Register

Place Des Moines Iowa

Date 7/3/66

THE PATIENT over 65 who expects hospital care to be "free" now that Medicare is in effect is in for some surprises when he gets his bill.

Each patient will have to pay the first $40 of hospital expense out of his own pocket. If the patient wants a private room, he will have to pay the difference between the rate for semi-private (two beds in a room) and private care.



CRANBERG

After 60 days of hospitalization for a particular illness, the patient must pay $10 a day until the ninetieth day, when he is on his own. The cost of all special conveniences, such as TV, telephone and private duty nurses must be borne by the patient.

Many services performed for the patient in the hospital are only partially covered. Congress drew a distinction in the Medicare Act between services by physicians and hospital services.

As a result, Part A was set up to defray hospital expense and Part B for doctor bills. No premium is charged for Part A coverage, but the patient must pay $3 monthly to have coverage for doctor bills. About 10 per cent of those covered by Part A are not insured under Part B. Those covered by Part B must pay the first $50 of doctor bills and 20 per cent of other physician charges.

Congress concluded that many of the services performed in hospitals are by physicians directly in behalf of patients and should be covered by Part B. Among the specialists in this category are pathologists, radiologists, physiatrists (specialists in physical therapy) and specialists who interpret encephalographs and electrocardiograms.

But Congress also concluded that a "hospital component" exists in these services in the form of non-medical technicians, space and equipment provided by the hospital. Congress provided, therefore, that a portion of the bill for pathology, radiology and other services by specialists in the hospital should be paid under Part A as hospital expense.

The arrangement worked out between one Des Moines hospital and its pathologist calls, for example, for a $5 charge for tissue examination. The "hospital component" for this procedure, figured in terms of the cost to make the slide and the time of the technician to prepare it, is 20 per cent of the total, or $1.

Since this is classed as a hospital charge, it is covered by Part A and will be paid in full by Medicare. The 80 per cent of the charge, or $4, considered to be the "physician component" of the service is covered by Part B, and 20 per cent of this will have to be paid by the patient. Many procedures, however, have a much higher "hospital component" in the charge.

Hospitals and specialists are working out varying relationships as a result of the law. In one Davenport hospital, the pathologist has leased the hospital laboratory, thereby making its operation a physician service exclusively, and all pathology services in the hospital are covered only by Part B.

In most Iowa hospitals the basic relationship remains the same and such services will fall under both Parts A and B. To the extent the service is a "physician component," and comes under Part B, the patient will have to pay a portion of the bill.

The total effect of Medicare, of course, will be to greatly ease the strain on the patient's pocketbook. But no one should expect a stay in the hospital to be without cost.

Paper St. Louis Post-Dispatch

Place St. Louis, Mo.

Date July 1, 1966

Form HEW-123
(9-54)

As Medicare Begins

Doctors are in no way bound by an American Medical Association resolution urging its members to bill Medicare patients directly. We hope that doctors everywhere, upon mature reflection, will agree this action of the House of Delegates is a fit of childish pique, and disregard it.

Billing Medicare patients directly would place an unjustified burden on the aged, in our opinion. They would have to produce the money to pay doctors' bills before obtaining the receipt necessary for reimbursement from fiscal agents for the program. Furthermore, physicians who bill directly may charge what the traffic will allow, leaving patients to collect only 80 per cent of prevailing charges found to be reasonable.

Does the medical profession really want to be in the position of making Medicare as tough as possible on its beneficiaries? Enlightened physicians, we think, will prefer to follow the astute advice of the AMA's new president, Dr. Charles L. Hudson of Cleveland. Dr. Hudson told AMA members in his inaugural address that freedom of professional judgment would not be restricted under Medicare. Instead of "belaboring the past," he said, doctors should help make Medicare work. If doctors participate in shaping health care programs, their criticism of the finished product would be more meaningful and probably less necessary as they see it.

Dr. Hudson warned that Medicare might be expanded into a national health service unless the national standard of private health care is constantly improved. Study after study has shown that this nation ranks second best, sometimes much lower, in the distribution of its unparalleled medical skills. That is a cause. Medicare is an effect. In Dr. Hudson's words, doctors shape their own futures.

Is not Dr. Hudson's approach more appropriate and more professional for an honored calling? Is it not less demeaning than asking elderly patients to "protect" doctors from the very program that will ease the burden of providing charity care?

St. Louis Post-Dispatch
St. Louis, Mo.
July 2, 1966



Morning News
Enid, Oklahoma
7-02-66

Physician Advises On Medicare

At midnight on July 1st Medicare went into effect in Garfield County and all over the nation. An Enid woman who fell and broke her hip became the first Medicare patient in Garfield County less than an hour after the health care law became effective.

Like it or not, Medicare is here and we think here to stay.

Dr. James Z. Appel, outgoing president of the American Medical Association, offered some advice to his fellow physicians in a statement over the weekend. Militant foes of Medicare within the AMA, he declared, will "only invite hostility" from the mass of Americans by denying patients care under the new law.

There are still physicians who main unreconciled to the Medicare act. For these, Dr. Appel had these words:

"Refusal of care, or deprivation of the patients' legal rights will only invite hostility for the profession in the very people who are the only ones who can change the present erroneous course of the nation . . . Even under the harmful atmosphere created by Medicare, the profession's first concern must be to the patient. It must continue to render the best quality care that is possible."

Dr. Appel's position is not one of endorsing Medicare as such. He urges doctors to accept it so that there will not be further governmental encroachment into the medical field.

We don't profess to know the problems of the medical profession but Dr. Appel's words sound like common sense and good advice.

The Daily Oklahoman - July 1, 1966

First Medicare Patient Admitted

By Katherine Hatch

Oklahoma City's first Medicare patient got a 1½-hour jump on the midnight deadline Thursday night to become a genuine Sooner under the federal government's new health care program.

Mrs. Iva Raymer, 85, Oklahoma City, checked into Deaconess Hospital at 10:25 p.m. Thursday, but hospital officials said by the time she was processed and officially "admitted" to the hospital, midnight had struck, signaling an expected rush for the new health program.

Rev. R. E. Butterfield, hospital administrator, would not comment on Mrs. Raymer's illness, but said she will be covered under Medicare.

Medicare comes to Oklahoma City Friday amid demands of nurses and hospitals for more money and an uncertain future for county charity patients.

Private registered nurses belonging to the state nurses association announced a rate increase Thursday, effective Friday.

Two of the city's three hospitals which handle 90

(Continued on Page 2, Column 2)

Medicare's Prognosis

MEDICARE'S advent brings differences of opinion concerning the adequacy of available facilities, doctors, nurses and technicians.

But with regard to one aspect of the program there is remarkable unanimity. Almost everybody willing to express an opinion is agreed that the benefits promised at the outset will prove relatively modest in comparison to Medicare's probable eventual scope.

The experience with social security suggests that broadened benefits will be promised with the regularity of the election years and the country will be lucky if it escapes socialized medicine eventually.

Social security's pensions started as a rather meager retirement supplement to persons 65 and above. The promised stipend was increased with rising living costs, and the age limit was reduced to 62 for women who took reduced pensions. Disability insurance was added and was limited at first to persons 50 and over. Subsequently the age restriction was lifted altogether and the interpretation of "disability" was broadened.

A similar gradual expansion of coverage and benefits is anticipated in the case of Medicare.

First Medicare Patient Jumps Gun in City Hospital

CONTINUED FROM PAGE ONE

percent of the charity patients said they need more money from county commissioners to continue handling these patients.

A week ago, licensed professional nurses in Oklahoma City announced they would increase their fees, beginning Friday.

St. Anthony Hospital, which handled about 60 percent of the county's charity patients in the past 11 months, told commissioners Thursday it must receive $41.18 per day for those patients, starting Friday.

Presently, commissioners pay hospitals $13.50 per day for charity patients admitted.

Commissioners said they have offered to pay Mercy Hospital $25 per day, and hope a similar compromise might be reached with St. Anthony.

Mercy Hospital handled about 40 percent of the charity patients in the past 11 months.

Third hospital which regularly accepts charity patients, though not nearly as many as St. Anthony and Mercy, is Presbyterian Hospital.

A spokesman there said Thursday the hospital has not been offered $25 per day for charity patients, but said that would "in no way approach the cost" which was $43.64 last year per patient per day.

Commissioner Ralph Adair, saying he did not "want to start a fight" but promising "not to run from one," said commissioners cannot pay the figure asked by St. Anthony.

Taxpayers in Mind

"We're looking out for the taxpayers," Adair said.

"We don't want to be arbitrary, but we are not going to certify anyone as a county welfare patient above $25."

Asked what commissioners will do if charity patients are no longer acceptable at St. Anthony, Mercy or Presbyterian hospitals, Adair replied:

"We'll just try to channel them elsewhere and hope the others accept them."

Commissioners said the county's average cost per day for a charity patient at the county hospital is $4.10.

For out-patient care, hospitals are paid $4.50 per patient from the county for charity cases.

Statistics Cited

That can be raised to $5 per day, commissioners said Thursday.

Records of the county commissioners showed the following number of county charity patients was handled at hospitals during the year which ended June 30, 1965. (The first figure is for patients admitted and kept; the second figure is for those who received out-patient care.)

St. Anthony, 644; 19,210; Mercy, 405; 8,344; Presbyterian, 43; 793.

Other hospitals which took charity patients as in-patients only and were paid by the county were Capitol Hill General, one; Hillcrest, two, and Edmond, one.

In the past 11 months ending May 31, St. Anthony had 407 charity patients admitted for a total of 3,658 days, and treated 16,545 out-patients.

New Fees Voted

Mercy Hospital admitted 232 county charity cases who spent a total of 2,405 days in the hospital, and treated another 4,616 as out-patients.

A new schedule of fees charged by Oklahoma and Canadian County members of the private duty registered nurse section of the Oklahoma State Nurses Association was announced Thursday, to begin Friday.

Daily rates will increase from $20 to $25 for eight consecutive hours of duty, with other rates up less sharply.

The increases were voted statewide by private duty nurse members of the association, and some increases already have become effective in Tulsa, a spokesman said.

Rates Listed

Here is the new rate schedule, to become effective at 7 a.m. Friday. Old rates are in parentheses.

Daily rate, $25 ($20); hourly rates, or a fraction thereof, $6.25 ($6); successive hours, or fraction thereof $3.15 ($2.50); multiple nursing, each patient daily, $18.75 ($15), and overtime, hourly, $3.75 ($3).

Last Friday the Oklahoma and Canadian County branch of the state's licensed practical nurse association announced a rate hike, also effective this Friday.

Medicare Program Goes Into Effect For 19 Million

WASHINGTON, June 30 — (UPI) — Medicare, biggest extension of Social Security since old age pensions were provided 30 years ago, goes into effect Friday for 19 million Americans over the age of 65.

Its advent was welcomed by President Johnson, in a statement issued at the White House Thursday, as "a blessing for older Americans."

For the first time in history, the President said, "nearly every older American will receive hospital care—not as an act of charity but as the insured right of the senior citizen."

The Medicare Law, passed by Congress last year after a long controversy, provides for two supplementary types of coverage.

First, there is the basic hospitalization program, which is available free to men and women over 65, with a few exceptions. The exceptions are recently-arrived aliens, convicted subversives and certain retired Federal employes who have their own program.

The basic program provides up to 60 days of hospital care, with the patient paying the first $40. If additional hospital treatment is required, the patient must contribute $10 a day, and Medicare will cover the rest of the cost for another 30 days.

Doctors' bills are not included in the basic program. But insurance against them and certain other medical expenses is available under the second part of Medicare, which is optional. It costs $6 a month, but the Government pays half of the cost, so that the premium charge is only $3 a month. More than 90 percent of the Americans over 65 have signed up for this bargain.

When they get sick, they'll have to pay the first $50 of their doctors' bills in any calendar year. Thereafter, they can look to Medicare for reimbursement of a large part of their doctors' bills.

Specifically, Medicare will pay 80 percent of any doctor's bill that comes within the limits of what is determined to be a "reasonable charge" for the service performed. The determination of "reasonable charges" will be made in each community by the local Blue Shield or other private insurance carrier designated to handle Medicare claims.

If a doctor wants to charge more than the "reasonable charge," he is free to do so. The difference, however, will come out of the elderly patient's pocket.

A doctor may, if he chooses, bill the patient directly, and leave care. The American Medical Assn. has recommended that doctors use this procedure.

Paper Rocky Mtn News

Place Denver, Colo.

Date 7/1/66

Medicare Off, Running As Massive Program

Denver Post 7-1-66

WASHINGTON — (AP) — The massive Medicare program providing hospital insurance for all 19 million of the nation's senior citizens went into effect Friday, hailed by President Johnson as "a blessing for older Americans."

Swinging into operation with the program was an optional doctor-bill insurance plan for which 17.3 million elected to pay $3 a month.

The two programs were brought into being at 12:01 a.m. in one of the biggest operations in medical history.

CALLED TEST

Doctors and patients reserved any prognosis, but the President pronounced it a success in advance. He called it "a test of our willingness to work together."

By Public Health Service count, 6,714 institutions — or 91 per cent of all the country's 7,374 general hospitals with roughly 93 per cent of the beds — opened their doors for the insured care of any American aged 65 or over.

EMERGENCY RULE

The nonparticipating hospitals were mainly in the South. Most were barred from Medicare payments by their failure to comply with the no-racial-discrimination provisions of the Civil Rights Act.

To make extra sure that no one dies for want of access to a participating hospital, the government ruled Thursday night that federal hospitals — veterans, military and others — may be used for critically ill Medicare patients in emergencies.

Previously it had been announced that any other nonparticipating hospital could be used — private or public, with Medicare picking up the bill — if a bed in a participating hospital could not be found to avert the threat of death "or serious impairment" of health.

There was no sign in early reports of a general rush by the elderly to hospitals. Hospital administrators said they expect the real impact on July 5, after the Independence Day holiday.

But thousands of elderly patients already in hospitals were automatically transferred to Medicare status for bookkeeping purposes.

AMA stands fast against Medicare. Page 5.

Symbol SSA

Paper Denver Post

Place Denver, Colo.

Date 7/1/66

THE GRAND ISLAND DAILY INDEPENDENT
Grand Island, Nebr. Saturday, July 2, 1966

Page 1

Both Hospitals Here Affected on First Day

By JOE KRANZ

Although Medicare admissions were listed at both the St. Francis and Lutheran hospitals in Grand Island on the first day of the new program (July 1), there was actually only a minor change in the number of patients.

Most of the admissions were transfers on the books of patients presently under treatment at the hospitals and who qualify under the Medicare program, spokesmen said.

A total of 22 patients at the Lutheran Hospital were transferred to the program and three new patients entered the hospital under the program Friday, Hospital Administrator Sherman Jackson said.

At the St. Francis Hospital, "two or three persons" qualifying under the program entered Friday. The staff was checking on the possibility that about 30 present patients would also qualify, Office Manager Thomas Baird said.

Baird also stated that it would expedite matters if persons entering the hospital would be sure to bring along their hospital identification claim card. Some have forgotten the card which makes it necessary to check Social Security records and complicates the admission, he said.

Robert Fahnstock, assistant manager at the Social Security office, had only the figures for a regional report reflecting the situation as it was of May 13. He said that it showed that 90 per cent of the persons age 65 and over had signed up for the program. He assumed the same percentage could be applied locally.

On a state-wide basis, he had a report showing that about 87 per cent of the eligible people had taken advantage of the voluntary insurance provisions of the program. This report also showed figures of 156,000 persons enrolled out of a total of 179,000 persons who would be 65 or over by July 1.

Fahnstock offered as a possible explanation of the lower percentage that some of the people had been under plans which provided better coverage and had no reason to make a change.

* * * * * *

Denial Issued in Story Patients Were Evicted

Page 2

CORINTH, N.Y. (AP) — The director of the Adirondack Regional Hospital has denied published reports that eight elderly patients were evicted from the hospital Friday because the building failed to meet medicare standards.

Dr. Bruce Scidmore told the Associated Press Frday that the eight — all over 65 — were advised by their own physicians that they could remain hospitalized only if they agreed to pay their bills privately.

Scidmore said five of the patients voluntarily left the tiny hospital after discussing the matter with their doctors and hospital administrators.

The other three decided to remain and refuse to accept the medicare benefits made available through the federal plan which took effect Friday.

Scidmore said the five who were discharged were taken to their homes until they could be transferred to other facilities.

Dr. Max Vinicor, chief of staff of the 30-bed facility, said, "All of us were angry about the situation."

He added, however, that the problem stemmed from difficulties "in getting the hospital going rather than the medicare decision."

Many of the beds at the facility are in a wooden section that is not fireproof, Scidmore said.

Vinicor said the hospital has not sought federal certification because a preliminary study showed that it would not meet the standards.

The hospital, near Saratoga Springs, is supported by the towns of Lake Luzerne, Hadley and Corinth.

DEPARTMENT OF
HEALTH, EDUCATION, AND WELFARE
PRESS CLIPPING LABEL

No.

Symbol

Paper
OMAHA WORLD-HERALD

Place
Omaha, Nebr.

Date
7/1/66

Form HEW-123

Here Comes Medicare

Ready or not, here comes Medicare, starting today.

It begins with momentous problems and with conflicting opinions about the immediate effect on the hospital patient load and that of doctors' offices.

Since no one can know what will happen, we propose to hold off comment until it begins to happen.

THE GRAND ISLAND DAILY INDEPENDENT
GRAND ISLAND, NEBRASKA
JULY 1, 1966

President Hails Medicare, as It Begins

(A related item answering questions about Medicare is found on Page 21 of today's Independent.)

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WASHINGTON (AP) — The massive medicare program providing hospital insurance for all 19 million of the nation's senior citizens went into effect Friday, hailed by President Johnson as "a blessing for older Americans."

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Over 90 Per Cent Participate

By Public Health Service count, 6,714 institutions — or 91 per cent of all the country's 7,374 general hospitals with roughly 93 per cent of the beds — opened their doors for the insured care of any American aged 65 or over.

The nonparticipating hospitals were mainly in the South. Most were barred from medicare payments by their failure to comply with the no racial discrimination provisions of the Civil Rights Act.

To make extra sure that no one dies for want of access to a participating hospital, the government ruled Thursday night that federal hospitals — veterans', military and others — may be used for critically ill medicare patients in emergencies.

Previously it had been announced that any other nonparticipating hospital could be used — private or public, with medicare picking up the bill — if a bed in a participating hospital could not be found to avert the threat of death "or serious impairment of the health.

Administration Pleased

Despite the serious gaps in participation — only 25 per cent of Mississippi hospitals were in the pool — administration aides were jubilant over the generally high participation nationwide.

"We've done far better in the South than we had dared to hope a month or two ago," one Public Health Service official said.

"And more hospitals will be desegregating when they begin to feel the pressure from unhappy local residents, both white and black," he added.

Twenty-three states entered medicare with 100 per cent participation by their qualified hospitals, and some others came close to that.

President's View

In his medicare's-eve statement, President Johnson said he had no doubt of the success of the twin medicare programs if these three things happen:

"If hospitals accept their responsibility under the law not to discriminate against any patient because of race."

"If doctors treat their patients with fairness and compassion. I feel sure that most doctors do not plan to drive hard bargains with needy patients."

"If old patients cooperate in scheduling treatment and do not demand unnecessary hospital and medical services."

He concluded: "I have no doubt for the future. I believe that July 1, 1966, marks a new day of freedom for our people."

The government has poohpoohed forecasts that a tide of elderly patients will swamp the hospitals. Hospital administrators generally agree that there will be some difficult local situations but that they can handle the expected average increase of not more than 5 per cent in the patient load.

This judgment was reinforced as each recent day brought scores of new hospitals into compliance. Officials expect that many more will meet both the medical care standards and the civil rights test during July.

The states which already had 100 per cent certification of hospitals for compliance as of midnight were Alaska, Arizona, Colorado, Connecticut, Hawaii, Idaho, Indiana, Iowa, Maine, Maryland, Massachusetts, Minnesota, Montana, Nebraska, Nevada, New Hampshire, New Jersey, North Dakota, Oregon, Rhode Island, South Dakota, Vermont and Wyoming. The territories of Guam, Samoa and the Virgin Islands also had full participation.

At the other end of the scale were Mississippi with 33 of 133 hospitals certified for rights compliance, South Carolina with 46 out of 93, Louisiana with 78 out of 144 and Georgia with 107 out of 176.

Florida had 159 complying out of 188, Virginia 84 out of 119, North Carolina 138 out of 166 and Tennessee 138 out of 163.

What Medicare Does, Doesn't Do Is Outlined

WASHINGTON (AP) — Here are answers to some of the questions most frequently asked about medicare, starting Friday for all Americans 65 and older:

Q. If the hospital I choose is overcrowded, does medicare guarantee me a bed?

A. No. Medicare just helps pay the bill.

Q. If I have to go back into the hospital two or more times, do I pay the $40 "deductible" each time?

A. No. You pay just the first $40 of hospital charges in each "spell of illness."

Q. What's a "spell of illness."

A. To medicare it's a period of time, not an ailment. It starts the day you enter a hospital. It ends 60 days after your discharge from the hospital. Or from a nursing home — after next Jan. 1, medicare will provide posthospital convalescent care in nursing homes for those needing it.

'Different' Illness Defined

Q. Suppose I go back to the hospital for a different sickness?

A. To medicare it doesn't matter. It's all one "spell of illness" if the new admission comes within 60 days of the last discharge.

Q. Do I have to go back to the same hospital?

A. No. Your benefits follow you from hospital to hospital and from city to city. Just show your red, white and blue card. Any participating hospital can tell instantly, by check to a computer in Baltimore, Md., whether you have used up all your "benefit days."

Q. If I'm in a hospital when medicare starts, does medicare pick up the bill?

A. Not for past days. Medicare picks up as of July 1, and you'll still have to pay the $40 deductible as well as the charges for the days preceding medicare.

Q. I've signed up to pay $3 a month for the voluntary doctor bill insurance. It has a $50 deductible; how often do I have to pay that?

A. Just once each year, regardless of how much your doctor bills add up to in a year.

Other Policies?

Q. Should I cancel my old health insurance policy?

A. If you are 65 but your wife is not, she's not covered by medicare. You may want to keep her policy in force.

Q. We are both over 65. Should we buy the "supplemental" plans offered to over-65 persons by Blue Cross, Blue Shield and other private insurers for additional protection?

A. That depends on your own needs and inclinations. Some policies are designed to cover medicare's "deductibles" and provide benefits beyond the limits of medicare. Another type of policy pays off in cash benefits for each day of hospitalization; the money could be used for the inevitable costs of an illness, or for "extras," such as a bedside telephone or a private room instead of the semiprivate accommodations paid for by medicare.

Q. Medicare's doctor bill insurance covers 80 per cent of a doctor's "reasonable charges," after the $50 deductible. Does the doctor send his bill to medicare or to me?

A. Either one. He can send it to medicare's local "intermediary" agency — in most cities, the local Blue Shield organization — which will pay him 80 per cent of what it deems a "reasonable charge" for his treatment or operation; the other 20 per cent would come from you. Or he could send the whole bill directly to you.

Q. In the latter case what do I do?

A. Pay it, then apply for reimbursement to the "intermediary."

U.S. Orders Aged Patients Evicted

CORINTH, N.Y. (AP)—Eight elderly patients were ordered evicted here from a tiny community hospital, because federal officials said the hospital did not meet standards for the new government medicare program.

The two other patients at the Adirondack Regional Hospital in this village near Saratoga Springs also were over 65 and covered by medicare but were permitted to remain because they are heart patients who cannot be moved, Dr. Bruce Scidmore, head of the hospital, said.

The eight were considered well enough to go home until other accommodations could be found, he said.

The health insurance agencies that had been paying their bills automatically dropped coverage, with the advent of medicare at midnight. Thus, the eight, aged 67 to 87, could not afford to remain. The medicare program will pay for the critical ones, aged 70 and 78, until they can be moved.

Dr. Scidmore told a reporter he hoped the people would approve a bond issue before the end of July for improvements in the 30-bed, wood and brick hospital.

Social Security officials decided that too many of the hospital beds were in the old, wood portion, which is not fire proof.

THE GRAND ISLAND DAILY INDEPENDENT
Grand Island, Nebr. Saturday, July 2, 1966

As Medicare Program Opens

Hospitals Report Some Incidents, Some Problems, But Few Patients

EDITOR'S NOTE — Members of a special AP task force kept a close watch throughout the first day of medicare in a group of hospitals around the country. The following account is based on their reports.

NEW YORK (AP)—Down the corridors of Miami's Jackson Memorial Hospital figures in white passed each other with a cheerful greeting: "Happy medicare!"

For the nation's hospitals Friday was indeed happy medicare —the first day of the Social Security hospital program for persons 65 years and older had gone smoother than anyone had dared hope.

Still, there were problems: mountains of paper work, missing forms, bewildered patients, lost medicare cards, and one woman who got mad and swung her purse at a hospital worker.

By midafternoon, in the usually frantic emergency room at Jackson Memorial, interns sat with their feet propped on a table.

Not Much Doing

"It's the quietest day we've had," said Dr. James Connaughton, who joined the Miami hospital last month after graduation from the University of Indiana.

The situation was virtually the same in hospital after hospital across the United States. Fear expressed by some that medical facilities would be swamped by elderly people evaporated as the day wore on like any other before a July 4 holiday.

Northwest Hospital in Seattle, the first in the nation to be certified for medicare, admitted not a single medicare patient. Six elderly patients already in the hospital, however, were automatically switched over to medicare at its start, 12:01 a.m. Friday.

But Then Tuesday

"Heaven help us when Tuesday comes," said Alfred E. Riley, business manager of St. Elizabeth's Hospital in Chicago. Riley said he looks for a big inflow of patients then because of the people who wanted to be home for the holiday or delayed entry because so many doctors would be away for the weekend.

At 9 a.m. on the first day, Anna Winston, 71, of New York City, showed up in the emergency room at mammoth Mt. Sinai Hospital complaining of "aches and pains." Within an hour she became one of the hospital's 19 first-day medicare admissions.

"I knew I'd wind up in the hospital because I was very sick," Mrs. Winston said. "I should have been here a month ago, but I couldn't get into this or any other place."

More Book Work

The biggest problem faced by the hospitals is the increased load of paper work. Mt. Sinai added 41 clerks just to handle all the new forms and extra bookkeeping. Other hospitals are also taking on new help.

At St. Joseph's Infirmary in Atlanta, business manager David Messinger recalled that he had spent 20 years in the Air Force as a medical budget officer. He shuffled the forms piled high on his desk and said, "I'm right back home again. I haven't had much sleep in three days. I can't sleep any more, trying to figure out what to do about medicare."

An information desk was set up on the main floor at Detroit's Henry Ford Hospital, where more than 200 elderly persons came with questions about the program.

One Unhappy

One elderly woman insisted a girl behind the counter was wrong when she explained that medicare doesn't cover all expenses. "You're trying to line your pockets with my medicare money," the woman shouted, and swung her purse at the girl. The girl ducked and the blow

(Turn to Page 2, Col. 3)

Hospitals—

(Continued from Page 1)

glanced off her hairdo. She retreated into a nearby office and the woman stomped out.

"They're generally surprised to learn that everything isn't paid for," said Thelma Cogswell, clinics admitting officer at Massachusetts General Hospital in Boston.

Many Under Medicare

By the end of the first day at Massachusetts General the hospital had 941 patients, of whom 260 were over 65 years. During the day the hospital admitted 67 new patients, 18 of them under medicare.

Queen of Angels Hospital in Los Angeles didn't have a single medicare admission until midafternoon, when a doctor called to advise he was sending in a male heart patient.

"The hospital census always goes down to rock bottom on July 4," said a hospital spokesman.

Also affecting admissions, he said, was the fact that California put into effect its own program March 1, absorbing early the influx of patients.

'Had to Report'

Some hospitals reported that a few elderly persons had shown up to "get their medicare." They weren't sick, but they mistakenly thought they had to report to the hospital.

"The people who come in under medicare often are too old and too sick to know about the program," said Alan Transue, credit manager of Research Hospital and Medical Center in Kansas City.

"They don't have cards, they can't find cards, they don't know what we are talking about," he said.

At the Boston Hospital one woman outpatient refused to produce her red, white and blue card—until she had a chance to go to the ladies room and unpin it from her underwear.

Ex-Governor Enters

E.D. Rivers, 70, of Lakeland, Ga., Georgia governor from 1937-40, entered the hospital for a periodic checkup. His admission form bore the green-ink stamp "Medicare 65."

"I've been in Social Security for some little bit now," Rivers said. "I paid in a lot of money. They don't put it on the basis of need, but on the basis of right."

MEDICARE

Close Check Kept on Setup

FROM PAGE 1

forms are in the mail from the government and will be in the Blue Cross office Tuesday at the latest.

Sewall said his office has been busy handling phone calls. Hospitals wanted information on patients in the hospitals who had lost their Medicare cards and information on forms and procedures. Many people eligible for Medicare also sought information.

Sewall also said, "There is nothing abnormal in the way of people moving into hospitals."

The Social Security Administration headquarters in Baltimore is keeping a close check on conditions throughout the country, he said.

George J. Maselli, registrar at the Veterans Administration Hospital, said that government hospitals, the Public Health Service, the Defense Department and other federal agencies were prepared to open their facilities to Medicare patients on an emergency basis if the load should become overwhelming.

NO ADMISSIONS

But, Maselli said, there were no Medicare admissions to the VA Hospital Friday.

Hospitals checked by The Denver Post backed up the statements of the administrators and officials involved in the program.

Don Arnwine, director of hospitals at Colorado General Hospital, said three Medicare patients were admitted Friday. He said this is about normal for this age group. There were also 50 visits by outpatients under the program. This, too, is normal, he said.

TRANSFER CASES

The hospital had 55 transfer cases. Transfer cases are those people 65 or over who were already in the hospital at the time Medicare went into effect at 12:01 a.m. Friday.

Arnwine said, "Colorado is a leg up on other states that don't have such state medical programs. We (Coloradans) have had experience, with local government at least, in dealing with this kind of program."

Ronald Struxness, administrator of Lutheran Hospital, said there were 45 in the hospital when the program began, nine were dismissed, and three more were admitted.

Some forms weren't received, according to Struxness, but the program has gone smoothly in general.

ADDED TO LOAD

Struxness said it will add to the administrative load. One person already has been hired in the bookkeeping office to handle Medicare cases. He said the hospital staff has tentatively scheduled a meeting to evaluate the program after it is well under way.

He said the forms that were missing were the doctors' billing forms, which doctors use to bill the hospital for services.

Struxness said the major complication will be the mechanics of figuring the various deductions for medical services and the cooperative insurance plans used by Medicare.

CALLED CHALLENGE

Struxness said he is looking forward to handling the Medicare program and considers it a challenge.

Jack Houtz, assistant administrator of Rose Memorial Hospital, said the Medicare patient load there was normal.

There were 96 transfer patients and six new ones admitted Friday.

He said the hospital staff has been preparing a long time and the change to Medicare went smoothly.

Mrs. Marjorie Doty, director of admissions at Denver General Hospital, said there were 46 transfer patients, two new admissions and eight in the outpatient department.

"We expected a landslide, but we didn't get it." she said.

FORMS NEEDED

She, too, said she experienced some difficulty in getting all the proper forms.

James Henderson, superintendent of Presbyterian Medical Center, said four or five were admitted Friday and there were 75 in the hospital when the program began.

Mercy Hospital reported its patient load as normal. John Carroll, controller, said the only thing that surprised him was the number of people already in the hospital. There were more than 60 transfer patients. Not many were admitted Friday, he said, but exact figures weren't available.

Jess Kline, controller of Beth Israel Hospital, said they were prepared to meet a large load, but the load remained normal.

Hospitals contacted out of Denver also reported normal activity.

Poudre Valley Memorial Hospital in Fort Collins transferred 65 patients to Medicare. No Medicare patients were admitted Friday.

27 TRANSFERS

Gene Barron, administrator of Boulder Community Hospital, said there were 27 transfer patients. One refused to accept Medicare, Barron said. There was one admission Friday.

Frederick Sage, administrator of Brighton Community Hospital, said there were three transfers and one new patient. He said this is about normal for the hospital.

But, according to Jepkes, the Blue Cross official, there will be many administrative problems because the program is so complex.

"Wait a week or two," he said, "then we'll be better able to tell just what the exact impact is. But, on the whole, it has gone reasonably well in Colorado."

Most of the hospital and Medicare officials agreed with Jepkes and expect it to continue that way.

The Denver Post
Denver, Col.
July 2, 1966

THE DENVER POST- Denver, Colorado

July 2, 1966

Enter Medicare—a big week for nation's aged

By MARGRIT PITTMAN

SAN FRANCISCO — This is an important week in the lives of 19.1 million elderly Americans.

On July 1 they become eligible for a measure of security unprecedented in the richest country on earth: the right to — at least partial — medical aid without regard to financial status.

Passage and implementation of the medicare legislation is the greatest step forward in federal social legislation since passage of the Social Security Act. in 1935.

It took the labor movement and its allies all of 30 years to wrest this new measure from the Establishment.

The vast importance attached it by its recipients found expression when an incredible 91% of those eligible (93% in California) signed up for the voluntary $3-a-month supplementary insurance plan designed to cushion the cost of doctor bills and other medical services not covered by the law.

STILL BEHIND

The measure, as it stands, still leaves this country far behind modern industrial nations in caring for its sick.

"In the foreign programs the medical component looms large," writes Dr. Charles I. Schottland, a former commissioner of Social Welfare (Hospitals, Doctors and the Public Interest, Harvard University Press, Cambridge, Mass., $8.50), "and in most countries, health insurance and medical care are an important part of the social security system.

"Fifty-eight countries provide benefits for permanent disability or invalidity through their social security programs; 59 countries provide cash payments for temporary illness and maternity care or have some type of health and maternity insurance or related programs, and many countries finance medical services through the social security agency."

Socialist countries offer comprehensive cradle-to-grave medical coverage for the whole population, in some countries, as in the Soviet Union, noncontributory.

But even the limited program offered by medicare is already beset by a multitude of problems, bred by years of medical neglect and the greed of those who have made prodigious profits from illness.

DIRTY ECONOMICS

Volumes have been written about the dirty economics of the great humanitarian task of healing in this country.

The nation's health and medical bill amounts to $35 billion a year, a little more than 5% of the Gross National Product.

"The great human tragedy lurking behind this expenditure," Harold J. Gibbons, president of the Teamsters Joint Council 13 in Missouri, told a recent meeting of the Group Health Assn. "is that the American people are not getting their money's worth in the highly competitive, wasteful and uncreative market place economics that dominate the 'power to heal'."

Gibbons, who calls for a comprehensive national health and medical program for all Americans, characterizes medicare as "one slight faltering step in this direction," representing a "significant breakthrough in our social thinking."

What will medicare do for those who greet it so eagerly?

Coverage under the Social Security Act will provide for:

- Inpatient hospital benefits equivalent to semi-private accommodations, and all normal services for a total of 90 days for one "spell of illness." For the first 60 days all but $40 is covered by medicare payments; for the next 30 days all above $10 a day.
- Extended care benefits for 100 days following hospitalization in a nursing home. The insurance will cover the first 20 days of this treatment, and for the remaining 80 days, the cost above $5 a day.
- Home health benefits following hospitalization and including part-time nursing care, therapy and the use of medical appliances.
- Outpatient diagnostic benefits above the first $20 charge for X-rays and laboratory tests.

DOCTORS STILL COST

Physicians' and surgeon's fees are not included in any of these services. This is what makes the supplementary medical insurance so important and accounts for the eager participation.

For $3 a month, to be matched by the federal government, this voluntary insurance will pay 80% of doctors' fees after the first $50 a year, and will also cover some services not included in the medicare bill.

(Continued on Page 11)

The provisions of both parts of medicare together then do not take the financial problem out of sickness. They merely alleviate it.

For those barely able to make ends meet on old age pensions it will still be a problem to pay a $3 a month doctors insurance to scrounge up the $50 deductible and to meet the 20% of the doctors' fee.

At best a very partial solution, the program is also shackled to many of the problems that already beset medical service.

Most of these are based on what Gibbons describes as the "well entrenched economic self-interest and deadening restrictive practices that have dominated the 'power to heal' for many, many generations . . . This power has become a major economic self-interest monopoly and part of a political cartel that would hold back necessary social changes while scientific and technological progress achieve new heights in the human endeavors of man."

The government, for example, has committed itself to payment of "reasonable" but unspecified fees for medical services.

This concession, which bought the cooperation of the medical establishment, has a stranglehold on the plan already.

Even before the program went into effect, Arthur Hess, director of the U. S. Bureau of Health Insurance, told U. S. News & World Report (May 9) there was no assurance the $3-a-month fee for medical expenses would prove adequate.

"The cost of medical services," he said, "like everything else, will rise over future years. At some future time, the premium may have to be increased, too.



No Medicare Rush In Area Hospitals

No rush of patients to "cripple" Medicare materialized Friday in Colorado and Denver area hospitals.

Joseph Sewall, Denver district manager of the Social Security Administration, said the Friday load was normal.

Nationally, hospital administrators and officials had the same thing to say: "It's business as usual."

Many attributed the normal level to two things — the holidays and existing medical welfare plans.

Martin Jepkes, director of the Medicare division of Colorado Blue Cross and Blue Shield, said his office had predicted a normal patient load.

Jepkes was one of many who credited Colorado's welfare program, but also said group medical plans like Blue Cross had enabled Coloradans to receive good medical attention in the past, so there was no great increase now.

"Because of Colorado's liberal and comprehensive medical plan, plus those on Blue Cross and those who carry their own insurance, I don't see that there are going to be great masses of people swamping the hospitals," Dick MacLeish, director of the Colorado Hospital Association, said.

There were problems, but they were minor. Both the Blue Cross offices and the Social Security Administration were swamped with calls from hospitals and prospective patients seeking information.

Jepkes said some hospitals had experienced difficulties in getting all the forms required for processing patients. But all had the necessary admission forms, and Jepkes said billing

Continued on page 3.

Pueblo (Colo.) Star-Journal, Friday, July 1, 1966

Pueblo Hospitals Admit First Medicare Patients

Picture on Page 1

A 78-year-old retired plumbing engineer, visiting his daughter in Pueblo, is the first patient admitted to St. Mary-Corwin Hospital under federal Medicare that became effective today.

George Murray was admitted of treatment of chronic bronchitis. He and his wife, Ruby, are spending the summer with his daughter and her husband, Mr. and Mrs. Ronald O. Byerly, 331 Yeta.

During the winter, the Murrays reside in Mesa, Ariz. In the spring, they travel throughout the west in their trailer. Murray and his wife are avid rockhounds. Before his retirement nine years ago, Murray was a plumbing engineer at Ft. Ord, Monterey, Calif.

Mrs. Cleason O. Cox, 2019 E. 14th, was the first patient to register at Parkview Episcopal Hospital. She was admitted at 9:30 a.m. Friday for treatment of a heart condition.

Her husband is a retired construction worker. The couple moved to Pueblo from Grand Junction 16 years ago. Both signed for Medicare soon after it became available.

Coming under Medicare today are 75 patients at St. Mary-Corwin Hospital and 50 at Parkview Episcopal Hospital. Colorado State Hospital officials reported that an estimated 50 patients are eligible to participate in the program, but that it is unlikely that any patient will be admitted to the hospital solely because of medicare.

Officials at Parkview and St. Mary asserted they expect no large increase in the number of petients because of Medicare. Each hospital normally operates under a capacity situation.

St. Mary-Corwin had 85 patients over 65 years of age at midnight Thursday. This figure, representing 22 per cent of the total patients, is below the normal figure for that age group. Usuallly, about 25 per cent of the patients are over 65.

Bookkeeping Big Problem

Bookkeeping represents the biggest problem for both hospitals. Under government regulations which went into effect with Medicare, a more elaborate system of keeping books is necessitated. Parkview has increased the help in the business office by about 30 per cent. St. Mary-Corwin had business personnel working o ver-time, but has not yet increased the staff. Sister Marie Edgar, hospital administrator, said she expects that more help will be hired.

A special "Part-B Coffee" was held at St. Mary's this afternoon for employes, visitors and the general public. The "Part-B" refers to the optional medical insurance portion of Medicare. Under this plan, the patient pays the first $50 on bills for doctors and other covered medical services in any calendar year, and then also pays 20 per cent of his covered medical expenses, with the government paying the other 80 per cent.

Questions Answered

To emphasize this program, Sister Marie Edgar said the coffee sold for two cents per cup, rather than the usual 10 cents. The figure is 20 per cent of the usual cost, the same as the Medicare policy. Written explanations were distributed with the coffee, and staff members answered questions.

Thirteen hospitals in the Pueblo and Arkansas Valley area have been certified to participate in the Medicare, according to Carl Bruner, manager of the Social Security district office here.

All Costs Not Covered

For older people who are in the hospital between now and the end of the year, Medicare will pay hospital costs over and above the first $40 of services provided July 1 or later, Bruner said. Costs over the $40 deductible are covered for a stay of 60 days or less. If the older person stays in the hospital for more than 60 days, Medicare will pay all but $10 a day for an additional 30 days.

Bruner said that both the basic hospital insurance part of Medicare and the voluntary program of medical insurance go into effect today. The coverage of home health visits, provided under both the basic hospital plan and the voluntary medical insurance plan, also began today.

However, payment for post-hospital extended care in skilled nursing homes does not become effective until next Jan. 1.

COLORADO SPRINGS, COLORADO

JULY 1, 1966

FREE PRESS

COLORADO SPRINGS, COLORADO * FRIDAY, JULY 1, 1966



—Free Press Photo By George Lantz

ONE OF FIRST—Youthful geriatric patient Dulaney Moberly, 70, of 306 E. Cucharras now hospitalized at Memorial Hospital is first to assume Medicare status at facility from Mrs. Rosemary Stutheit (left), admitting registered nurse Thursday. When clock struck midnight, some 13,000 local persons aged 65 and over qualified for government's new Medicare program. While health benefits are extended to senior citizens when they reach age 65, each must personally contact Social Security Administration office for Medicare card and enrollment in medical and hospital program. Those who do not apply do not receive coverage.

FRONT PAGE

COLORADO SPRINGS, COLORADO

JULY 2, 1966

FREE PRESS FRONT PAGE

No First Day Overcrowding

Hospitals Handle Medicare Easily

BALTIMORE, Md. (UPI)—The nation's hospitals, most of them prepared for a deluge of patients that never came, took the first day of Medicare in stride Friday. It came as a surprise to critics who had predicted turmoil.

Nearly every American 65 years or older became eligible at 12:01 a.m. EDT for benefits under the health insurance amendment to the Social Security Act. But most of those who intended to use the plan apparently decided to wait until after the July 4 weekend.

SOCIAL SECURITY Administrator Robert H. Ball told a news conference at his headquarters here that the vast program began "very smoothly with no indication of hospital overcrowding."

Ball thus confirmed reports to UPI from hospital administrators across the country that the jam-up forecast by some failed to materialize.

A government telephone survey of 100 hospitals disclosed that admissions were "running at normal rates," Ball said. Only 10 of the 100 were filled completely and "none attribute overcrowding to new Medicare admissions," he said.

However, there were some reports of administrative difficulties over handling Medicare patients' paperwork.

MOST HOSPITAL administrations predicted that the influx of Medicare patients from among the 19 million older Americans would pick up considerably after Independence Day. July normally is a slow month for hospitals, and this was one reason officials decided to start the program on July 1.

Ball said there were 160,000 patients now in hospitals whose bills will be paid by Medicare. Most were admitted before the program began.

Surgeon General William H. Stewart told reporters that 320 hospitals still had not met desegregation requirements for participation in medicare.

Of the non-qualifying hospitals, 198 were in Alabama, Mississippi, Louisiana, Georgia, South Carolina, Virginia and Florida.

The other 122 hospitals, also in-

See MEDICARE, Page 2

MEDICARE . . .

Continued from Page 1

eligible because of the nondiscrimination section of the 1964 Civil Rights Act, are being reviewed by the Public Health Service to determine whether they have changed their policies to comply.

Ball and Stewart said 6,593 hospitals had received either full or temporary approval.

ALL PARTS of the country reported possible "firsts" for a Medicare enrollment. But all said Mrs. Lillian Grace Avery, 68, of Naperville, Ill., officially was the first to enroll because her name was the first received over the Social Security Administration's national communications network.

COLORADO SPRINGS, COLORADO

JULY 2, 1966

FRONT PAGE

GAZETTE TELEGRAPH

COLORADO SPRINGS—SATURDAY, JULY 2, 1966



MEDICARE EARLY BIRD — Mrs. Gertrude Snyder, 77, of Cumberland, Md., signs up for Medicare at University of Maryland Hospital, where she is being treated for throat and skin ailments, as nurse Anne T. Hammerlund observes. Mrs. Snyder was one of first in Baltimore to apply for health program effective yesterday. (AP Wirephoto)

* * *

Medicare Desegregates Some Hospitals

By STERLING F. GREEN

WASHINGTON (AP) — With hospital-like efficiency the nation's medical plant easily absorbed Friday the first-day impact of medicare — and, in many Southern cities — desegregated thousands of hospital beds.

City after city reported, "no rush," "everything normal," "no problems," "going smoothly." Some hospital officers predicted heavier admissions after the Fourth of July. Others cautioned that the full impact is still a month or more away.

"An auspicious start," commented the U.S. surgeon general William H. Stewart.

Stewart and Robert M. Ball, Social Security administrator, estimated that 94 per cent of the nation's general hospitals, representing 95.9 per cent of the beds, were prepared and qualified to participate in medicare.

They met reporters jointly in Social Security's Telecommunications Center in Baltimore, Md. There, a nationwide wire network will feed data on the 19 million medicare policyholders into and out of computers.

The totals given by Ball and Stewart were a bit higher than those from other federal offices, but all sources agreed on this:

(Turn to Page A2, Column 6)

Medicare Desegregates Some Hospitals

(Continued From Page One)

Hospital participation was far broader, especially in the South, than authorities had dared to hope for a month or two ago.

Most of the several hundr Southern hospitals outside t program had failed to comply with the no-racial-discrimination provisions of the Civil Rights Act. They are therefore ineligible for federal payments under medicare of any other federal program.

President Johnson — known to have been seriously concerned a few weeks ago at predictions that elderly patients would suddenly swamp understaffed hospital facilities — was notified by telephone of medicare's flying start and strong participation.

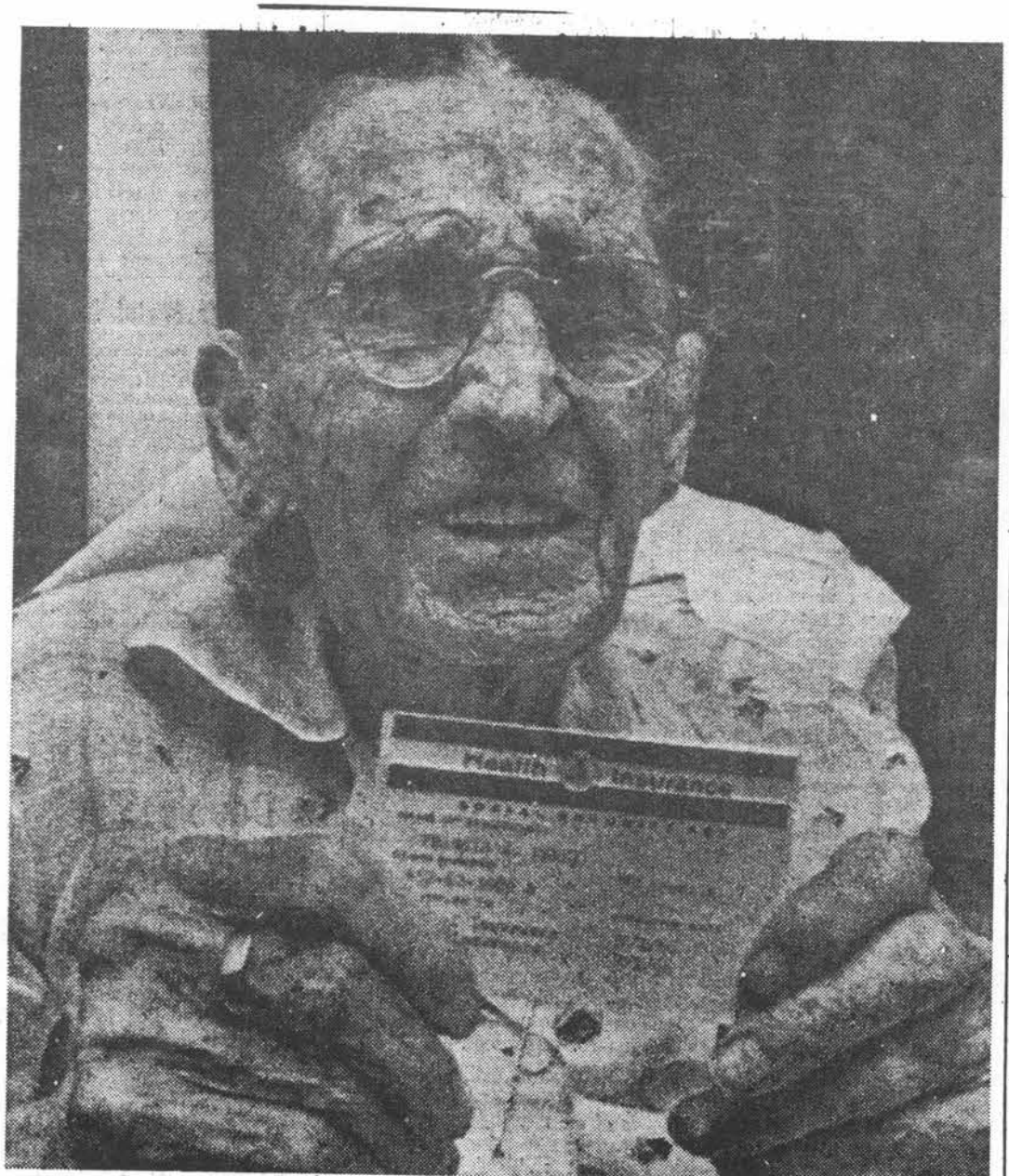
Thousands of patients 65 and older who were already in hospitals became the instant beneficiaries of medicare at 12:01 a.m., by a mere bookkeeping transaction. Medicare automatically picks up their bills from July 1 until their 90 days of benefits expire, except for a $40 "deductible."

At the same moment, Eugene Schneider, 65, an embroidery worker from West New York, N.J. showed up at New York's Polyclinic Hospital for treatment — and became hospital's first new medicare admission.

COLORADO SPRINGS, COLORADO

JULY 2, 1966

FREE PRESS -- FRONT PAGE



—Free Press-UPI Telephoto

FINALLY SHE HAS MEDICARE—Frances Perry of Dallas might not know just exactly what it is all about—"explain it to my daughter," she said—but at age 100, she is more than eligible for Medicare. Mrs. Perry, born on May 5, 1866, has the 65 age requirement beat by many years. When Medicare was explained, Mrs. Perry allowed as how it might be a good thing since some people can't afford to pay. She pointed out however that she had always been able to struggle through. The Medicare program took effect Friday.

COLORADO SPRINGS, COLORADO

JULY 2, 1966

FREE PRESS -- FRONT PAGE

AMA Rebellious Over Medicare

CHICAGO (UPI) — The American Medical Association Thursday rejected warnings it might be inviting costly anti-trust suits and stuck by its proposal that hospital-based doctors boycott any hospital that does not allow them to bill patients separately for services.

Staging its second floor revolt in two days, the AMA house of delegates voted almost unanimously not to reconsider a resolution, passed Wednesday, making that suggestion.

THE POLICY - MAKING house held to its stand over the objections of leaders who warned that it contained "severe risks" and that the matter should be studied further.

Joseph B. Copeland of Austin, Tex., a member of the AMA board of trustees, pleaded for reconsideration of the resolution to avert possible costly litigation. He said that already the AMA was "getting about two suits a week" and that a $19 million suit now is pending against the organization.

SUPPORTERS OF the measure argued against reconsideration.

Wendell G. Scott, a delegate from St. Louis, Mo., said:

"Gentlemen, if we are afraid of being sued we could not practice medicine."

In another action at the concluding session of the AMA's 115th annual convention the house approved a resolution saying doctors should not be required to attest that they do not discriminate racially in treating Medicare patients.

The resolution said physicians should not be required to sign any agreements indicating compliance with the 1964 Civil Rights Law while rendering professional services under federally-assisted programs.

The new AMA president-elect, Milton O. Rouse of Dallas, Tex. said Thursday he was going to practice medicine in the Medicare era just as he always did.

"I DON'T HAVE to be concerned with the Medicare law," he told a news conference. Asked if he had read the law, he parried:

"Why should I clutter up my brain with the Medicare law?"

COLORADO SPRINGS, COLORADO

JULY 3, 1966

GAZETTE TELEGRAPH--FRONT PAGE

No Rush Seen By Patients For Medicare

DENVER (UPI)— The federal government started paying part of the hospital bills Friday for elderly Coloradans who signed up for Medicare benefits.

There was no rush on the state's 84 hospitals certified under the government program. Those patients immediately affected already were hospitalized.

An estimated 3,000 patients covered by Medicare were in the federally certified hospitals in Colorado when the program officially went into effect one minute after midnight Friday.

Beth Israel Hospital reported 47 of its 114 patients automatically came under the program. St. Joseph Hospital had 97, Mercy Hospital had about 60, St Luke's had 115, Swedish Hospital in Englewood had 45, Boulder Community Hospital had 27, Boulder Memorial Hospital had 24, and Poudre Valley Memorial Hospital at Fort Collins had 16

Some Colorado hospital administrators felt the number of Medicare patients in their hospitals would increase during the fall.

The program pays all hospital costs except the first $40 for patients hospitalized for 60 days, and all but $10 for patients hospitalized up to 90 days.

COLORADO SPRINGS, COLORADO

JULY 3, 1966

ROCKY MOUNTAIN NEWS--PAGE 29

15 Pounds Lighter

Dreamy Way To Shed Fat

By PASQUALE MARRANZINO

SUNDAY, JUNE 26 (The Lord's Day) — Slim, trim **Barron B. Beshoar,** chief of the Time-Life Bureau here, was telling about the reducing experience of a fat friend whose obesity led him to a doctor for advice. The doctor prescribed a 7-day smash program which he guaranteed would shed 15 pounds. "All you do is take one of these pills every night before bedtime," the doctor said, "and you will be 15 pounds lighter." The fat man followed the order but observed that each night he dreamed an exasperating dream of chasing a girl with proportions like Sophia Loren and never quite catching her. But at the end of the week he was 15 pounds lighter. An equally fat friend observed the loss and made inquiry and ended up with the same doctor. At the end of the week the second fat man appeared before his doctor and noted that he had lost 15 pounds. "But," he explained, "my friend dreamed he was chasing a beautiful girl. Instead, I dreamed I was being chased by a huge, ugly gorilla. How come?" "You wanna know how come," the doctor answered with anger. "I'll tell you how come. "You're on Medicare!"



Marranzino

Denver Post, Denver, Colo.
July 3, 1966



UPI Telephoto

WORKERS IN MEDICARE DIVISION AT TULSA, OKLA., BLUE CROSS AREN'T BUSY
Only a trickle of Medicare patients reported to Tulsa hospitals on Friday.

AMA Plans Direct Bills In Medicare

CHICAGO—(AP)—Consideration of the Medicare program highlighted the week-long American Medical Association (AMA) convention attended by 15,000 doctors.

The AMA's House of Delegates, its policy-making body, overruled an AMA advisory committee when it adopted without dissent recommendations of the Board of Trustees and delegations from Florida, Iowa and Illinois.

The final action put the AMA on record as calling on "each and every member of this association" (214,000) to submit his bill directly to the Medicare patient, rather than collect their fees from an assigned agency of the federal government.

Both methods are permissible under the Medicare act.

The AMA also adopted a Florida delegation resolution recommending that no special review or mediation committees be set up in hospitals solely to handle Medicare cases. It recommended that the standard mediation or review mechanism of the county medical society be utilized.



Denver Post Photo by David Mathias

CHESTER C. HADDAN, LEFT, EXAMINES ARTIFICIAL LIMB
Charles Smith, 865 E. Alameda Ave., was fitted with the new limb Friday.

Denverite, 79, Will Go Fishin' With Help of Leg by Medicare

A 79-year-old Denver man, anxious to return to his favorite pastime of fishing, Friday became the first Coloradan to receive an artificial limb under Medicare.

Charles Smith, 865 E. Alameda Ave., was fitted with a new leg by Chester C. Haddan at Gaines Orthopedics, 1633 Court Place.

Haddan, recently appointed state Medicare chairman for prosthetics and orthotics by the American Orthotic and Prosthetic Association, had been working with Smith for several weeks in preparation for Medicare, which started Friday.

Under Medicare, such services are provided those over 65 on their doctor's prescription.

Smith had his right leg removed recently as a result of a circulatory illness.

Haddan told of another Denver man who lost both his legs. He was able to pay for one several months ago, bought it and has been walking with the one leg and a crutch waiting for Medicare to begin to obtain the other, Haddan said.

He said it usually takes about a month for a person to learn the use of a new limb. But in Smith's case, it may not be that long, he said.

"He's itching to go fishing," Haddan said.

Denver Post, Denver Colo,
July 3, 1966

MEDICARE PROBLEMS FEW

Worries Take a Holiday

(Editor's Note—Members of a special AP task force kept a close watch throughout the first day of Medicare in a group of hospitals around the country. The following account is based on their reports.)

NEW YORK — (AP) — Down the corridors of Miami's Jackson Memorial Hospital figures in white passed each other with a cheerful greeting: "Happy Medicare!"

For the nation's hospitals Friday was indeed happy Medicare —the first day of the Social Security hospital program for persons 65 years and older had gone smoother than anyone had dared hope.

CARDS LOST

Still, there were problems: mountains of paper work, missing forms, bewildered patients, lost Medicare cards, and one woman who got mad and swung her purse at a hospital worker.

By midafternoon in the usually frantic emergency room at Jackson Memorial interns sat with their feet propped on a table.

"It's the quietest day we've had," said Dr. James Connaughton, who joined the Miami hospital last month after graduation from the University of Indiana.

The situation was virtually the same in hospital after hospital across the United States. Fear expressed by some that medical facilities would be swamped by elderly people evaporated as the day wore on like any other before a Fourth of July holiday.

FIRST IN NATION

Northwest Hospital in Seattle, the first in the nation to be certified for Medicare, admitted not a single Medicare patient. Six elderly patients already in the hospital, however, were automatically switched over to Medicare at its start, 12:01 a.m. Friday.

"Heaven help us when Tuesday comes," said Alfred E. Riley, business manager of St. Elizabeth's Hospital in Chicago. Riley said he looks for a big inflow of patients then because of the people who wanted to be home for the holiday or delayed entry because so many doctors would be away for the weekend.

At 9 a.m. on the first day, Anna Winston, 71, of New York City, showed up in the emergency room at mammoth Mt. Sinai Hospital complaining of "aches and pains." Within an hour she became one of the hospital's 19 first-day Medicare admissions.

'VERY SICK'

"I knew I'd wind up in the hospital because I was very sick," Mrs. Winston said. "I should have been here a month ago, but I couldn't get into this or any other place."

The biggest problem faced by the hospitals is the increased load of paper work. Mt. Sinai added 41 clerks just to handle all the new forms and extra bookkeeping. Other hospitals are also taking on new help.

At St. Joseph's Infirmary in Atlanta, business manager David Messinger recalled that he had spent 20 years in the Air Force as a medical budget officer. He shuffled the forms piled high on his desk and said, "I'm right back home again. I haven't had much sleep in three days. I can't sleep any more, trying to figure out what to do about Medicare."

223 LAB TESTS

Most frightening to him is the requirement for itemized billing for laboratory tests. There are 223 lab tests listed by the hospital, and special billing forms are required — and at least two sets must be filled out for Medicare.

An information desk was set up on the main floor at Detroit's Henry Ford Hospital, where more than 200 elderly persons came with questions about the program.

One elderly woman insisted a girl behind the counter was wrong when she explained that Medicare doesn't cover all expenses. "You're trying to line your pockets with my Medicare money," the woman shouted, and swung her purse at the girl.

GIRL DUCKED

The girl ducked and the blow glanced off her hair. She retreated into a nearby office and the woman stomped out.

"They're generally surprised to learn that everything isn't paid for," said Miss Thelma Cogswell, clinics admitting officer at Massachusetts General Hospital in Boston.

She said the clinic patients were used to being "whisked through" the formalities of being checked in. But Friday there were delays because of the Medicare forms to be filled out. Miss Cogswell added:

"The hardest part at this point is that nothing is cut and dried. If we had been given a few simple rules to follow it would be a lot easier."

By the end of the first day at Massachusetts General the hospital had 941 patients, of whom 260 were over 65 years. During the day the hospital admitted 67 new patients, 18 of them under Medicare. Eight of the Medicare patients entered the hospital after 5 p.m.

HECTIC NIGHT

"The newness of it all gave us a hectic night," said John Stella, night admitting officer.

Queen of Angels Hospital in Los Angeles didn't have a single Medicare admission until midafternoon, when a doctor called to advise he was sending in a male heart patient.

"The hospital census always goes down to rock bottom on July 4," said a hospital spokesman.

Also affecting admissions, he said, was the fact that California put into effect its own program March 1, absorbing early the influx of patients.

NEED FORMS

Plaguing some hospitals was the fact that they had not received all the necessary forms. That produced the only crisis at Miami's Jackson Memorial Hospital. The forms necessary to transfer 154 patients already in the hospital to Medicare didn't arrive until Friday morning.

Massachusetts General didn't get two of the forms at all, and Thursday afternoon hospital officials sent a few of the sample copies to the printers for a rush order.



AP Wirephoto

AT 112, SHE'S AMONG FIRST MEDICARE PATIENTS Mrs. Sarah Edwards of Orlando, Fla., walked into the Florida Sanitarium Friday. She says she is suffering from "infirmities of old age" and has entered hospital to be "built up." Her doctor says she is doing fine.

Paper Rocky Mtn News Place Denver, Colo. Date 7/2/66

Colorado Medicare Plan Takes Effect Quietly

By WILLIAM LOGAN
Rocky Mountain News Writer

So quietly did Medicare take effect Friday for 177,000 Coloradans that the faintest old heart boomed loud and clear through hospital stethoscopes.

In a sampling of about a dozen hospitals of the 84 in Colorado certified eligible to participate, no mass influx of patients was found to materialize.

Only an estimated 3000 persons 65 or older were in the federally certified hospitals' 12,438 beds.

"We wish to assure everyone today the doors were not torn down," said Harry Yaffee, administrator at Beth Israel Hospital. "We hadn't anticipated they would be."

Hospital administrators said Medicare went into effect apparently at a carefully timed moment—and said there probably could be a rush later.

Holiday Effect

It's summer, they said, and the living is easy. It's the beginning of a 3-day Fourth of July holiday —and who, they asked, wants to enter a hospital if they can possibly put it off until later?

Yaffe's hospital had the highest percentage of Medicare patients among institutions checked. He said 47 out of 114 patients—or 41 percent—automatically fell under the program.

"We had very few admissions today," Yaffe added. "Later, toward the fall, we may note a rise."

All programs under Medicare except skilled nursing began. That starts Jan. 1.

Under the hospitalization program, the patient pays the first $40, then the federal Health Insurance Program pays the remainder through the 60th day of hospitalization.

For patients hospitalized longer, the Federal program pays all but $10 for the 61st through the 90th days. There's no Medicare provision from the 91st day on.

Under the physicians' services program—available at $3 a month for elderly patients—there's a $50 deductible provision on a calendar year basis. Thereafter, the program pays 80 percent of doctors' reasonable charges. The patient pays 20 percent—plus anything beyond a reasonable charge.

Blue Shield has been designated by the Federal Government to determine a reasonable physician's charge. It will receive and pay physicians' bills in Colorado, and Blue Cross will receive and pay bills under the Medicare hospital insurance program.

Where blood is needed, the patient pays for the first three pints. The Medicare program pays for the rest.

At St. Joseph Hospital, Miss Natalie Katt, publicity director, said, "I went down to see if we had a big calamity on the first day of Medicare. It was very quiet.

"We have 97 who are over age 65 (22 percent) of the 452 patients today. It may be up a little bit, but I would say very few of the patients are elective at this point. They needed hospitalization.

"I keep thinking this may be the calm before the storm."

John Carroll, comptroller at Mercy Hospital, said, "Today has been pretty calm, actually. We had more than 60 in the house who had benefits that took effect, about 25 percent of our patients.

"I didn't expect it to be quite this high,—to begin with anyway. We have two or three coming in this afternoon."

'Too Early to Say'

Arnold Knutsen, assistant administrator at St. Luke's Hospital, said, "It's too early in the game to say. There seems to be an indication a certain number of surgical procedures were postponed until patients became eligible for Medicare.

"But I can't say it's overwhelming now. We have 115 in the hospital eligible, approximately 25 to 30 percent of our patient load at this time.

"This is a grand experiment, of course. We don't know how it's going to work out. We're just going to have to watch it and develop hospital procedures as required."

E. V. Kuhlman, assistant administrator at St. Anthony's Hospital, said:

"There's been no marked impact at the moment. We had 50 patients who qualified for Medicare and we expect a gradual increase."

Gene R. Barron, Boulder Community Hospital administrator, said of the 98 patients in the 110-bed hospital at midnight Thursday, 27 fell under Medicare.

Subdistricting Amendment

Signatures Obtained	Signatures Still Needed
44,008	2247

(46,255 signatures required to put question on Nov. 8 ballot. Backers seeking 52,-000 names by July 8 to be assured of getting enough valid signatures. Above totals released Friday by Howard N. Yates, vice president of the Colorado Plan for Apportionment Inc.)

Rocky Mtn News
Denver, Colo. 7-2-66

Rejected Program

"One said he didn't want anything to do with Medicare," Barron said. "And one went home. We've admitted no patients today over 65. On Monday we have two patients over 65 scheduled to come in and on Tuesday we have one. This would be a normal thing."

The office of Arvid Brekke, Swedish Hospital administrator, reported, "We have 45 out of 191 patients who are 65 or older.

"But we don't feel people over 65 in Colorado have had as much lack of care as those in some other states."

Jack Houtz, assistant administrator at General Rose Memorial Hospital, said, "So far as billing procedure is concerned, we're well prepared to handle the paper work.

"We really haven't had an impact yet. About 23 percent of our 96 patients at midnight fell under Medicare. We will admit six later today."

'Average Day'

Dr. David Cowen, Denver health and hospitals manager, said Denver General Hospital had "an average" day.

"As the holiday weekend progresses and doctors' offices are closed, we're bound to have a rise in out-patients, particularly with cuts and abrasions from picnics and outings. But I think our load thus far is normal," Dr. Cowen said.

Warren Clark, Boulder Memorial Hospital administrator, said 24 of the 67 patients in his hospital went under Medicare.

"The only increase we expect is in the paper work — that's going to swamp us," he said.

Mrs. Dorothy Hadwick, public relations director at Poudre Valley Memorial Hospital in Ft. Collins, said 16 patients, or 17 percent of the patient load, were tranferred to Medicare Friday.

"Most of the 16 are over 80 years old," she said.

Paper Denver Post

Place Denver, Colo.

Date 7/1/66

Form HEW-123

AMA Standing Fast On Direct Bill Plans

SEE STORY PAGE 1

CHICAGO — (UPI) — The American Medical Association (AMA) ignored the possibility of federal antitrust suits Thursday and urged boycotts of hospitals that didn't allow doctors to bill patients separately.

The AMA's stormy 115th annual convention came to a close on the eve of perhaps the biggest change ever to hit the U.S. medical profession — the advent of Medicare.

WARNING ISSUED

The AMA's new president, Charles L. Hudson of Cleveland, Ohio, asked the AMA's policy-making House of Delegates to reconsider its resolution calling for the boycotts which it passed Wednesday. A debate flared after Hudson warned the AMA might get hit with a federal antitrust suit.

Joseph B. Copeland of Austin, Tex., a member of the AMA Board of Trustees, asked reconsideration to avert costly litigation.

The AMA is "getting about two suits a week" and a $19 million suit now is pending against the group, he said.

"Gentlemen, there are many people who want you wiped out as an organization," he said.

AMPLE DEBATE

Wendell G. Scott, a delegate from St. Louis, Mo., replied, "We should stand behind our resolution. It was made after ample debate.

"How long, of Lord, how long will it be before this house makes its own decisions," Scott pleaded.

In another action on the last of the five days of convention deliberation, the house resolved that doctors do not have to sign affidavits to prove that they are practicing in accordance with the civil rights act in Medicare matters.

Dr. Donald R. Hayes, chairman of a house reference committee, said such signed statements are not necessary under federally assisted programs.

NO BAIS

Further, he said, such a requirement "is unacceptable to physicians who have traditionally treated patients regardless of color, creed or national origin."

Milton O. Rouse, newly chosen president-elect of the AMA, strengthened the position later at a press conference. He said he was going to practice medicine as he always has after Medicare became effective Friday.

"I don't have to be concerned with the Medicare Law," Rouse said. He said he planned to bill his patients directly and let them worry about being reimbursed by the government.

Asked if he had read the act, Rouse jibed, "Why should I clutter up my mind with the Medicare Law?"

The house Thursday, also approved a rise in AMA dues from $45 to $70, a program for sending medical aid to Viet Nam and strict control of drugs such as LSD.

Rocky Mtn. News
Denver, Colo.
July 1, 1966

15 Pounds Lighter

Dreamy Way To Shed Fat

By PASQUALE MARRANZINO

SUNDAY, JUNE 26 (The Lord's Day) — Slim, trim **Barron B. Beshoar,** chief of the Time-Life Bureau here, was telling about the reducing experience of a fat friend whose obesity led him to a doctor for advice. The doctor prescribed a 7-day smash program which he guaranteed would shed 15 pounds. "All you do is take one of these pills every night before bedtime," the doctor said, "and you will be 15 pounds lighter." The fat man followed the order but observed that each night he dreamed an exasperating dream of chasing a girl with proportions like Sophia Loren and never quite catching her. But at the end of the week he was 15 pounds lighter. An equally fat friend observed the loss and made inquiry and ended up with the same doctor. At the end of the week the second fat man appeared before his doctor and noted that he had lost 15 pounds. "But," he explained, "my friend dreamed he was chasing a beautiful girl. Instead, I dreamed I was being chased by a huge, ugly gorilla. How come?" "You wanna know how come," the doctor answered with anger. "I'll tell you how come. "You're on Medicare!"



Marranzino

AMA War Chest Is Enlarged in Fight on Medicare

CHICAGO, June 30—(AP)—The nation's physicians taxed themselves another $4 million in dues Thursday mainly to finance opposition to the Government Medicare program, which starts Friday.

The American Medical Assn. House of Delegates voted 168-46 to increase annual dues from $45 to $70. The association has 168,000 dues paying members. The AMA's annual budget is now about $28 million.

Many delegates who opposed the increase on the floor expressed concern that it might keep young physicians from joining the AMA.

Denver Post
Denver, Colo.
7/3/66

CHAMPAIGN-URBANA COURIER

Friday, July 1, 1966—Delivered on R.F.D. Routes July 2

No Long Medicare Lines

But 100 Local Patients Now Eligible.

By Jean Andrews

As expected, no lines of elderly persons formed in front of local hospitals Friday morning to be admitted under Medicare. The trend was expected to be more gradual than that.

However, somewhat more than 100 persons, already patients in the hospitals, became eligible for Medicare at midnight.

"We are getting ready to transfer the ledgers," a member of the business office staff at Mercy Hospital said at midmorning. Some 54 Mercy patients had become eligible for the government program at midnight.

Burnham Hospital had 26 patients 65 or over in the hospital who at midnight became Medicare patients. The admitting office at 11 a.m. reported, that as it happened, not one new patient over 65 had been admitted so far that morning.

30 Expected

At Carle Hospital "four are about to be admitted" under Medicare, it was reported. These were persons who had seen their physicians and had appointments for hospitalization in advance. By the end of the day some 30 Medicare patients, counting those already hospitalized, were expected to be under the plan at Carle Hospital.

Local hospital officials previously had predicted that it would be as long as 30 days, or more, before an added load from the "free" hospitalization becomes evident.

Predictions of what the added load will be evenutally have ranged from 5 to 50 per cent. One local hospital administrator felt that a 20 per cent increase might be a safe guess.

Area Hospitals

Participating hospitals in the area surrounding Champaign-Urbana reported no rush of elderly patients admitted. They include hospitals at Gibson City, Paxton, Tuscola, Mattoon and Charleston.

It was pointed out that Friday is a day on which admissions are relatively light at most hospitals because little surgery is scheduled in advance for the end of the week.

MEDICARE BEGINS

The Medicare program, providing hospital insurance for the nation's 19 million senior citizens, went into effect Friday along with an optional doctor-bill insurance plan.

A few hours earlier, the American Medical Association (AMA) concluded its 115th convention in Chicago with a resolution urging doctors to boycott hospitals that don't allow them to bill patients separately.

The AMA urged physicians to bill Medicare patients directly and let the patients collect from the government. And it predicted "serious problems" in Medicare.

TULSA DAILY WORLD 7-2-66 TULSA, OKLA.

Medics Gear for Flood, Then Wade Into Trickle

By CHUCK WHEAT
Of the World Staff

The fear that Medicare would gobble Tulsa's medical facilities like a lion among sheep proved false Friday.

Medicare marched in like a lamb.

Friday's first day of government-financed medical care for the aged proved to be a quiet one. Spokesmen for Tulsa's hospitals said there was not a flood of patients now that Medicare will help pay the bill; there didn't even seem to be a wavelet.

"We were geared up for a mob," said one admissions officer, "but they stayed away in droves."

During the morning hours, the hospitals performed the paperwork to transfer oldsters already being treated to the Medicare payment system.

The first batch of forms went to the Blue Cross plan—Oklahoma's secretariat for the hospital end of Medicare—shortly after noon. It was from Hillcrest Medical Center and contained 47 patients who had been in the hospital already.

The first form in this group belonged to LaVerne Davis of 3536 E. 21st Place, who was admitted Thursday with an injured right hip.

Fifteen employes in "Medicare Manor," the Blue Cross building's annex north of the main headquarters, waited for a deluge that hardly dented the drouth.

Hillcrest admitted 6 new Medicare cases Friday and St. John's admitted 16. Hillcrest had about 100 and St. John's had about 140 already, and that paperwork provided the bulk of the Medicare action.

At St. Francis Hospital, no one kept count. The hospital's administrator estimated a patient load of "30 to 40" oldsters eligible for Medicare.

Oklahoma Osteopathic Hospital had about 100 oldsters, but no more than 10 new admissions Friday among Medicare eligibles.

Tulsa doctors, however, reported a small upsurge of action among older patients. So the hospitals are expecting a slow increase in admissions until the average load of new Medicare cases in all Tulsa hospitals reaches about 50 a day.

This week's unanimous resolution by delegates to the American Medical Association meeting in Chicago urges doctors to shun the forms for doctor payments under Medicare, and instead require patients to submit these forms themselves to the Medicare system.

Privately, many Tulsa doctors said they are going to ignore the AMA resolution. Some defended it, but others called it ridiculous.

Most said they will have some clerical worker in their office to help patients fill out and submit the forms.

A few said they are going to submit them for the patients. Doctors submit the paperwork for payment from Blue Shield and the state Welfare Department, and for insurance companies.

The difference in the method of payment is that if the patient submits the form for personal reimbursement, he must include a receipted bill. This means some old patients may have to borrow the money to pay the doctor, and then wait for the Medicare reimbursement.

One hospital reported an incident that may be symbolic of the confusion surrounding the coming of Medicare.

Bright and early Friday morning, an old gentleman walked into the admitting office and demanded a bed. He was sick and wanted treatment.

Hospital workers explained no one can be admitted to a hospital without a doctor's order to do so.

"Doctor? Doctor?" he raged. "You've got the doctors. Medicare takes care of all that now."

Six hospitals in Oklahoma City reported only about a half dozen admissions under medicare Friday while four in Tulsa had about 40.

One of the first to come under the new program was A. J. (Dutch) Strauss, managing editor of the Enid Morning News and Daily Eagle. He underwent surgery in an Oklahoma City hospital a few hours before medicare took effect.

The 69-year-old newsman said he has "never drawn a penny of Social Security." However, he said he "signed up for medicare for extra protection . . .it's here and we might as well accept it."

Tulsa Daily World
Sunday, July 3, 1966

No Medicare Problems Hit Kansas

No rush and no major problems. That was the way the Medicare program began in Kansas.

Wichita's five hospitals reported only nominal admissions of patients during the first hours of the program. They said some patients lacked identification cards, which were mailed to elderly persons earlier, but that this did not bar admission—just meant more paper work.

One Hutchinson hospital said it had received no Medicare patients. The other admitted one Thursday night and expected two more Friday.

No problems were noted at Salina.

At one hospital in south-central Kansas, a doctor showed up wearing a black arm band. He explained to a patient that "This is the first day of Medicare."

At Leavenwoth officials of St. John Hospital said 15 patients have been admitted who will be covered by provisions of the Medicare bill.

Tulsa Daily World
Sunday, July 3, 1966

Tulsa Tribune, Tulsa, Okla
July 1, 1966



MEDICARE TAKES OVER FOR MRS. DAISY COWDREY . . . patient at Hillcrest Medical Center

Clerks at Hospitals Are Busy

Tulsa hospitals took the arrival of Medicare in stride today.

The day was about normal at the city's major hospitals, with the greatest burden of extra work falling on clerical help.

Patients were in two categories (a) those 65 and over, already hospitalized, who were shifted to the medicare rolls, and (b) new admissions, which had totaled around 50 at noon. There were some 400 in the first group.

"We were prepared for anything, even lines waiting to be admitted," said one administrator.

"This did not materialize," he added.

ONLY ONE of the city's eight hospitals was without Medicare program today. It was Tulsa General, a small hospital at 1550 N. Memorial Drive.

St. John's had the biggest load, transferring 144 to the Medicare rolls, and admitting 25 more during the morning.

Only two St. John's patients eligible for the program were not enrolled. This was by their own choice, as they would rather pay their own way than let the government have a hand.

However, only 25 had their Medicare identification card, which makes the clerical job greater. Some had not yet received them. Others had forgotten to bring them.

HILLCREST Medical Center transferred 53 patients, and admitted five during the morning.

Oklahoma Osteopathic had 38 transfers and 12 admissions this morning.

St. Francis Hospital would not divulge Medicare information.

Byrne Memorial, Mercy and Moton Memorial—Tulsa's smaller hospitals—had fewer numbers but, like the major hospitals, about 25 per cent of their patients are now on Medicare.

Administrators emphasized that the proper procedure, except in emergencies, is to have admission booked through a physician.

MEDICARE benefits will amount to about $45 a day for the average qualified patient. Private rooms are available through Medicare, if the physician certifies that one is needed for recovery.

For those not needing private rooms, the added Tulsa cost to the patient will be $7 to $10 per day, one hospital estimated.

Hospital rooms are covered up to 90 days for each illness—60 days in full, plus all but $10 a day for the next 30 days.

Hospital out-patient diagnostic services are paid by Medicare on an 80 per cent basis after the first $20, which is to be paid by the patient.

KEN WALLACE, assistant administrator of St. John's, said he feels the program is off to a smooth start, and that it will continue to run smoothly, "about as usual."

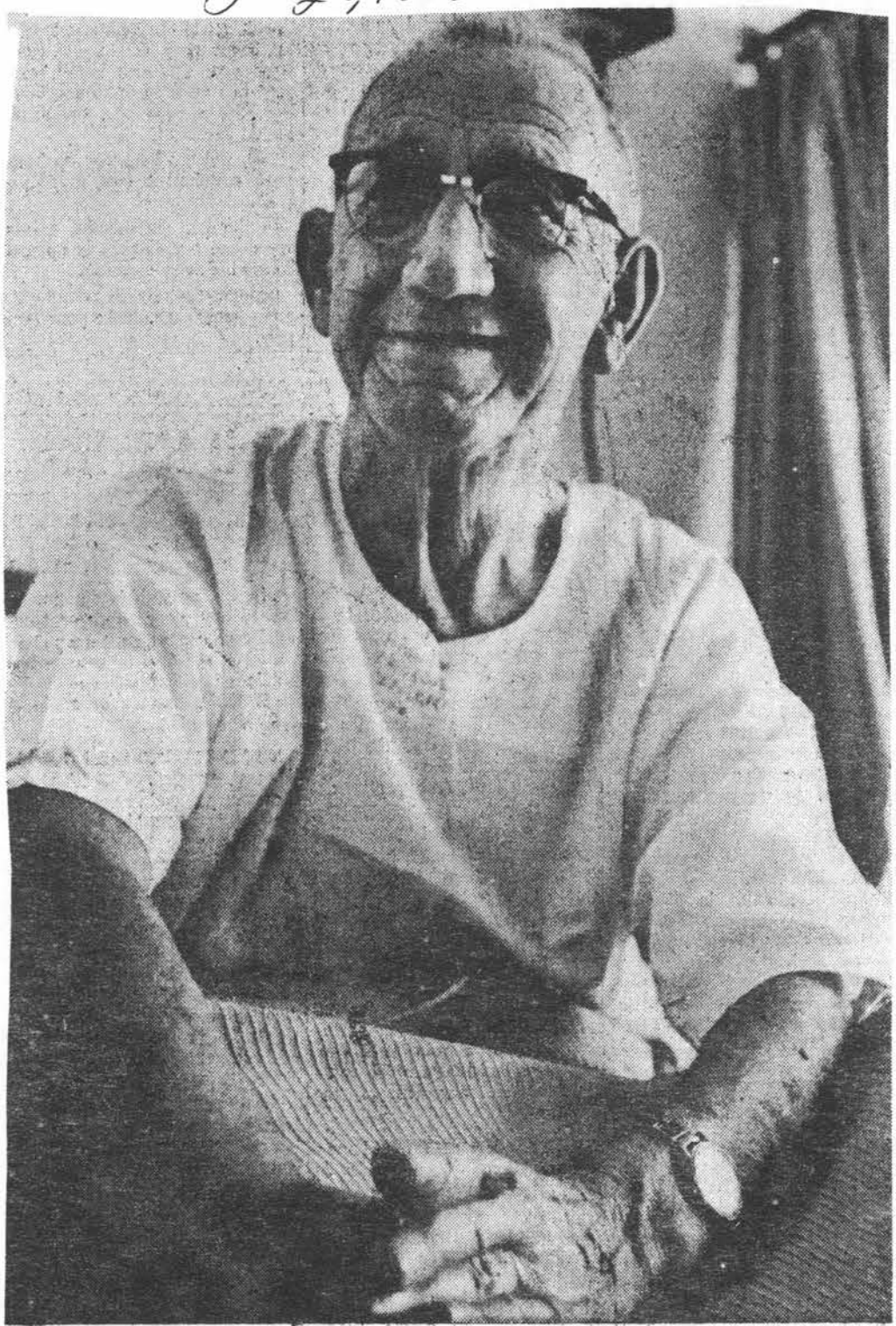
"Very few people want to enter a hospital. They only do it because they need to," he said.

The Tulsa area daily medicare load is expected to level off at about 500. This includes small hospitals in nine surrounding counties.

One of the effects of medicare in Oklahoma and Canadian counties has been an increase in the rates charged by private duty nurses from $20 to $25 for an eight-hour shift.

Tulsa nurses raised their rates last Jan. 15 to $25 for eight consecutive hours on duty.

Tulsa Tribune, Tulsa, Okla.
July 1, 1966



ONE OF THE FIRST MEDICARE PATIENTS—Vivian Tarr, 67, of 424 E. 13th St., admitted to Hillcrest Medical Center for abdominal surgery today, was one of the first Tulsans who will receive maximum medicare assistance. Several hundred others who are 65 or older were in Tulsa hospitals prior to the start of the program today—but cannot receive payment retroactively. However they went on the rolls today along with Tarr and some 50 other new admissions. (Related stories and pictures, page 25). (Tribune Photo)

Tulsa Tribune
Tulsa, OKla
July 1, 1966

Work Is Done 'by the Numbers'

Computers Make Medicare Possible

By BOB FORESMAN

"We couldn't administer the Medicare program if it weren't for our computer, and the big one at the Social Security Center in Baltimore," said the big man at the Blue Cross office.

"The computers do most of the job," added W. Ralph Bethel, vice president of the Oklahoma Blue Cross and Blue Shield organization with offices at 1215 S. Boulder Ave.

The Tulsa office will handle the entire hospital end of the Oklahoma Medicare program, with some 400 new patients being admitted daily.

It will compute the costs, certify them, and then send them by digital code to the Baltimore office.

To handle the huge job of Medicare accounting, Blue Cross purchased the two-story Remington Rand Building nearby at 1203 S. Boulder Ave.

THE FIRST 13 employes have been on the job several days making practice "runs." Four others were added to man the computer in the headquarters building.

"We don't know how many we will eventually need, but 13 seemed like a starting point," said Bethel.

Hospitals will send admission data to the Tulsa office from all parts of the state the same day the patient is admitted.

There are two areas on the Medicare admission forms—shaded and unshaded. The information in the unshaded area must be sent to the machine in Baltimore.

ALL INFORMATION is coded to numbers, which the computers gobble up like strawberry shortcake.

The initial information on each patient is transcribed on a high speed tape. The numbers include such data as the patient's name, health insurance claim number, address, date of birth, date of admission and other pertinent facts.

The information is routed through Blue Cross' national computer in Chicago, which duly stores it.

This is in case a patient might go to another state and have a claim to be processed from there.

ALL TULSA transmission must be completed by 2 p.m. daily. The Baltimore computer digests all the information from the 50 states, and then that night begins spewing it out.

"It will reject any patient not properly registered or ineligible to continue," said Bethel.

As the patient continues to be treated, the computer relays detailed information to Baltimore.

For example, if the patient develops cirrhosis of the liver, it will duly report this by the code "581.0" but if it develops that cirrhosis is attributed to alcoholism, the computer will send in the numbers "581.1" and the Baltimore machine will digest this.

INFORMATION converning patients is not scanned by employes or officials. The machine does it all, and each two weeks it will add up what each hospital will receive—including the fee for a blood transfusion for Aunt Minnie in room 109 at Podunk Hospital.

Then it will issue a check to the hospital.

Annually it will audit its "books" and issue a check for an adjustment, if necessary.

"We couldn't have handled the program without a computer. Our computer saves us 200 employes," said Bethel.



CAROL HILL WITH TAPED MEDICARE DATA

Enid Eagle
Enid, Okla.
July 2, 1966

ADVICE COMES LATE

Former Vice President Richard Nixon's advice to doctors to get into politics and fight Medicare comes about five years too late.

While the leadership of the American Medical Association has been active in Washington for 10 years or more in opposing socialized medicine, the rank and file of doctors throughout the country has been generally indifferent to what was going on in that field.

The Kerr-Mills Law worked fine in paying the medical and hospital bills of persons who could not afford to pay their own, and if the doctors generally had joined actively with others who oppose socialized medicine on principle before John F. Kennedy became president, the Kerr-Mills Law might have been continued and Medicare headed off.

But now Medicare is a fact, and it would take a nationwide reversal of opinion to get it repealed regardless of the fact that all workers from the time they take their first job until they become 65 are paying higher Social Security taxes to provide medical service to all who are over 65, regardless of how wealthy those persons may be.

If such a nationwide sentiment does not develop, the next step will be extension of Medicare to all disabled persons under 65, and it will be only a short jump from there to complete socialized medicine as it operates in England. There some doctors still practice outside government medicine, but the vast majority are serving in the system on government salaries, and they are assigned large numbers of patients to look after.

We have made two trips to England, and we learned from friends that they often have to wait one to three weeks to see the doctor they are assigned to. The system is so unsatisfactory that many doctors have quit and left the country, and several other persons we talked to about it were quite unhappy with it.

But that is where we in this country are headed unless we have a social revolution that will head off any further expansion of Medicare. — *Norman Transcript*

Medicare Still Big Mystery

Hundreds of over-65 Oklahoma City residents Friday were asking, "What Is Medicare?"

Even after months of talk, implementation and preparation, many don't understand it.

Medicare is a broad system of health insurance available to virtually all people 65 or older and is run by the Social Security Administration.

Insurance Automatic

Essentially, here's what's offered:

ONE—Automatic hospital insurance to pay hospital bills.

TWO—Medical insurance to help pay doctor bills and related services.

These are spoken of as "Free Medicare" and "$3 Medicare."

Under hospital insurance the patient pays the first $40 for covered services the first 60 days and Medicare pays the remainder. The next 30 days in the hospital, the patient pays $10 a day and Medicare the rest.

Doctor bills, including surgeon fees; services related to a physician's treatment and major dental surgery. It also pays for home services even if the patient has not been hospitalized first.

Costs that aren't covered by the $3 insurance premium include:

Physical checkups, fitting for glasses or eye examinations, hearing examinations, regular dental care, immunizations, services of chiropractors and some others, self-administered drugs, hearing aids, and patent medicines.

Benefits Listed

The limit for hospital care is 90 days.

Under "$3 Medicare" the patient may agree to pay $3 per month premium for a number of services. For treatment, the patient pays the first $50 each year. Of the remainder, Medicare pays 80 percent, the patient 20 percent.

A patient admitted to a hospital gets these benefits:

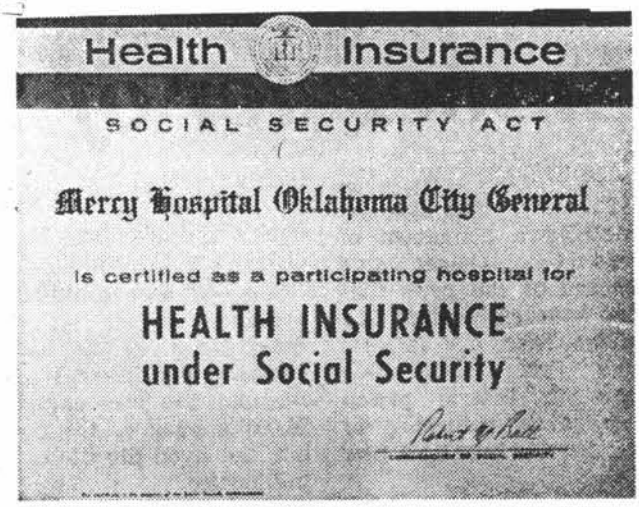
Room and board in a semprivate room, drugs furnished by the hospital, charge for operating rooms, therapeutic services, diagnostic services and blood transfusions (except for the first three pints).

This doesn't include doctor bills, private-duty nurses, a private room or extras such as radio or television.

Patients Helped

Services for nursing home care — effective January 1 for Medicare patients — are roughly the same with limits for care extending to 100 days per illness.

Under the medical insurance plan, patients get these benefits:



First hospital in Oklahoma City officially approved for participation in Medicare was Mercy Hospital. This plaque was presented to the hospital with a letter from John M. Mullane of the regional Social Security Administration office in Dallas. The plaque was given to all city hospitals participating.

Impact Due Next Week

Tulsa Medicare Load Increase Likely Soon

Tulsa's Medicare patient load is expected to pick up after the Independence Day weekend.

On Friday, the first day, the program got off to a slow start, to the amazement of some hospital administrators, who had expected the oldsters might even be waiting in line to enter.

Today, however, hospitals reported that physicians were making reservations in increasing numbers for Monday or later next week.

"We don't expect to feel the impact of Medicare until well into next week," one hospital spokesman said.

FEWER THAN 50 Medicare patients were admitted Friday. These were in addition to slightly more than 300 already in the hospitals, who were transferred to the Medicare rolls. There were few new patients this morning.

Medicare admissions Friday were: St. John's 12, Hillcrest Medical Center 6, Oklahoma Osteopath 12, Mercy 1, Bryne Memorial and Moten Memorial, nine, and St. Francis, no report.

Numbers in hospitals who were transferred to Medicare at midnight on Thursday:

St. John's 144, Hillcrest 58, Oklahoma Osteopathic 38, Mercy 18, Bryne 1, Moton Memorial none, and St. Francis, no report.

The only Tulsa hospital which has yet to qualify as a Medicare treatment center is Tulsa General, at 1550 N. Memorial Drive.

Tulsa Tribune 7/2/66
Tulsa, Okla.

OKLAHOMA CITY ADVISER
OKLAHOMA CITY, OKLAHOMA
JUNE 30, 1966

Everyone's Ready for

Friday Medicare Start

Local arrangements for the beginning of Medicare on Friday are just about complete. Joseph J. McCain, Social Security district manager in Oklahoma City, who has been keeping track of progress in getting the new program of health insurance for the aged into operation said Wednesday that all steps possible have been taken to insure the program's smooth start.

Hospitals in the area are braced for some increase in the number of over-65 patients, but not an overwhelming number. William D. Mulinix, President of the Oklahoma City Area Hospital Council, said that there had been some scheduling of elective surgery for July in anticipation of Medicare, but said that he did not expect occupancy of hospitals and beds to go above that during some of the winter months each year when respiratory illnesses fill more beds.

Hospitals may have to put additional beds into some larger private rooms or other available space, he said.

A total of 145 general hospitals in Oklahoma with more than 95 per cent of available beds have been certified eligible to participate in the Medicare program. They have been surveyed by the Oklahoma State agency and found to meet the standards for participation in medicare. They have also been found by the Public Health Service to be in compliance with Title VI of the Civil Rights Act of 1964. Thus, it is expected that virtually all of the 169 general hospitals in Oklahoma will be approved, at least provisionally, before July 1 and will be ready to provide "covered" services on Friday. For all practical purposes, the number of beds cleared under Title VI of the 1965 Civil Rights Act represents the number of beds available for Medicare patients and this clearance is near 100 per cent in Oklahoma.

In Oklahoma City, final approval has already been received for all hospitals listed as having over 50 beds.

Blue Cross, as administrator for the hospital portion of Medicare, is prepared to begin handling an estimated 400 cases a day from over the state, W. R. Bethel, executive vice president of Oklahoma Blue Cross and Blue Shield, said.

"We have been making preparations for months," he added, "everything is in a state of readiness to commence service to the 246,000 Oklahomans eligible for the government-sponsored health care program."

Bethel explained that the estimate of 400 Medicare cases per day was arrived at through research on hospitalization of persons over 65 years of age by Blue Cross and the Social Security Administration. Despite some uncertainties concerning use of Medicare by the elderly, he felt the estimate was realistic, even though there may be a larger number in the early weeks of the program as a result of admissions for elective types of conditions that have been delayed for one reason or another.

As "fiscal intermediary" for Medicare, Blue Cross will process Medicare caims for payment between hospitals and the government.

The intermediary will check with the Social Security Administration and notify the hospital as to: (1) The patient's eligibility: (2) the number of hospital days he has remaining of the 90 days covered in each spell of illness; and (3) whether or not he has met the $40 deductible that is payable by the patient toward the hospital bills for each spell of illness. This check of Social Security's central records will ordinarily take no more than 48 hours.

For older people who are in the hospital between June 30 and the end of the year, Medicare will pay hospital costs over and above the first $40 of services provided July 1 or later. Costs over the $40 deductible are covered for a stay of 60 days or less. If the older person stays in the hospital for more than 60 days, medicare will pay all but $10 a day for an additional 30 days.

While the basic hospital insurance part of Medicare and the voluntary program of medical insurance go into effect on Friday McCain said payment for post-hospital extended care in skilled nursing homes will not become payable until January 1, 1967.

The coverage of home health visits provided under both the basic hospital plan and the voluntary medical insurance plan begins in July. Forty-one home health agencies in Oklahoma have applied for participation and others are expected. In addition, it is anticipated that a number of hospitals will institute such a service within the months ahead.

All physicians in Oklahoma have been sent personal copies of the Physician's Reference Guide, along with copies of the Medicare Handbook that was mailed during June to the 19.1 million people 65 and over who are covered by the Medicare program.

The Physician's Reference Guide describes the benefits payable for the Nation's elderly people under the hospital insurance program and the payments for doctor bills and other medical services covered under the voluntary program of medical insurance for which 9 out of 10 of those 65 and over have enrolled.

Aetna Life and Casualty will receive and pay physicians' bills in Oklahoma under the Medicare program, determining the "reasonable charges" that will be the basis of reimbursement.

Dan Morley of Aetna reports much work has been done to get ready. First claims for payment under the voluntary medical insurance plan are not expected for a few days, Morley said. This is because payment under the medical insurance plan does not begin until after the patient has incurred expenses of at least $50 for services provided July 1 or later.

There will be two ways to claim payment for doctor bills under the voluntary medical insurance part of Medicare and it is up to the doctor and the patient as to which of the two methods of payment will be used. The doctor can continue to bill his patient, if he wishes, and the patient can claim reimbursement, or the doctor can apply for payment directly. The same simple, one-page form can be used for either method.

Medicare beneficiaries will find answers to most of their questions in the green Medicare Handbooks sent to them through the mail. However, the District Office in Oklahoma City will be glad to explain any point that may not be clear, McCain said. The Handbook tells what is and what is not covered by medicare and how the benefits will be paid.

Most people 65 and over in Oklahoma have already received the handbooks and red, white, and blue health insurance identification cards, McCain said. Identification cards were mailed first to those signed up for both the hospital insurance and the voluntary medical insurance.





—World Staff Photos

Where Is the Flood of Medicare Paperwork?

Paperwork transferring records of patients already in the hospital who went under the Medicare program Friday involved the bulk of the program's opening day in Tulsa rather than a rash of new patients. Above, Helen Reed, left, claims examiner, and Meriene Heginbotham, Medicare section supervisor of Blue Cross, go over forms. At right, work in the St. John's Hospital admissions office is handled by, from left, Pauline James, Miki Compeau and Florabel Masoner.

WEST AND FAR WEST STATES

Oregon

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Idaho

Montana

Wyoming

Hawaii

Alaska

Paper Idaho Daily Statesman

Place Boise, Idaho

Date 6/30/66

None Knows the Cost of Medicare 6/30/66

Experts of the U.S. Department of Health, Education and Welfare estimate that medicare benefits for persons over 65, under the Social Security System will cost $3.5 billion in the first year beginning July 1. This is almost a third as much as all private health insurance payments to people of all ages in 1965, The Stateman's Washington columnists Allen and Scott report.

Medicare will pay 25 to 30 per cent of the operating expenses of the average hospital. Nineteen million people will be eligible for medicare on July 1. A million of those eligible under Social Security have indicated they do not want this medical insurance.

If the costs of the elderly medicare program have been figured, none seems to know exactly how much money will be needed to finance Title 19 of the Social Security Act — the law which provides medical assistance to indigents, the blind and handicapped and dependent children.

Title 19 states the secretary of HEW will pay to each state, which has a plan approved under the title, for each quarter of the year at least 50 per cent and no more than 85 per cent of the total cost of the state program.

The Idaho Legislature, out of necessity, approved state participation under Title 19. Bill Child, director of the Idaho Department of Public Assistance, plans to carry out the program under the limits of the $35 million biennial overall department budget set by the lawmakers. He has no idea as to how much the program will cost, although his state plan has been approved by HEW. Actually, the experts in HEW are not sure either of the total expense. Why? Because only experience in medical insurance can evaluate future expenditures. The actuaries of insurance companies base their premium rates on past experience and considerable research in health and hospital care.

The program begins July 1. Most Americans are willing to give it a try. There may be failures. The cost may be exorbitant. Medicare is a new, startling government venture. The public must be prepared to pay.

Roswell Daily Record
Roswell, New Mexico
July 1, 1966

EDITORIAL PAGE

FRIDAY, JULY 1, 1966

NOTHING IS FREE

AS the government and the medical profession seek to discharge their duties to older people under the medicare law, everyone should be reminded again and again that there is no such thing as a "free" service. Nothing in this world is free and nothing new has been created under medicare. By law, the taxpayers are paying some of the medical bills of a selected group of people. As time goes on, the law may be revised to include care of other age groups. Medicare may be extended until it becomes a national health service such as was adopted in Britain nearly 18 years ago.

The British plan of government medical care which was to provide free service to all is threatened with a disastrous breakdown. A British Medical Association reports that, "Unless vast new sums of money are made available—from some source or another—the present concept of a hospital service must be abandoned. . . . Half of the nation's hospitals are more than 80 years old, and only two new general hospitals have been built since 1939. The British Medical Association report concludes: 'If the public wishes to have an unrestricted health service, it must be prepared to pay for it. . . .'"

The medical profession in the United States is going to do everything possible to facilitate the operation of medicare. It will do its utmost to preserve the all-important, doctor-patient relationship that is so vital to the high medical standards to which we have become accustomed. It is the obligation of the people, all of us, to remember that medicare does not mean "free" medical care. The more that is demanded in the way of service from hospitals and doctors, the more it is going to cost unless we wish to end up with a bankrupt medical system as Great Britain appears to have done.

Missoula, Montana

The Missoulian

Founded May 1, 1875

Friday Morning, July 1, 1966



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Medicare Begins Today Amid High Hopes, Many Worries

By RICHARD SPONG
Editorial Research Reports

The hospital provisions of Medicare go into effect today.

Medicare is ushering in a virtual revolution in medicine and hospital administration in the United States. The full effects may not be realized for several years.

The burden that will be placed upon hospitals is still a matter of conjecture. Medicare comes, really, in two parts. The part that pays hospital bills is available without charge starting today to nearly everyone aged 65 or more. The second part covers doctors' bills and some other medical expenses for people 65 and more.

This optional protection, which also starts July 1, costs $3 a month per person. The Social Security Administration as of June 3 had processed applications of 17,337,000 oldsters for the voluntary coverage. This service, incidentally, has the deductible feature familiar to most health insurance plans. Benefits start after the patient has paid $50 of his own money.

Still another service begins on Jan. 1, 1967. Medicare will then provide funds for up to 100 days in an extended care facility like a nursing home in each illness after a hospital stay of at least three days.

The fear is widespread that the nation's medical, nursing, and hospital disciplines just won't be able to accommodate the upsurge of older persons seeking help under Medicare. This could cause political disturbances. Old people who have been told that their ills will be taken care of could be awfully cold to tales of doctor, nurse, and hospital bed shortages.

The Johnson administration already shivers at the memory of 1946, when voters who couldn't get meat expressed their indignation very pragmatically at the polls.

On the other hand, California, which implemented the federal Medicare program with special state legislation put into effect last April 1, reports no great hospital crush. Dr. Ralph C. Teall, president of the California Medical Association, on April 27 said that the state's first month of experience with Medicare appeared to refute predictions that hospitals would become clogged when the program went into effect nationally.

"We should have seen a tremendous pressure on hospitals during the past month," Dr. Teall said, "but the pressure has been only relatively minor."

At the same time, Dr. Philip D. Bonnet, president of the American Hospital Association, predicted a "bulge" of about 5 per cent of new patients when Medicare became a reality. Dr. Teall said he believed that there would be a gradual decline rather than an increase in the number of hospitalized persons after the 5 per cent bulge.

In any event, a shortage of medical specialists already pinches, regardless of the pressures, however debatable, of Medicare. The Federal Nurses Training Act of 1964 is aimed at assuring a 1970 total of 680,000 registered nurses even though the Surgeon General's Consultant Group had forecast a need for at least 850,000 professional nurses by that time.

The ratio of physicians to civilian population has fast deteriorated in recent years. We should be turning out about 11,000 doctors of medicine a year, but we are falling far short of that number.

In 1961 the dean of the Yale Medical School, Dr. Vernon M. Lippard, calculated that our needs could be met only by "the establishment of at least 20 new schools of medicine during the 1960s."



"I SUPPOSE THERE ARE TIMES WHEN WE MUST GO ALONG WITH THE INEVITABLE."



Editorials

Lifting the Fears Of Old Age

MEDICARE, taking effect today, will lift from millions of Americans the fear of going into old age without hope of them having the means to pay the costs of illness that may overtake them.

At the same time, it lifts from many millions of younger Americans the burden of having to take care of medical costs for their aged parents.

Medical care in this country has thus reached a great turning point. The people who can make this turning point lead to better health care or older people are, first, the doctors and the hospitals and, second, members of Congress and Government agencies concerned with Medicare. The new president of the American Medical Association is taking a positive attitude toward it, and he is to be commended for that. The action of the AMA House of Delegates in urging doctors not to let any Medicare fees come to them direct from the Government seems rather doctrinaire and far-fetched, but we do not expect this to become a real or important obstacle.

SINCE THE LAW is on the books, the rational thing to do is to make it work for the good of people. Health does not belong in partisan politics. We therefore hope that Republicans in Washington who are beginning to criticize Medicare with "I'm for it, but . . ." statements will think twice about that.

THE DAILY REVIEW
HAYWARD, CA.
JULY 3, 1966

Side Effects Of Medicare

MEDICARE BECAME the newest national institution Friday and bureaucrats at every level have jousted with columnists in attempting to explain what impact the far-reaching program will present to Medicare recipients, hospitals and the taxpaying public.

Most observers concede that advent of free medical care for some 19 million Americans 65 years of age and older, whether they are needy or not, soon will thrust an overload on all medical facilities ranging in degree from serious to overwhelming.

Leverage on the federal budget is expected to be almost as shattering, with the most recent concession from a federal official suggesting the first year's cost may quadruple the figure approved by Congress.

However, aside from the troubles at the top, what will the advent of Medicare mean to Southern Alameda County?

Eden Hospital in Castro Valley quite likely will have its vacancy problem solved. Washington Hospital in Fremont, which has been considering a new building addition, may have to push its plans a little harder.

But will this expected elimination of the local vacancy factor boost hospital income and lessen the hospital district tax rates? Most unlikely. Increased staffing and higher salaries — which are being negotiated now with nurse groups — probably will offset the budgetary benefit of the higher patient load and maintain, if not escalate, the present costs to patient and taxpayer.

PROBABLY THE FIRST difference to become discernible to the South County citizen will be his difficulty in getting a hospital bed when he wants one for that hernia operation he has been putting off for a couple of years. He may have to wait a few months for a bed. If he comes down with a serious rupture, of course, he will have to go immediately. Perhaps the hospital can find a place for another bed in a hallway.

Assuredly, Medicare will introduce many significant ramifications into the American way of life. Making medical care actually available to the elderly persons who cannot afford it will be only a splinter by-product of a great tangle of costly problems.

There were a number of easier and more practical ways to accomplish the same goal but they would have given the Great Society less of a claim on the elderly folks when poll time came around.

Longview Daily News
Longview, Washington
July 1, 1966

News and Views...

By J. M. McCLELLAND Jr.

Medicare Problems Seen

THE START UP of anything as big and new as Medicare is bound to be troublesome. And complicated. It will be a long time before everyone who is covered understands what he is and is not entitled to. Many are going to be angry at someone, probably the government, when they find out that it isn't all free—that everyone has to pay a part of his hospital or doctor bill.

Others will be upset when they get bills directly from the doctor who treats them. The law provides that a doctor either can send his bill to Blue Cross or whatever other agency is handling Medicare payments in a community, or he can send it directly to the patient. If he follows the latter course, the patient then has to make payment and get reimbursement from the Medicare agent. The AMA, which has been opposed to Medicare right along, recommends that its members follow the latter procedure.

This will further complicate matters, because Medicare will have maximum fees that it will be willing to pay for medical and hospital services, just as insurance companies that sell health insurance do. But doctors are not bound by these schedules. They make up their own schedules of charges. When these exceed what Medicare allows, there will be more senior citizens upset.

Add these troubles to those that are likely to occur if there are not enough hospital rooms, enough nurses or even enough doctors in some instances to take care of a large segment of the population to whom health care services have suddenly become cheap, and the result will be pressure on Congress for relief. There is not a chance that Congress would respond by backing away from this initial experiment with government-paid medicine. Once the first step is taken—once a taste of "free" medical care is provided—there will be no turning back. As a consequence it can be considered virtually certain that Medicare will go the way of Social Security—becoming year by year more liberal to the recipients and more costly on the tax bill.

If there are not enough hospital rooms, federal funds will have to pay for them. If there are not enough nurses and doctors, federal money will have to be provided to train them. If charges by hospitals, doctors and rest homes exceed the limits set up in the Medicare schedules, the schedules will have to be revised, always upward.

These aren't certainties, just predictions based on the experience the country has had with other phases of welfare. There is never a cutback. It is always the other way. If we do not end up eventually with something even more far-reaching than Britain has, we will be surprised.

THE MERIDEN JOURNAL

AN INDEPENDENT NEWSPAPER

Be A "Defensive Driver"

General Motors, in large advertisements timed to reach the eyes of drivers before the holiday week end, is urging the practice of "defensive driving." It's a good phrase, although not a new one.

"Defensive driving" means simply driving to stay out of accidents. The defensive driver is prepared to have the car ahead of him stop suddenly, so he stays far enough behind to bring his own car to a safe halt in that event. He encourages "tailgaters" to pass: does not try to speed up to get away from them. He lets other cars go by when he can see in the mirror that they are proceeding at a faster rate than the speed he is maintaining. He signals his intentions clearly before he passes or makes a turn. He does not leave his own lane without warning. He is always ready to yield the right of way rather than dispute it with another driver. He stays alert at all times: pulls off the road for a rest when he gets fatigued.

There are far too many aggressive drivers, who act as if the whole road belonged to them. Put two aggressive drivers in a tough traffic situation and "somethin's gotta give." There's a squealing of brakes and tires followed by a crashing impact in which human bodies do not stand a chance.

The "defensive driver" does stand a chance, even in a bad spot. He makes it for himself. That's the way to drive this week end and at every other time.

Medicare Hospital Provisions In Effect

The hospital provisions of Medicare go into effect today — and hospitals are still wondering about the size of the increase in patient load they may expect. For a hospital already loaded to full capacity, the problem is somewhat academic for the time being, but will come down to earth if immediate expansion is forced.

Medicare comes really in two parts. The part that pays hospital bills is available without charge, as of now, to nearly everyone aged 65 or more. The optional protection, also in effect, costs $3 a month per person. Everyone eligible has been amply forewarned Still there are probably many who have missed the boat. The service, incidentally, has the deductible feature familiar to most health insurance plans. Benefits start after the patient has paid $50 of his own money.

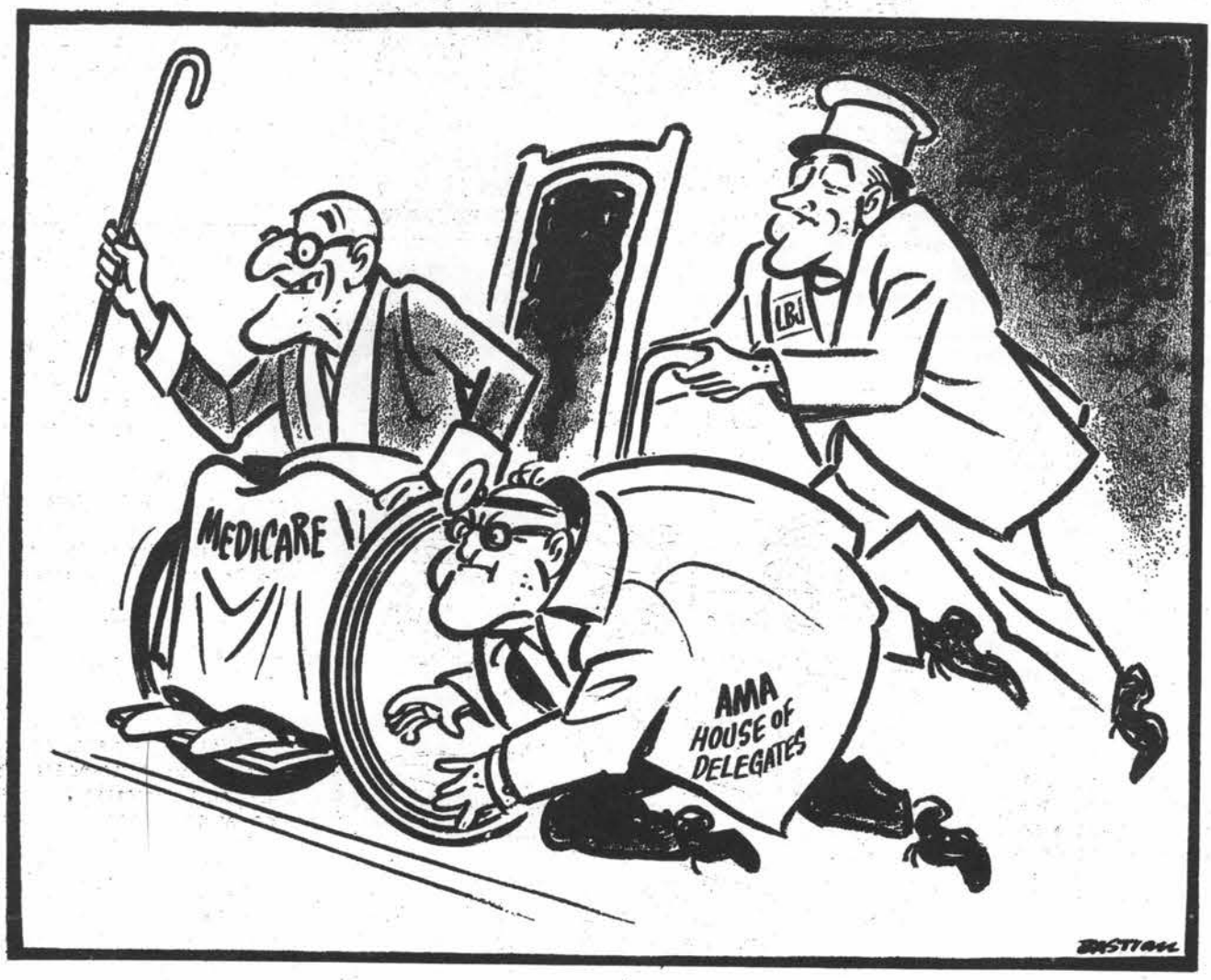
Still another service begins on Jan. 1, 1967. Medicare will provide the funds for up to 100 days in an extended care facility such as a nursing home in each illness after a hospital stay of three days.

Undoubtedly many recipients of Medicare will be dissatisfied with its operation. The eligibles who have to wait long periods before getting into a hospital will almost certainly be raising protests. If there is widespread dissatisfaction, the results could show up in the next election.

One state which has had experience with Medicare offers encouragement that the problems it raises will not be too serious. California implemented the federal Medicare program with special state legislation put into effect last April 1. It reports no great hospital crush. Dr. Ralph C. Teall, president of the California Medical Association, said that the pressure on hospitals has been "relatively minor." Yet Dr. Philip D. Bonnet, president of the American Hospital Association, predicted that Medicare will bring a "bulge" of about 5 per cent of new patients in most hospitals.

A shortage of medical specialists is already pinching. The ratio of physicians and nurses to civilian population has deteriorated in recent years. The United States should be turning out about 11,000 doctors of medicine a year: instead, it is falling short by about that number.

San Francisco Chronicle
July 1, 1966



Ready ... set ... go!

California

Medicare Begins Tomorrow

Doctors, hospital administrators, government officials and "average citizens" are all about to embark on one of the biggest and most controversial social welfare programs ever attempted, with Humboldt County reflecting the same confusion that exists nationally. On the eve of the inception of Medicare, a program which will require cooperation from all concerned, battle lines are drawn.

The nation's doctors, meeting in the American Medical Association convention, have restated their philosophical opposition to Medicare. Some have even suggested "civil disobedience" in the form of non-cooperation with the program's provisions. Their opposition is not solely based on fear of more work, but primarily on the fear that Medicare will lower the quality of treatment provided the ill of our country.

Humboldt-Del Norte Medical Society members, speaking through their executive committee, have gone on record with a harsh statement criticizing Medicare as a "politically inspired scheme" to get votes by promising free medical care. Simply, the doctors say that first class medical care is expensive, Medicare is not to be operated on a realistic cost basis, and that it therefore will not work.

The H-DN Medical Society does pledge, however, that patients will continue to receive first class care. "We shall not lower our standards to accommodate a politically inspired scheme," they say. How much opposition to Medicare this statement forecasts is unpredictable.

We agree with the doctors that Medicare is beginning with less than ideal organization. Paper work is confused, the impact of the program is impossible to predict, the doctors feel that they were left out of preliminary planning and are being coerced. These problems are real. Real, also, is the fact that Medicare will begin tomorrow, whether or not any segment of our society is for or against, happy or unhappy.

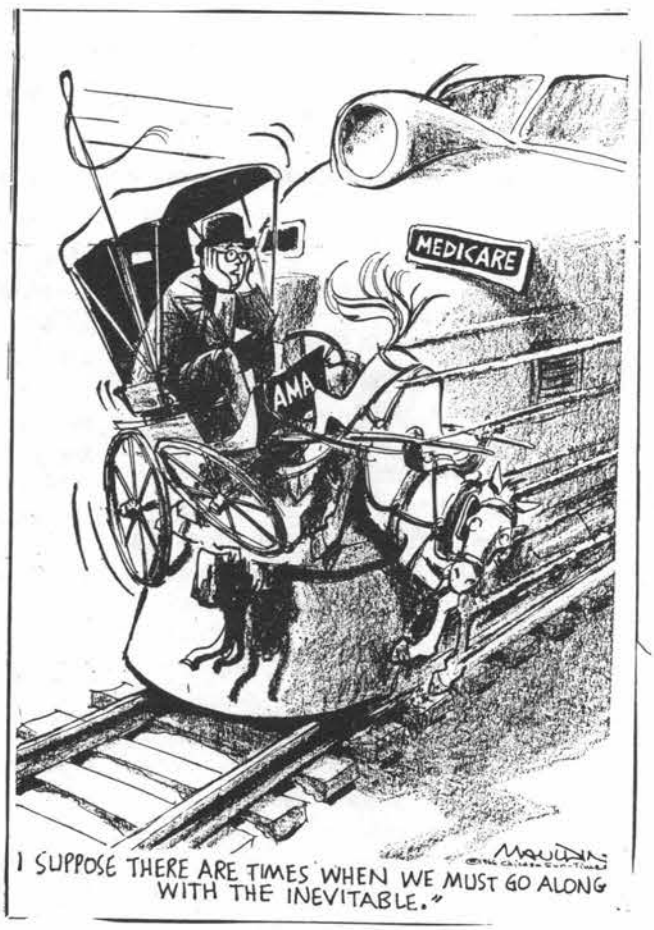
Medicare did not come from nowhere. It was hammered out in Congress, where compromise is the rule and no individual ever gets everything he wants. It was passed through Congress with the help of several Republican Senators and Representatives, who obviously were not about to do anything to help Lyndon Johnson's "Great Society" plan. It is not unreasonable to state that Medicare, to pass Congress, had to be something that our legislators felt was in the best interests of the nation.

Americans traditionally regard their doctors as being above the usual petty politicking so often practiced in the world of commerce and government. This regard has been earned by a profession which has created the world's best medical care and finest standards.

Medicare, the philosophy and the program, present a challenge to our doctors' reputations as well as to their work loads. We sympathize with their dilemma, caught as they are between the professional obligation to serve and the obligation of citizenship to fight for what they believe will benefit the country.

At this point, however, we would also plead with our doctors to do their best to make the transition to Medicare as easy as possible, through cooperation with both the spirit and letter of the Medicare law. Their role is essential.

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I SUPPOSE THERE ARE TIMES WHEN WE MUST GO ALONG WITH THE INEVITABLE."

The Sacramento Union
Sacramento, Calif.
July 3, 1966

Time Holds Answer

Medicare Takes Over, But Question Still Big

There is a mounting sense of anticipation as well as apprehension across the nation as it prepares for the advent of government-supported medical care, despite its smooth start July 1.

The anticipation is from many of the 19 million American senior citizens eligible under the medicare program for limited hospital and medical costs.

It would be a national disgrace if their hopes were cruelly dashed by inadequate service because of crowding, expenses not anticipated, or long waits to receive necessary treatment.

The apprehension is from the communities and on the part of officials who have seen the steady erosion of quality in other nations that have experimented with socialized medicine.

It is ironic that the United States of America is taking its first giant step into socialized medicine, also the first day that Great Britain is taking its biggest step away from it.

After 20 years of socialized medicine in Great Britain many people have reached the point where they are willing to pay cash for hospital and medical service that the state is "giving" them. As a result, private insurance companies are flourishing.

Complaints are specific, and typical of any nation in which socialized medicine has been inaugurated. Doctors are thrust into the political arena to receive just compensation. Shortages are rampant, service is perfunctory because of heavy loads, and the wait to enter hospitals extends into months for non-emergency cases.

It is not a reassuring picture for the United States, especially since Social Security administrators and others already point to deficiencies —even before the program begins. These include a nation-wide shortage of doctors, nurses, technicians, and hospital beds.

Total cost of the first year of the program is expected to be $86.56 billion, of which $829 million will come from the general treasury. But even this is an unknown area. The cost and additional payroll taxes could impose another burden on the working man. He already may pay twice — once in payroll taxes and another time in higher hospital costs resulting from medicare enrolment.

The medical profession in the United States has long called attention to these problems, and originally opposed the medicare program. It is a tribute to doctors today that they agree for the most part to cooperate in medicare and make it work if possible. It is the law of the land and good citizens obey the rules. The public must follow the doctors' lead and cooperate as much as possible. It is to be hoped, also, that we have the courage to retreat from the program should it become necessary.

San Luis Obispo, Calif.

San Luis Obispo County
Telegram-Tribune

Thursday, June 30, 1966 Page 14

Medicare's real question

Medicare begins tomorrow and it will usher in a virtual revolution in medicine and hospital administration in the United States. The full effects may not be realized for several years.

The burden that will be placed upon hospitals is still a matter of conjecture. Medicare comes, really, in two parts. The part that pays hospital bills is available without charge to almost everyone aged 65 or more. The second part covers doctors' bills and some other medical expenses for people 65 and more. This optional protection, which also starts Friday, costs $3 a month per person. More than 17 million oldsters have applied for the voluntary coverage. This service has the deductible feature familiar to most health insurance plans. Benefits start after the patient has paid $50 of his own money.

Still another service begins next Jan. 1. Medicare will then provide funds for up to 100 days in an extended care facility like a nursing home in each illness after a hospital stay of at least three weeks.

The fear is widespread that the nation's medical, nursing, and hospital disciplines just won't be able to accomodate the upsurge of older persons seeking help under Medicare. This could cause political disturbances. Old people who have been told that their ills will be taken care of could be awful cold to tales of doctor, nurse, and hospital bed shortages. The Johnson administration already shivers at the memory of 1946, when voters who couldn't get meat expressed their indignation very pragmatically at the polls.

On the other hand, California, which implemented the federal Medicare program with special state legislation put into effect last April 1, reports no great hospital crush. Dr. Ralph C. Teall, president of the California Medical Association, said that the state's first month of experience with Medicare appeared to refute predictions that hospitals would become clogged when the program went into effect nationally.

"We should have seen a tremendous pressure on hospitals during the past month," Dr. Teall said, "but the pressure has been only relatively minor."

At the same time, Dr. Philip D. Bonnet, president of the American Hospital Association, predicted a "bulge" of about 5 per cent of new patients when Medicare became a reality. Dr. Teall believes that there would be a gradual decline rather than an increase in the number of hospitalized persons after the 5 per cent bulge.

Our hospitals are braced for Medicare's start. Here, as everywhere, there will doubtless be dislocations in service, a multiplication of paper work, and perhaps a worse shortage of medical specialists, which already pinches.

But may these drawbacks not be more than balanced by the increased medical care and the peace of mind that Medicare will provide for the nation's elderly? That really is the meaningful question that awaits an answer.

SAN JOSE NEWS

AN INDEPENDENT NEWSPAPER

J. B. RIDDER — Publisher

KENNETH S. CONN, Executive Editor
ANTON F. PETERSON, General Manager

THURSDAY, JUNE 30, 1966

Medicare Arrives, Impact Not Known

Friday is Medicare day. The one thing the friends and enemies of this program agree on is that Medicare represents one of the most significant pieces of social legislation passed in decades.

Starting Friday the federal government will help pay for necessary hospital care for virtually all people over the age of 65. Under the Casey Act, also known as the California Medical Assistance Plan, the State is extending this coverage somewhat.

There has been a great deal of speculation as to just what effect these programs will have on hospital facilities and on the quality and form of medical care. Nobody really knows at this time.

One thing is clear: the attitude and performance of the individual physician is of critical importance. A great many doctors were strongly opposed to the passage of the Medicare legislation. But Medicare is with us now. Both the outgoing president of the American Medical Assn., Dr. James Z. Appel, and his successor, Dr. Charles L. Hudson, urge doctors to help make Medicare work.

Dr. Appel warned physicians not to raise their fees or use other means to thwart the program. He said, "Refusal of care or deprivation of the patient's legal rights will only invite hostility for the profession." Dr. Appel urged his colleagues "to help administer this law in such a way as to minimize its harsh effects." And Dr. Hudson, in effect, warned that unless doctors try to make Medicare workable they face heavier encroachment from the government.

People eligible for Medicare must not expect too much. Both basic Medicare and the supplementary insurance coverage require some payment by the patient. And the nursing home section of the Medicare bill will not go into effect until next year. The benefits of Medicare have been extensively publicized in the press and through handbooks mailed to all who signed up for the program. Nevertheless, this can be a confusing business. Anyone with questions can contact the district Social Security office at 1010 The Alameda.

The first day of Medicare is not too soon for the medical profession and the government to open intensive studies of the program and its impact. Some adjustments—perhaps major surgery—may be required.

Medicare Can Become Disaster Prescription



Lyndon Johnson's Great Planned Society has always been a moral disaster. Now there is new evidence that it is a practical shambles as well.

Morally, the disaster involves a program which turns people into government dependents to exploit them politically. Institutionalizing poverty and then forming the poor into a solid voting bloc is an example.

The practical shambles comes to light in such operations as the highly publicized Medicare program. Its impractical nature is seen in the peril in which it places the entire Social Security system, already stretched thin financially.

★ ★ ★

THE ADDITION of Medicare-like features in France, where the system also was stretched thin, has brought virtual bankruptcy. The millions who support Social Security here have grave causes to worry about what the Medicare program will do during the next few years to the U.S. system.

In the shorter range, there is equal evidence of flaws in Medicare as wide as the Grand Canyon.

It is now obvious that many elderly Americans either are confused or misled by the program. The fact that government offices stayed open Memorial Day in the hope that more eligible folks would sign up for the program clearly shows there is general confusion.

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AND IT IS SLOWLY beginning to seep in on many persons that Medicare does not supply medical care in the usual sense. It supplies payment for a rigidly limited number of hospital-care services during a period of 60 days a year.

But more important, the Medicare program, such a highly charged part of Lyndon Johnson's presidential campaign, has been undertaken despite a crisis in American medical care. That crisis is the now critical shortage of doctors and nurses.

In a few months, when many older folks will be lined up for benefits under Medicare, they are going to find instance after instance in which their demands will overtax already straining hospital facilities and staffs. The result will be a crushing new weight, perhaps even a dangerous one, on an already perilous medical structure.

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A YEAR AGO, for instance, American doctors were able to fill only about 21,000 of 38,000 openings for resident physicians in U.S. hospitals. A dozen years ago we used to have more than 50 physicians for every 100,000 citizens. Now we have only about 45 physicians for every 100,000.

Nursing has been shrinking at an even greater rate. One major city had more than 5,000 nurses 30 years ago. The same city now lists only 3,500, and they are paid less than the city's garbage collectors, according to one critic.

These shortages, I am convinced, are one of the tolls we are paying for government policies which regularly shortchange professional incentive, exploit the most productive, dedicated and creative members of society and which seek to turn nursing and doctoring into a government "corps" rather than permit them the freedom which has, in the past, helped make them such meaningful careers.

Medicare, as with everything else in the Great Planned Society, is a political promise built on moral and practical quicksand.

The Daily Review
Hayward, Calif.
July 1, 1966

Los Angeles Times
EQUAL RIGHTS
LIBERTY UNDER THE LAW
TRUE INDUSTRIAL FREEDOM

4—Part II FRIDAY MORNING, JULY 1, 1966 ★

TIMES EDITORIALS

To Make Medicare Work

Under policies adopted by its House of Delegates, the American Medical Assn. is generally committed to cooperation with the government in making Medicare work.

But the vast health program activated today contains major flaws which will require administrative and congressional action as well, if they are to be remedied.

Some of these problems, of course, far antedate Medicare. Trained manpower and health facility shortages, for instance, have been with us for years and will continue.

★

It is in other areas however, that mounting congressional concern has been evidenced. The worry centers chiefly around cost factors which are turning out to be far greater than Congress expected.

Medicare comprises the basic hospital insurance plan financed under Social Security, the voluntary supplementary plan for doctor bills paid for by participants and tax revenues, and the extension of the Kerr-Mills program for the elderly to cover most needy persons.

Fiscal problems at all three levels could seriously hamper effectiveness of the program.

Reimbursement guidelines for hospitals, for example, are being criticized as too generous. A Senate Finance Committee staff report estimates that they will boost costs $75 million a year above the estimates furnished Congress when the act was passed in 1965. Another $40 to $50 million may be added if the guidelines are carried over to the Kerr-Mills extension.

There is a 2% bonus set up for hospitals to allow for growth, which Sen. Clinton P. Anderson (D-N.M.,) a principal author of Medicare, says was not mentioned by Health, Education and Welfare officials during congressional hearings. Despite strong opposition by members of both parties on the Finance Committee it appears that HEW intends to retain the bonus.

Department spokesmen told Congress in 1965 that the Kerr-Mills extension would cost $238 million the first year if all 50 states participated. Thus far, seven states and Puerto Rico have such programs, and the costs already exceed that estimate by $262 million. In addition, New York is ready to participate, and has requested $217 million.

★

Some congressmen have warned of possible increases in Social Security taxes. Others have suggested that perhaps not all the money requested by HEW will be appropriated. One economist predicts that the total cost of health care for all Americans will be boosted 20% during the initial year of operation of the new program.

The full impact of the program cannot be assessed. But it is already obvious that the fullest cooperation of doctors and hospitals, a realistic attitude on the part of HEW, and a watchful congressional eye will all be required if the people are to be assured the health care they need.



"Very contagious . . . He's a Medicare insurance carrier!"

New Mexico

THE
SUNDAY TRIBUNE

20 SUNDAY, JULY 3, 1966

RAYMOND MOLEY

Medicare Is Off, --With Confusion

Editor's Note: The following views are those of the author and are presented here to give readers a variety of viewpoints. The Tribune's opinions are expressed only in editorials.

When the man who is called "the father of Medicare" calls the law "fuzzy" and views with alarm the inequities in its prospective administration, it is small wonder that so many others are concerned. State officials, hospital managers, doctors and prospective beneficiaries are even more concerned than Sen. Clinton P. Anderson, who labored for at least four years to get the program approved by Congress.

In an interview with Anderson published in the Albuquerque Tribune, in Anderson's home state, the senator said recently:

"When we passed the Medicare bill, there was a great deal said that the hospital end of it was fairly well understood. We in Congress talked about it for years and knew what it meant. Now we find out the law is fuzzy."

Reckless Promise

This confusion is an old story. The present idea of a Medicare program originated in the heat of the 1960 Presidential campaign. It was advocated by John F. Kennedy as a fine gesture to win the votes of the millions who passed the age of 65.

Apparently it worked as a political issue. But the promise was recklessly made when its political sponsors hadn't the faintest idea of how the plan was to be operated. All they said was that it would be tied into the Social Security system. The details were left to Congress and the states.

In such a political campaign, the candidate and his helpers have little time for laborious planning. Getting the votes is paramount. And Mr. Kennedy's running mate, Lyndon B. Johnson, excoriated everyone who pointed out the inequities and difficulties of putting such a gigantic plan in operation as blind and callous about the medical needs of old people.

He sneered at those who said that the plan should be limited to people who not only needed the care but whose financial means were insufficient.

After John Kennedy and Lyndon Johnson were elected there was a great hullabaloo designed to push the plan through Congress. That failed in the Kennedy years. Congressional committees wrestled with the idea without successfully creating a plan. Then after the death of President Kennedy his successor, with greater influence, pushed the bill through a still doubting Congress.

Tremendous Cost

That the legislation goes far beyond even Mr. Kennedy's glowing picture in 1960 is shown by Title 19 of the act. This provision proposes to cover not only the medically needy people over 65 included in the Kerr-Mills plan enacted during the Eisenhower administration, along with the blind and the impoverished children provided for earlier, but a great many others.

Up to now eight states have passed enabling laws. Others are still trying to meet the target date as this is written. The Health, Education and Welfare Department hasn't the slightest idea of how much federal money will be needed to meet the demands of the states.

Many observers, including this writer, pointed out four or five years ago that no one could estimate the cost. Now that prediction is realized. Hospitals are faced by an unbearable burden. Doctors are unhappy about the fees allowed. The old people are waiting to flood the facilities in great numbers.

And, as noted above, even the "father" of Medicare is unhappy about the very law he helped to pass.

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DISTRICT OFFICE, LAS VEGAS, NEV.
7/3/66- Review Journal

First Day Medicare Eyed

EDITORS — Members of a special AP task force kept a close watch throughout the first day of medicare in a group of hospitals around the country. The following account is based on their reports.

NEW YORK (AP)—Down the corridors of Miami's Jackson Memorial Hospital figures in white passed each other with a cheerful greeting: "Happy medicare!"

For the nation's hospitals Friday was indeed happy medicare —the first day of the Social Security hospital program for persons 65 years and older had gone smoother than anyone had dared hope.

Still, there were problems: mountains of paper work, missing forms, bewildered patients, lost medicare cards, and one woman who got mad and swung her purse at a hospital worker.

By midafternoon, in the usually frantic emergency room at Jackson Memorial, interns sat with their feet propped on a table.

"It's the quietest day we've had," said Dr. James Connaughton, who joined the Miami hospital last month after graduation from the University of Indiana.

The situation was virtually the same in hospital after hospital across the United States. Fear expressed by some that medical facilities would be swamped by elderly people evaporated as the day wore on like any other before a July 4 holiday.

Northwest Hospital in Seattle, the first in the nation to be certified for medicare, admitted not a single medicare patient. Six elderly patients already in the hospital, however, were automatically switched over to medicare at its start, 12:01 a.m. Friday.

"Heaven help us when Tuesday comes," said Alfred E. Riley, business manager of St. Elizabeth's Hospital in Chicago. Riley said he looks for a big inflow of patients then because of the people who wanted to be home for the holiday or delayed entry because so many doctors would be away for the weekend.

At 9 a.m. on the first day, Anna Winston, 71, of New York City, showed up in the emergency room at mammoth Mt. Sinai Hospital complaining of "aches and pains." Within an hour she became one of the hospital's 19 first-day medicare admissions.

"I knew I'd wind up in the hospital because I was very sick," Mrs. Winston said. "I should have been here a month ago, but I couldn't get into this or any other place."

Asked her opinion of the new program, she said: "I feel very strong about medicare. This is a very, very rich country—why shouldn't we have it? And why shouldn't it work?"

The biggest problem faced by the hospitals is the increased load of paper work. Mt. Sinai added 41 clerks just to handle all the new forms and extra bookkeeping. Other hospitals are also taking on new help.

At St. Joseph's Infirmary in Atlanta, business manager David Messinger recalled that he had spent 20 years in the Air Force as a medical budget officer. He shuggled the forms piled high on his desk and said, "I'm right back home again. I haven't had much sleep in three days. I can't sleep any more, trying to figure out what to do about medicare."

Most frightening to him is the requirement for itemized billing for laboratory tests. There are 223 lab tests listed by the hospital, and special billing forms are required—and at least two sets must be filled out for medicare.

An information desk was set up on the main floor at Detroit's Henry Ford Hospital, where more than 200 elderly persons came with questions about the program.

One elderly woman insisted a girl behind the counter was wrong when she explained that medicare doesn't cover all expenses. "You're trying to line your pockets with my medicare money," the woman shouted, and swung her purse at the girl.

The girl ducked and the blow glanced off her hairdo. She retreated into a nearby office and the woman stomped out.

"They're generally surprised to learn that everything isn't paid for," said Thelma Cogswell, clinics admitting officer at Massachusetts General Hospital in Boston.

She said the clinic patients were used to being "whisked through" the formalities of being checked in. But Friday there were delays because of the medicare forms to be filled out. Miss Cogswell added: "The hardest part at this point is that nothing is cut and dried. If we had been given a few simple rules to follow it would be a lot easier."

By the end of the first day at Massachusetts General the hospital had 941 patients, of whom 260 were over 65 years. During the day the hospital admitted 67 new patients, 18 of them under medicare. Eight of the medicare patients entered the hospital after 5 p.m.

"The newness of it all gave us a hectic night," said John Stella, night admitting officer.

Queen of Angels Hospital in Los Angeles didn't have a single medicare admission until midafternoon, when a doctor called to advise he was sending in a male heart patient.

"The hospital census always goes down to rock bottom on July 4," said a hospital spokesman.

Also affecting admissions, he said, was the fact that California put into effect its own program March 1, absorbing early the influx of patients.

Some hospitals reported that a few elderly persons had shown up to "get their medicare." They weren't sick, but they mistakenly thought they had to report to the hospital.

"The people who come in under medicare often are too old and too sick to know about the program," said Alan Transue, credit manager of Research Hospital and Medical Center in Kansas City.

"They don't have cards, they can't find cards, they don't know what we are talking about," he said.

At the Boston Hospital one woman outpatient refused to produce her red, white and blue card—until she had a chance to go to the ladies room and unpin it from her underwear.

Willa Smith of Birmingham, Ala., a patient at the Ochsner Foundation Hospital at New Orleans for the past week, was happy to have her records switched over to medicare Friday.

"I'm not sure if medicare is a good thing, but I'll be glad for some help in paying my bill," said Mrs. Smith.

In the same hospital, Herbert Leonard, an oil jobber from Ponchatoula, La., said he objected to medicare and wouldn't have signed up if his private insurance company hadn't reduced his hospital coverage due to the federal program. "I still think an American would rather pay his own way," he said.

Plaguing some hospitals was the fact that they had not received all the necessary forms. That produced the only crisis at Miami's Jackson Memorial Hospital. The forms necessary to transfer 154 patients already in the hospital to medicare didn't arrive until Friday morning.

Massachusetts general didn't get two of the forms at all, and Thursday afternoon hospital officials sent a few sample copies to the printers for a rush order.

Of the 40 patients admitted to the Arkansas Baptist Medical Center at Little Rock, seven were medicare patients. Another 40 patients in the hospital were transferred to medicare when it became effective.

One of those admitted was Virgil Edward Paul, 71, of North Little Rock, who developed sudden stomach cramps early in the morning. Paul, a retired carpenter whose only other hospital visit was six years ago for an appendectomy, said he hoped his vist would be brief.

The only hitch in his admission came when it was discovered he'd left his medicare card at home. A relative was sent to get it.

When medicare went into effect St. Joseph's in Atlanta transferred 50 age-eligible patients to the program. During the day six checked out and three more were admitted.

E.D. Rivers, 70, of Lakeland, Ga., Georgia governor from 1937-40, entered the hospital for a periodic checkup. His admission form bore the green-ink stamp "Medicare 65."

"I've been in Social Security for some little bit now," Rivers said. "I paid in a lot of money. They don't put it on the basis of need, but on the basis of right."

Madge English, 72, of Dallas, admitted to Parkland Memorial Hospital at midmorning for treatment of a broken hip, said of medicare: "It's a wonderful thing. It's God's blessing to the old people."

Dr. Fred Bonte, chief of radiology at Parkland, said, "It's a lot easier than we thought it would be." Five medicare patients were admitted Friday and 82 others in the hospital were automatically transferred.

Said administrator Jacke Price: "I'm not surprised at the small number of medicare admissions. After all, old folks don't like to go to the hospital any more than anyone else."

San Francisco Examiner

A HEARST NEWSPAPER

Truth, Justice • Public Service

☆ Sat., July 2, 196(

These cartoons are presented to our readers as a roundup of world and national opinion.



—Mauldin, Chicago Sun-Times

"I suppose there are times when we must go along with the inevitable."



—Hesse, St. Louis Globe-Democrat

Germ warfare.

Friday, July 1, 1966

BROTHER JUNIPER



"It's better to light one little candle than curse the mosquitos."

GRIN AND BEAR IT



"We cheap skates have only ourselves to blame! Didn't we vote down the bond issue to put an all-weather dome over the horseshoe pitch?"

Coffin's Needle

By Harold Coffin

Medicare is an honest effort to cure your aching back by giving your doctor a pain in the neck.

•

These days a fellow isn't supposed to get married until he's 21 and can't get sick until he's 65.

•

Medicare is not compulsory. You can choose socialized medicine from your friendly government—or get the unsocial kind through your friendly loan company.

•

When a senior citizen gets sick he doesn't know whether to see a doctor or consult an accountant.

•

Middle-age is that difficult period between Aid to Needy Children and Medicare when you have to pay your own doctor bills.

7/1/66

THE FRESNO BEE
FRESNO, CAL.

Medicare Starts Great Role In Social Advance

When in the course of human progress burdens are shifted or created it becomes necessary to emphasize the reasons this is so. Such is the case with medicare which begins today a social revolution ranking in extent and importance the establishment of Social Security itself.

In the very core of the democratic system is the duty of society to insure its citizens have the opportunity, insofar as is possible, to live out their lives in serenity, free from the fear their sicknesses will not be cared for.

Medicare will provide hospital insurance for nearly everyone aged 65 or over, plus optional, low-cost protection for doctors' bills and some other medical expenses for more than 17 million oldsters.

This great advancement in furthering the American dream of well-being for all citizens did not occur overnight. On Nov. 19, 1945, less than three months after the end of World War II, President Harry S Truman sent Congress a special message on national health needs. He said:

> We are a rich nation and can afford many things. But ill health which can be prevented or cured is one thing we cannot afford.

Twenty years later Congress passed a health care bill and President Lyndon B. Johnson traveled to Independence, Mo., to sign it in Truman's presence. It was Truman, President Johnson declared, who gave the people of America hope and Truman replied the new law will provide dignity, not charity, for those who have moved to the sidelines.

The American Medical Association, which bitterly fought the advent of medicare, since has taken the official position it is the obligation of physicians to try to make it work.

The advice of Dr. James Z. Appel, AMA president, is pertinent. He said the medical profession cannot surrender to resentment but must prevent, as far as it can, disruption of service to patients.

Medicare is here and there will be problems. But society has determined it is needed in the name of compassion. It is this spirit which must guide all who have anything to do with putting it into practice.

Mercury and NEWS

San Jose Mercury

AN INDEPENDENT NEWSPAPER

J. B. RIDDER, Publisher | KENNETH S. CONN, Executive Editor | ANTON F. PETERSON, General Manager

44 SAN JOSE, CALIF., THURSDAY, JUNE 30, 1966

211 West Santa Clara Street, 95113.

Medicare Bound To Raise Questions

Some 19 million Americans, including nearly 60,000 in Santa Clara County, will come under the protection of the nation's new medicare law tomorrow.

It will be, quite literally, the dawn of a new era, and like many a dawn, the visibility may prove to be limited at first. Providing medical and hospital care for citizens 65 years and older is bound to be both a complex and a gigantic undertaking.

However, in California, the medical profession and the Social Security Administration have cooperated closely and well in setting up procedures whereby doctors will be able to deal directly with their patients and not through a new bureaucracy of the federal government. This is what everyone wants: the doctors, their patients and the federal administrators who would much rather work with established medical insurance plans, such as Blue Cross and California Physicians Service, in making actual payment of bills.

Santa Clara County residents are fortunate in that the Social Security District Office is located at 1010 The Alameda, San Jose, where District Manager John J. Cassidy and his staff are prepared to answer the many questions that are bound to arise with the establishment of an entirely new, complex and far-reaching program. Cassidy this week invited such queries, adding that the office's telephone number is 286-2525.

With tomorrow being Medicare Day, the number is one that Santa Clara County's over-65 population may well want to memorize.

THE SACRAMENTO BEE
Sacramento, Calif.
July 1, 1966

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SANTA MONICA, CALIFORNIA
EVENING OUTLOOK
SATURDAY, JULY 2, 1966

'Business As Usual'

Medicare Fails To Jam Hospitals As Anticipated

From Evening Outlook News Services

A funny thing happened to Medicare on the way to its trial as "the great experiment" —it didn't jam up the nations' hospitals on its first day.

Though hospitals braced for it and doctors predicted "bedlam," the anticipated flood of Medicare admissions Friday turned out to be just a trickle at hospitals from coast to coast.

In scores of checks, hospital administrators had the same thing to say: "It's business as usual."

"There's practically a dearth of patients being admitted," said John B. Brewer, executive director of the Hospital Council of Southern California.

Beginning Smoothly

Social Security Administrator Robert M. Ball, the man in over-all charge of the new health coverage for 19 million Americans over 65, said a government check of 100 hospitals disclosed admissions "running at normal rates" and the program beginning "very smoothly."

Although general hospitals in Cook County, Chicago, and Los Angeles disagreed on which was the nation's largest, they were unanimous on Medicare's impact: Practically unnoticeable.

The program went smoothly into effect in Los Angeles hospitals without a rush of patients, medical spokesmen reported.

But eight patients have left at least two non-Medicare hospitals elsewhere in Southern California.

Patients Transfer

At Fullerton Community Hospital in Orange County, six of nine patients eligible for Medicare benefits transferred to other hospitals because the Fullerton facility declined to participate in Medicare.

Two patients, for similar reasons, left Sierra Vista Hospital in San Luis Obispo.

The two hospitals are privately owned.

Queen of Angels Hospital in Los Angeles didn't have a single Medicare admission until midafternoon, when a doctor called to advise he was sending in a male heart patient.

Hospital Census Low

"The hospital census always goes down to rock bottom on July 4," said a hospital spokesman.

Also affecting admissions, he said, was the fact that California put into effect its own program March 1, absorbing early the influx of patients.

Other reasons advanced for the unexpectedly low admission rate were many.

Some officials said Friday is always a day of fewer admissions and summer is the slack season. Others said some eligibles facing elective surgery stayed home because of the July Fourth holiday. They predicted a crush Tuesday.

In Florida it was reported some patients preferred to go into hospitals a few days ago, on their own insurance, to avoid the expected crowd Friday.

Despite the lack of any dramatic rush to benefit from Medicare, the program became a reality at 12:01 a.m. Friday for 160,000 elderly Americans already hospitalized.

For them it was a simple matter to complete the proper forms brought around by hospital officials and the benefits started.

A few problems developed over Medicare paperwork, and here and there a person already in a hospital found he left his card at home.

But for the most part complaints were few.

Montana

The Billings Gazette Friday, July 1, 1966 Morning Edition 6

Medicare Problems Absent

No problems were encountered as Medicare programs were born in two Billings hospitals midnight Thursday.

Nearly 55 patients 65 and older were in the hospitals at the time. But no great influx of patients with advance reservations for elective surgery is coming. The long holiday weekend with no scheduled surgery and the normally lower summer patient load were mentioned as administrators at the two hospitals talked about reservations.

Neither had any idea about possible admittances for emergencies or illnesses. A person just doesn't plan to have pneumonia on a certain day in July, Robert Howe, Deaconess administrator, pointed out.

Twenty-seven patients in Deaconess Thursday morning fell in the Medicare age group and the same number, 27, was counted in St. Vincent's Thursday afternoon.

At St. Vincent's two people 65 or older will be admitted Friday, Sister Alice Marie, administrator said. While Howe didn't know how many older patients had Friday reservations, he said it probably isn't many as surgery isn't scheduled Saturday.

Two of 18 patients with Tuesday reservations at Deaconess are known to fall in the Medicare age bracket. Three of the remaining number definitely won't be eligible for Medicare as they'll be in pediatrics, Howe noted.

The number of Tuesday admittances is larger than usual, Howe said, but not abnormal for a post-holiday. More patients can be admitted after a holiday as hospital occupancy is at its lowest, he added.

Patients will be fewer than last month, Howe said, "but this is traditional. Occupancy goes down in July."

St. Vincent's looks for a "fairly good schedule" of Monday night admissions, too, Sister Alice Marie said. But only two of the advance-reservations are for older patients.

Additional work connected with Medicare added a full-time employe at Deaconess for billing. St. Vincent's hasn't added help yet, but expects to as it enters the busier winter months.

The majority of Billings doctors probably will bill patients directly and leave it to the patients to collect health insurance benefits from the program, according to Dr. John Valley Medical Society president.

Dr. Hurly stressed he is speaking personally and not for the society as a vote hasn't been taken. However, he believed the feeling is the same in Billings as it is in the nation.

The American Medical Association urged the direct billing Wednesday. Howe said doctors have a choice in the matter; participating hospitals do not and must collect from the program.

Montana

The Billings Gazette Sunday, July 3, 1966 Morning Edition 18

Medicare Off to Flying Start

By ROBERT GOLDENSTEIN

CHICAGO (AP)—The medicare program is picking up steam with the nation's doctors free—if they choose—to charge whatever they wish for their services and to require elderly patients to handle the paperwork in seeking reimbursement from the government.

The American Medical Association, with 214,000 members, strongly urged doctors at their annual convention just ended to bill medicare patients directly, rather than collect their fees from the government.

Consideration of medicare and its ramifications was the highlight of the week-long convention attended by 15,000 doctors.

The AMA's House of Delegates, its policy-making body, overruled an AMA Advisory Committee when it adopted without dissent recommendations of the Board of Trustees and delegations from Florida, Iowa and Illinois.

The final action put the AMA on record as calling on "each and every member of this association" to submit his bill directly to the patient, rather than choose the assignment method.

Both methods are permissible under the medicare act.

Refuses Stand

But the AMA House of Delegates refused to take a stand on the issue at a special convention in October, stating: "The American Medical Association opposes any program of dictation, interference, or coercion, whether direct or indirect, affecting the freedom of choice of the physician to determine for himself the extent and manner of participation or financial arrangement under which he shall provide medical care to patients under Public Law 89-97.

In opposing an all-out AMA stand in favor of direct billing, the Reference Committee on Insurance and Medical Service contended such action would be "inconsistent."

The AMA not only came out for direct billing by all doctors, but adopted a Florida delegation resolution recommending that no special review or mediation committees be set up in hospitals solely to handle medicare cases. It recommended that the standard mediation or review mechanism of the county medical society be utilized.

Under direct billing, the doctor sends his bill to the patient and, after the patient has paid $50 in doctor bills within a year, he can seek reimbursement from the government of 80 per cent of the remainder of what is considered a reasonable fee.

For example, if a doctor charges $250 for a surgical operation where the reasonable fee" for that type of surgery is set at $150, the patient would pay the first $50 to qualify for reimbursement, 20 per cent of the next $100 (or $20), all charges above the allowable $150 reasonable fee (or $100)—for a total of $170. The government would pay the remaining $80 of the $250 bill. In addition, the patient pays $3 a month for his Part B medicare premium.

What's Reasonable?

If the doctor's charge is below the reasonable fee rate his charge is accepted as a reasonable fee.

The AMA Board of Trustees in its report to the House of Delegates said this week: "The matter of fees for physicians' services should be the subject of agreement between physician and patient but the physician who accepts an assignment has no assurance as to the amount that the carrier will determine to be the reasonable charge for his services.

Under the assignment method the doctor collects 80 per cent of his "reasonable" fee from the government and 20 per cent from the patient, after the patient has paid $50 in doctor bills within a year.

The doctor also would be required to fill out forms under this method, to seek the government payments.

Other Action

In another medicare action taken at the convention, the House of Delegates called for certain specialists to refuse to replace any hospitalized-based doctors who are barred from the institutions for billing patients directly.

The doctors involved are pathologist, radiologists, anesthesiologists and other specialists who practice inside a hospital.

The policy making body took the action despite warnings from the Board of Trustees that the move might cripple the AMA with lawsuits.

After the delegates completed their action on medicare, Dr. Milford Rouse of Dallas, the AMA president-elect, told newsmen he will continue to bill his patients directly.

But Dr. James Z. Appel of Lancester, Pa., the outgoing president, urged doctors to plan immediately to correct deficiencies in the program. He also urged doctors to refrain from raising their fees or from frustrating efforts of the elderly from gaining reimbursement under the plan.

And the new AMA president, Dr. Charles L. Hudson of Cleveland, made no mention in his inaugural speech of attempting to overturn medicare.

President Johnson sent a telegram to Dr. Appel at the convention saying, "I am positive that with your dedicated help and coperating, we can and will succeed in benefiting the many Americans who are greatly in need of this service."

He said he will continue to seek the counsel of organized medicine in the months ahead.

RENO EVENING GAZETTE

A NEWSPAPER FOR THE HOME

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Now for Medicare

MEDICARE is ushering in a virtual revolution in medicine and hospital administration in the United States. The full effects may not be realized for several years.

The burden that will be placed on hospitals is still a matter of conjecture. Medicare comes, really, in two parts. The part that pays hospital bills is available without charge starting next Friday to nearly everyone aged 65 or more. The second part covers doctors' bills and some other medical expenses for people 65 and more, This optional protection, which also starts July 1, costs $3 a month per person. The Social Security Administration as of June 3 had processed applications of 17,337,000 oldsters for the voluntary coverage. This service has the deductible feature familiar to most health insurance plans. Benefits start after the patient has paid $50 of his own money.

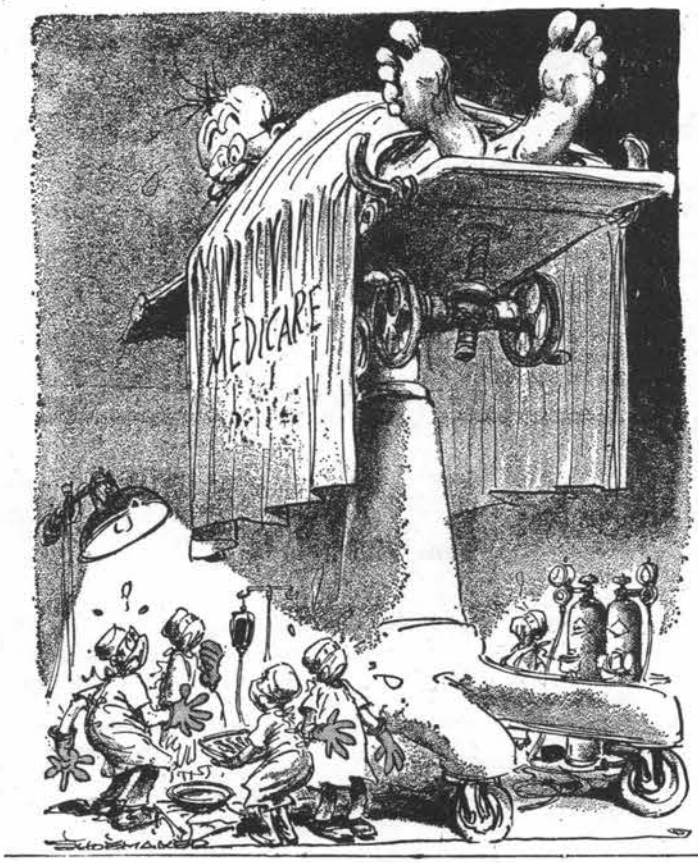
Still another service begins on Jan. 1, 1967. Medicare will then provide funds for up to 100 days in an extended care facility like a nursing home, in each illness after a hospital stay of at least three days.

The fear is widespread that the nation's medical, nursing and hospital diciplines just won't be able to accommodate the upsurge of older persons seeking help under Medicare. This could cause political disturbances. Old persons who have been told that their ills will be taken care of are not going to accept the excuse of doctor, nurse and hospital bed shortages, and the "senior citizen" vote is something for politicians to consider seriously.

In any event, a shortage of medical specialists already pinches, regardless of the pressures, however debatable, of Medicare. The Federal Nurses Training Act of 1964 is aimed at assuring a 1970 total of 680,000 registered nurses even though the Surgeon General's Consultant Group had forecast a need for at least 850,000 professsional nurses by that time.

The ratio of physicians to civilian population has fast deteriorated in recent years. Ther should be about 11,000 new doctors of medicine a year, but the increase is far short of that number. In 1961 the dean of the Yale Medical School, Dr. Vernon M. Lippard, calculated that the country's needs could be met only by "the establishment of at least 20 new schools of medicine during the 1960s."

Scalpel—and a Ladder



DISTRICT OFFICE LAS VEGAS NEV

7/3/66 Review-Journal

7/3 R-T

Patients Ordered Out In Medicare Law Row

CORINTH, N.Y. (AP) — Eight elderly patients were ordered evicted today from a tiny community hospital because federal officials said the hospital did not meet standards for the new government medicare program.

The two other patients at the Adirondack Regional Hospital in this village near Saratoga Springs also were over 65 and covered by medicare. But they were permitted to remain because they are heart patients who cannot be moved, said Dr. Bruce Scidmore, head of the hospital.

The eight were considered well enough to go home until other accommodations could be found, he said.

The health insurance agencies that had been paying their bills automatically dropped coverage with the advent of medicare at midnight. Thus, the eight, aged 67 to 87, could not afford to remain. The medicare program will pay for the critical ones, aged 70 and 78, until they can be moved.

A few hours before the federal medicare program for persons 65 or over went into effect today, hospital officials pleaded for a temporary permit without success.

In 1960, there were fewer than 100 mechanical cotton harvesters in North Carolina, which picked only three per cent of the crop that year. By 1965, the number had increased to 1,[illegible] pickers which handled 72 per cent of the state's cotton crop.

DISTRICT OFFICE, LAS VEGAS, NEV
7/2/66, Las Vegas Sun

Medicare Comes Sun 7/2 in Like a Lamb

Only two patients had been admitted to Southern Nevada Memorial Hospital by noon of the first day of Medicare yesterday, according to Jack Staggs, SNMH administrator.

"But there are about 30 patients already in the hospital who became eligible for aid under the Medicare Program when it went into effect yesterday," Staggs added.

A survey of business around the state disclosed that the arrival of Medicare scarcely caused a ripple in hospital activity. Some administrators actually reported fewer admissions than normal. Nationally, it was the same story.

"It's just the same as usual," Elko General Hospital reported. "We have some busy admittance days and some slow ones."

Although there had been predictions of a possible early rush to hospital admittance rooms, Staggs and other administrators around the state expect the build-up to be gradual.

"One factor to be considered in Nevada," noted Staggs, "is that only 2.8 per cent of our population is 65 or over, whereas the national average is about 10 per cent."

Nevertheless, thousands of Nevadans are eligible for the program, and there has been some concern they will tax hospital, nursing home and doctor facilities.

"Had Nevada adopted Title XIX in May," Staggs added, "there probably would have been a large congestion, but with only Title XVIII, Medicare, to worry about, we don't expect any problems we can't handle."

Title XIX, locked in the ways and means committee during the recent special session of the legislature, would have extended hospital and doctor facilities to anyone in the state classified as medically "indegent," too poor to pay, regardless of age.

"By the end of the first 30 days under Medicare, we should have something a little more conclusive to report than we do now," Staggs said.

Here's what will happen to a typical hospital bill under the new Medicare Program:

Suppose an elderly patient undergoes surgery and remains in the hospital for 10 days.

His bill for a semi-private room and general nursing services will come to about $270. The patient will pay $40 of this, and Medicare will pay the other $230.

He'll also be charged for use of the operating room, diagnostic tests, drugs furnished in the hospital and other services, totaling perhaps $200. Medicare will pay all of this.

Medicare will not pay for the extra cost of private rooms, private nurses, telephones or rental of a television set.

If blood transfusions are needed, the patient pays for the first 3 pints of blood and Medicare pays for any subsequent needs. Tom Underiner, SNMH assistant administrator, explained, however, that the normal cost of three pints of blood is $20, but that, under Medicare, about $13 of that would be paid for by the program, even for the first three pints of blood.

Services of an anaesthesiologist are covered by Medicare if he is a resident member of the hospital staff or an intern. If he's an outside specialist, his fee is treated like any other doctors' bill. It is not covered by the basic hospitalization program, but is eligible for partial reinbursement if the patient has the optional insurance against doctors' bills.

Surgeon's fees, of course, come under the heading of doctors bills—not covered by the basic program, but eligible for up to 80 per cent reimbursement under the optional program.

DISTRICT OFFICE, LAS VEGAS, NEV
7/1/66, REVIEW JOHRNAL

R-5-7/1

FOR SENIOR CITIZENS

Medicare Begins Today

WASHINGTON (AP) — The massive medicare program providing hospital insurance for all 19 million of the nation's senior citizens went into effect today, hailed by President Johnson as "a blessing for older Americans."

Swinging into operation with the program was an optional doctor-bill insurance plan for which 17.3 million elected to pay $3 a month.

The two programs were brought into being at 12:01 a.m. in one of the biggest operations in medical history.

Doctors and patients reserved any prognosis, but the President pronounced it a success in advance. He called it "a test of our willingness to work together."

By Public Health Service count, 6,714 institutions — or 91 per cent of all the country's 7,374 general hospitals with roughly 93 per cent of the beds — opened their doors for the insured care of any American aged 65 or over.

The nonparticipating hospitals were mainly in the South. Most were barred from medicare payments by their failure to comply with the no racial discrimination provisions of the Civil Rights Act.

To make extra sure that no one dies for want of access to a participating hospital, the government ruled Thursday night that federal hospitals — veterans', military and others — may be used for critically ill medicare patients in emergencies.

Previously it had been announced that any other nonparticipating hospital could be used — private or public, with medicare picking up the bill — if a bed in a participating hospital could not be found to avert the threat of death "or serious impairment of the health.

Despite the serious gaps in participation — only 25 per cent of Mississippi hospitals were in the pool — administration aides were jubilant over the generally high participation nationwide.

"We've done far better in the South than we had dared to hope a month or two ago," one Public Health Service official said.

"And more hospitals will be desegregating when they begin to feel the pressure from unhappy local residents, both white and black," he added.

★ ★ ★ ★ ★ ★ ★ ★ ★ ★ ★ ★

Vegas-Area Hospitals Have Normal Business

It's business as usual for Las Vegas area hospitals Friday, with the effect of Medicare barely being felt on its first day of its existence.

FEARS OF long lines of the elderly jamming all available hospital facilities — did not materialize.

At Southern Nevada Memorial Hospital, 38 patients are eligible for Medicare. Of the 38, only two checked in Friday, the first day of Medicare.

But Thomas Underriner, associate administrator of the hospital, predicted that more will arrive on Tuesday.

"Many of our would-be patients prefer to spend the July 4th weekend with their families and then be admitted after the holiday."

AT ROSE DE Lima hospital, a spokesman said there are only two patients covered by Medicare. One of the two checked in Friday.

The spokesman said Medicare will make little difference and predicts no influx of elderly patients.

At Sunrise there are some patients already in the hospital who became eligible for medicare coverage Friday, but no new arrivals.

The hospital is not expecting any rush, a spokesman said.

Section C

The Honolulu Advertiser

FRIDAY, JULY 1, 1966

As Program Opens Here Today...:

Light Medicare Impact Seen

By JIM RICHSTAD

Hawaii, with a large population of young people and comparatively few persons over 65, doesn't expect a major increase in hospital patients under Medicare, which becomes effective today.

Hospital bed usage is expected to go up 5 to 15 per cent nationally because of Medicare. The impact in Hawaii is expected to be one of the lightest in the country, medical authorities said.

* * *

ABOUT 34,000 Hawaii residents are registered for Medicare. About 3,500 others would be eligible if they signed up for the program.

Of Honolulu's 30 hospitals, 27 are taking part in Medicare. Two of the other three treat only children; the other is an institution for the care of persons with Hansen's disease.

The 27 participating hospitals have 3,873 beds with an average occupancy of 85 per cent. The Hospital Association of Hawaii believes this

See Editorial:
"Service & the State"
Page C-2

will leave enough beds to take care of the expected Medicare patients.

* * *

"WE DON'T anticipate a tremendous influx," Richard Davi, president of the association, said yesterday.

"We are dealing with a new program for the aged, but it doesn't mean all these people are going into hospitals for care overnight."

Davi said, however, that the number of Medicare patients may "increase considerably as the program becomes better known."

* * *

HERE IS HOW Honolulu's major hospitals have prepared for Medicare:

Queen's Hospital established a review committee six months ago, and on June 1 began a month's "dry run" under Medicare standards to work out the kinks.

Douglas Gibbs, administrative assistant at Queen's, said the hospital's 450 beds have about 85 per cent average occupancy.

The medical and surgical beds—those which would be most used by Medicare patients—run more than 90 per cent occupancy.

"We don't plan immediate expansion," Gibbs said. "We are always re-evaluating our needs, however. We anticipate a moderate increase in bed use due to Medicare."

He said occasionally a person without an immediate need for surgery may have to wait for admission, but all those with emergencies or pressing needs will be taken immediately.

Gibbs urged all Medicare patients to have their cards with them when arranging admission.

* * *

KUAKINI HOSPITAL reported about 92 per cent occupancy of its 185 beds, but doesn't expect a great increase due to Medicare.

Administrator Kenji Goto said: "People of Japanese descent do not forego medical care or hospitalization, and most of them who needed care were getting it already.

"That would indicate not too much of an increase in the number of hospitalizations."

Goto also said physicians "will use discretion, and not hospitalize patients without good justification."

He said occupancy varies from 70 to 100 per cent. He expects Medicare to increase the 92 per cent average and stabilize the daily occupancy level.

"But we are not going to have a deluge of patients over 65 years of age flooding the hospital," he predicted.

Kuakini plans expansion and modernization of supporting hospital departments, but no increase in beds, Goto said.

* * *

AT ST. FRANCIS Hospital, the outlook is to wait and see what happens.

Sister Aileen, assistant administrator, said the hospital's 260 beds have an average occupancy of between 75 and 85 per cent.

"It's impossible to say what will happen," she said. "We hope to be able to cope with the problems as they arise. Everyone is just waiting to see what will happen."

She said an increase of 15 per cent in bed patients could be handled, and the hospital doesn't plan to increase bed capacity.

One area in which she expects a big increase is the home-care program.

St. Francis is the only Oahu agency handling the Home Health Service benefit under Medicare. It will be under the hospital's previously established Honolulu Home Care Program.

The program provides nurses, physical therapists and other medical workers at home for patients who don't need full hospital care.

Sister Aileen predicted a 25 to 50 per cent increase in that service. There now are about 55 patients involved.

"This is one of the ways people can go home sooner and free us for acute patients," she said.

The Home Health Service will be handled by the State Department of Health on the other Islands.

* * *

A SPOKESMAN for Kaiser Foundation Hospital said: "We don't really expect a great increase because our patients have always been under a prepaid program. But we could be wrong."

Kaiser has 125 beds, and the spokesman said: "The bed capacity now is quite adequate to meet the Medicare requirements."

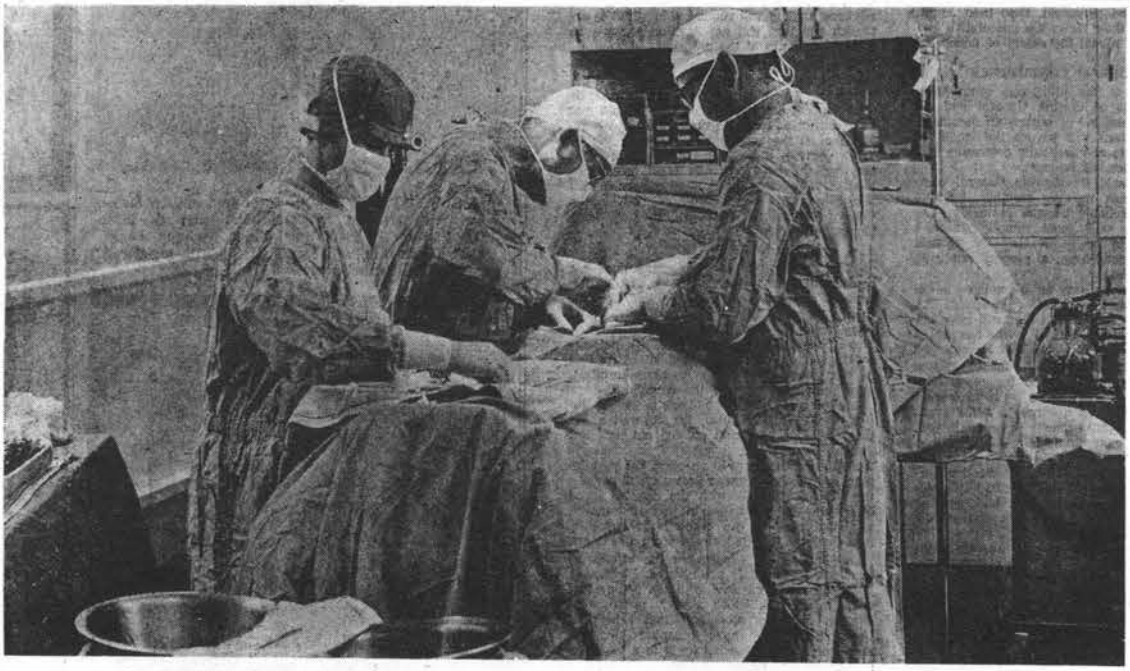
There are plans under study, however, to finish and open the hospital's unoccupied 10th floor. That would add about 36 beds.

The spokesman said preparation for Medicare has been under way for a year at the health foundation's

LONGVIEW DAILY

LONGVIEW, WASHINGTON, FRIDAY, JULY 1, 1966

NEWS



UNCLE SAM HELPS FIRST OF MANY MEDICARE PATIENTS

Doctors performed abdominal surgery this morning on Cowlitz General Hospital's first Medicare patient, Andrew Metsala, 74, of Rosburg. The elderly Finnish farmer, who has 10 daughters and a son who is a medical student, appeared at the hospital Thursday morning saying "President Johnson said it supposed to be all free on the first of July." Suitcase in hand, Metsala presented himself for admission without notifying a doctor or the hospital in advance. He had been bothered with an abdominal problem for several years.—Jan Fardell photo.

Medicare Patient Elects To Have First-Day Surgery

By GEORGE BURLEY
Daily News Staff Writer

Without saying a word to any doctor or sending advance notice, an elderly Finnish resident of the Rosburg area walked into Cowlitz General Hospital Thursday morning with a suitcase in hand.

"President Johnson said it is supposed to be all free on the first of July," said the hospital's first Medicare patient, Andrew Metsala, 74, asking to be admitted.

Metsala's straight - forward manner of taking advantage of the federal Medicare program was quite disarming for hospital personnel, who smiled and chuckled in relating the incident. They said the way he presented himself will probably be very typical of many future Medicare patients seeking help from hospitals.

Metsala told doctors he wanted an operation, elective abdominal surgery, for a recurrent problem that has bothered him for several years.

The blunt old gentleman, a farmer and retired logger who packed a bag and caught a bus to Longview, said he wanted to get his operation taken care of before the hospital got too full of Medicare patients.

This morning Metsala had his surgery. Doctors said he will be in Cowlitz General Hospital for about a week.

At 12:30 p.m. the hospital announced that his post-operative condition was good.

After discovering Metsala had a Medicare registration card, Administrator Rex von Krohn said, there was no problem with red tape. All he had to do was sign a special Medicare admission card.

Von Krohn added that since summer is the slack season, no real problems are anticipated by the hospital from any flood of Medicare patients.

Los Angeles Times

LARGEST CIRCULATION IN THE WEST. 845,150 DAILY, 1,184,384 SUNDAY

SATURDAY MORNING, JULY 2, 1966 — 62 PAGES

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U.S. Hospitals Easily Absorb Medicare Start

Thousands of Beds Desegregated in Southern Cities; Heavier Load Expected After Holiday

By Associated Press

The nation's hospitals easily absorbed the first-day impact of Medicare Friday, as city after city reported normal hospital operation. And, in many southern cities, thousands of hospital beds were desegregated.

But some officials predicted heavier use by Medicare patients after the July 4th holiday. Others cautioned that the full impact is a month or more away.

About 6,600 hospitals have applied and met the government's quality standards, William H. Stewart, U.S. surgeon general, and Robert M. Ball, Social Security administrator, said at a briefing in Baltimore, Social Security's telecommunications center for Medicare.

But 327 have been refused clearance on grounds of failure to comply with nondiscrimination rules, they said.

About 100 more could have met the quality tests, Ball said, but "chose not to apply, in many cases" because of the desegregation requirement.

Most Qualify for Medicare

Most of the noncomplying hospitals are in the South, they said. They estimated that 94% of the nation's general hospitals, representing 95.9% of the nation's hospital beds, are prepared and qualified to participate in Medicare.

The totals given by Ball and Stewart were a bit higher than those from other federal offices, but all sources agree on this:

Hospital participation was far broader, especially in the South, than authorities had dared to hope for a month or two ago.

Hundreds of southern hospitals have come into compliance in recent days, and Ball predicted "a great forward movement in those areas in July."

40% Comply Now

The Welfare Department in Washington reported that Mobile, Ala., identified by the White House as a "problem city" a few days ago, now has 40% of its hospital beds in compliance.

Thousands of patients 65 and older who were already in hospitals became the instant beneficiaries of Medicare at 12:01 a.m. Friday by a

Please Turn to Page 12, Col. 2

MEDICARE

Continued from First Page

bookkeeping transaction. Medicare automatically picks up their bills from July 1 until their 90 days of benefits expire, except for $40 that is "deductible."

A telephone survey of reservations in 100 hospitals through next Tuesday, made Thursday night and Friday by the Social Security Administration, confirmed that Medicare is having little or no immediate over-crowding effect.

Only 10 of the hospitals are at full capacity, the check showed, and none attributed the condition to new Medicare admissions.

Holdout Hospitals in Southland Lose Some of Patients

BY ERIC MALNIC
Times Staff Writer

Medicare went into effect smoothly at hospitals in Los Angeles County Friday, but patients at two hospitals in other Southland counties checked out when the hospitals chose not to join the federal health care insurance program.

At Fullerton Community Hospital in Orange County, six of nine patients eligible for Medicare benefits went home or transferred to other institutions because of that hospital's decision to stay out of Medicare.

And two of 16 Medicare-eligible patients at Sierra Vista Hospital in San Luis Obispo County transferred out when Sierra Vista chose the same course as the Fullerton hospital.

Fullerton Stays Out

A Fullerton Community spokesman said his hospital had voted to stay out of Medicare because it found some of the program's goals "inconsistent" with the hospital's operation. Sierra Vista administrator Travis Wilson said his hospital is staying out because Medicare will not pay enough to cover the costs of the patients it covers.

The two hospitals, both privately owned and profit-making institutions, have indicated they have met Medicare certification and standards and could participate in the federal program if they wished.

Of the Medicare-eligible patients who did not leave Fullerton Community, two decided to pay their own bills and the third—an emergency case—was to stay until well enough for transfer. All 14 who stayed at Sierra Vista decided they wanted to

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12 Los Angeles Times 2★ Part I—SAT., JULY 2, 1966



ONE OF FIRST — Mabel Lockman, 70, early Medicare patient at California Hospital, shows her card. Times photo

PATIENTS

Continued from First Page

pay their own way, Travis said.

In Los Angeles County, there were no reports of patients being denied Medicare coverage by certifiable hospitals. Hospitals apparently were having little difficulty adapting to Medicare and there was no evidence of a sudden overcrowding of medical facilities.

Hospital officials reported that admissions were running at near normal levels at most institutions, and there were no indications that individual physicians were being swamped by a flood of patients seeking treatment under the program.

Spokesmen for the Hospital Council of Southern California said the three-day July 4th weekend, which has tended to cause the postponement of non-emergency surgery until next week, undoubtedly helped to keep down new admissions Friday.

But most administrators said that even beginning next week, they expect that 65-and-over patients seeking attention under Medicare will bring only a gradual increase in patient load.

Whether that increase will continue until eventual overcrowding results is still an open question, although most administrators now seem to feel that any such congestion will be spotty rather than general.

Gradual Increase

The County Medical Assn. said a few member physicians — especially those treating a large number of elderly patients — reported a slight increase in patient load Friday.

Ron Harper, an assistant administrator at California Hospital, said that most Medicare patients at that institution Friday had been admitted before Medicare went into effect.

All told, he said, 81 of the hospital's 266 patients were found to be eligible for treatment under the program.

Of the 81, four indicated they did not wish to participate in Medicare, Harper, said.

One patient who decided to participate in the Medicare program was Miss Mabel E. Lockman of 431 Burnside Ave., a sprightly 70-year-old undergoing treatment for a cardiac condition.

While she had some reservations about Medicare, Mrs. Lockman said she has had "heavy medical expenses in recent years" and is "glad to have some financial help."

Hospitals See No Great Admission Surge As Result Of First Day Medicare Activity

By ANN SULLIVAN
Staff Writer, The Oregonian

See story on page 1, also.

Advent of Medicare in Oregon Friday brought no tremendous increase in hospital admissions — just a few — but it has caused a flood of concerned persons to suddenly inquire about hospitalization insurance.

Some of this "run" is among over 65 patients who mistakenly thought, in spite of widespread Medicare publicity of recent months, that their old private insurance would always cover them. Most carriers have rewritten their coverage to incorporate "Medicare coverage first." Some have dropped their over 65 coverage entirely.

One elderly man arrived at Good Samaritan Hospital in Portland Thursday to check in for a scheduled eye operation Friday. He just thought he was under Medicare but had never registered. He found out that he could at this time file claim for the hospitalization portion, part A, and get under that. But he had absolutely missed the doctor bill, of part B, filing deadline last month, in spite of repeated public warnings.

Responsibility Cited

He'll have to pay his own doctor bill. If he can substantiate his age, the hospitalization, less deductibles, will be paid by Medicare.

There was one over 65 gentleman, a very handsome man with a neat moustache, already registered for Medicare, who also came in for a scheduled eye operation. The Oregonian wanted his picture. At first it was OK. Then he thought about it for a while.

"None of my friends know I'm over 65. I don't look 65. Now that I think about it, I don't want to tell them."

Another patient at a Portland hospital checked in for exploratory surgery. He was registered for Medicare, but he still wasn't sure he liked it. He had opposed Johnson's program, he said, had been content with his original private coverage under Oregon Physicians Service. But he had to accept the new program to retain his coverage. He just didn't want anybody to know that he was accepting the federal "charity," as he called it.

"Medicare" Wanted

The admitting clerk at one hospital reported a white-haired little lady of extended age came in wanting her "Medicare."

Was she going to have an operation? No. Had her doctor sent her in? No. Had she been to see her doctor? No.

Well, was she ill? Oh no, she wasn't sick. But this was the time for Medicare, and she felt she wanted some.

Oregon hospitals, somewhat quiet because of the holiday, reported no great increase in admissions they could attribute to Medicare Friday, but some noted a slight proportionate increase in patients of that age.

Some administrators feel that some surgical procedures may have been "worked off" in the last month or so among private patients and their doctors, worrying about possible increase in bed occupancy, but the late-in-the-week admissions were up only slightly, and these not conclusively.

Wesley G. Lamer, administrator of Physicians and Surgeons Hospital, has a 161-bed institution. He had 102 patients Thursday night, 28 of whom would be eligible under Medicare because of their age.



A FIRST Medicare patient at Good Samaritan Hospital Friday, Walter H. Hastay, 6836 NE Rodney St., a retired Spokane, Portland and Seattle switchman, had not expected to use coverage. He was suddenly ill, and doctor sent him in for medical survey. Nurse is Sylvia Laine.

Providence Hospital reported 64 patients over 65 at midnight Thursday, but reported the number might "be on the high side of a normal day — but not significant."

Emanuel Hospital, not counting obstetrics and pediatrics, reported that Thursday's occupancy of the 364 beds of the medical and surgical floors was 313, or 86 per cent. The same day a year ago, there were 263 out of 365 beds, or 72 per cent; in 1964, it was 279 out of 365, or 76 per cent. Some beds were added in 1964, because of addition of an intensive care unit and an isolation unit.

But the same floors for the three years before that, without the intensive care units, had 305 patients in 336 beds in 1961, 91 per cent; 328 in 336 in 1962, 97 per cent occupancy, and 315 of 346 in 1963, or 91 per cent.

Good Samaritan Hospital reported an 87 per cent occupancy Thursday midnight, with 392 patients, 84 of them over 65.

The same date in 1965, there were 378 patients, 84 per cent occupancy.

In 1961, the figure was 350 patients, 78 per cent; 1962, 342 patients, 76 per cent; 1963, 319, 71 per cent, and 1964, 382, at 85 per cent.

Sister Mary Alban of McAuley Hospital, Coos Bay, reported five "previous" admissions eligible for Medicare, and some scheduled for next week, but the numbers were not significant.

Likewise Sister Mary Llewellyn, administrator of Mercy Memorial Hospital, Coos Bay, reported 9 previous admissions. She was not aware of any big backup of people, but she expected some increased activity after the holidays.

William Hanson, administrator of Salem General Hospital, counted 38 of his patients were eligible for Medicare Friday, but the figure was 33 a year ago.

He noted a significant decline of over 65 patients in these past few spring months, and then a mid-June upsurge, possibly among people worrying about using their private insurance before Medicare took effect.

Al Cobbin, administrator of Pendleton Community Hospital, arrived at his desk Friday to see a staff note: "Welcome To the New Era—Medicare." He said he had 5 previous Medicare admissions, had processed some 7 or 8 more for mostly elective surgical procedures. He expected that there might be a large increase in demands on laboratory and X-ray facilities after the holiday for out-patient care. Other than that, things were not far out of the ordinary.

More than 211,000 Oregonians over 65 are already signed up for the hospitalization, or part A, portion of Medicare, and 189,000 for the doctor, or part B, portion.

The district Social Security office, reported Paul Johnson its director, Friday, did not have any rush of people but the telephone lines were "hot" with inquiries.

The offices of various insurance carriers were busy with inquiries and customers.

The office of the doctor-sponsored Oregon Physicians Service-Blue Shield plan, one of the nation's oldest medical insurance programs, reported it was swamped with customers. OPS, like other carriers, has been rewriting coverage to insist that over 65 members have Medicare.

Don Chapman, OPS executive vice president, said there were so many people at the last minute desiring information on OPS and Medicare in general, that the office was having trouble getting telephone lines out. In the last few days, so many persons were coming into the office, that group information sessions had to be scheduled.

Among the Medicare developments of recent days is the incorporation in Oregon by 45 radiologists, physicians specializing in X-ray diagnosis and treatment of a cooperative accounting and billing program.

Co-Op Formed

It is called Medical Accounts Management. It has hired a manager, Norman Baker, and set up offices at 4315 SW Corbett St.

According to Dr. George R. Satterwhite, president of the board of the cooperative, the arrangement will enable cost-cutting on billing. At present 45 radiologists, most of them in the Portland area, are enrolled, and four pathologists have been accepted as subscribers.

Medicare has also resulted in a new designation for the Rehabilitation Institute of Oregon, 2010 NW Kearney St., as a general hospital.

The "rehab" center has 44 in-patient beds and treats about 40 out-patients a day. To qualify for Medicare reimbursements, it had to qualify as a hospital, not just a convalescent facility, so has now affiliated for surgical procedure and laboratory work with Physicians and Surgeons Hospital.

Long Beach, Calif. Independent Press-Telegram 7/3/66

Study Pins Some Doctors' Fee Boosts on Medicare

By DAVID R. JONES
New York Times News Service

WASHINGTON — There is evidence that some doctors in the United States are raising their fees because of the arrival of Medicare. But the men who advise doctors on business matters assert that this is only true in a minority of cases and government officials say it is too early to know how widespread the movement is.

A survey of medical fees among doctors and their financial advisers this week in several key cities confirmed recent government statistics indicating that doctor fees have been rising in the first five months of 1966, roughly twice as fast as in previous months.

The reasons for the sharper increases are difficult to pinpoint. Most medical business advisers blame them on mounting costs. But there is a suspicion among some government experts that the arrival of Medicare is spurring the rise, and some medical business consultants agree.

* * * *

THE IMPACT of the Medicare program, which began Friday, upon medical costs is a sensitive question fraught with political implications. Doctors generally believe the program will raise costs and push up fees. But liberal forces are on the lookout for fee gouging under the law, which would lead them to call for federal fee controls that doctors fear.

The Medicare program is designed to help those aged 65 and above to defray the costs of medical care. The law provides for federal payments for 80% of most annual doctors' bills, except for the first $50 in costs, and also pays some hospital bills.

The law, passed last year over strong opposition from the medical profession, specifies that the government will reimburse doctors' "reasonable charges" for Medicare patients. What is "reasonable" is determined by insurance companies, who must base their finding on the "customary charges" made by the doctors for such services and the "prevailing charges" in the locality.

Medical financial experts surveyed this week said the arrival of Medicare had prompted a widespread reexamination of fee structures. Most of these experts said they had advised their doctor clients to make such studies to be sure their "customary charges" cited under Medicare were in line with costs and the fees levied elsewhere in the community.

* * * *

THE MAJORITY of financial advisers agreed with Lewis A. Miller, executive editor of Medical Economics Magazine, who said that recent talks with perhaps 500 medical people had convinced him there was no widespread Medicare-inspired fee boosting.

Some advisers, however, indicated the increases were more widespread. William D. Huntington, northern division manager of Professional Management Midwest in Minneapolis, said Medicare "has been a very definite factor" influencing higher fees "pretty much across the board" in his region.

A New York consultant said "very few" of his clients had raised fees due to medicare but that he though many doctors had done so.

"We have found more consistent interest and concern about fee schedules in the past six months than I've seen in 15 years," Huntington said.

Morris C. Vlanders, president of Black & Skaggs Associates in Battle Creek, Mich., said a "vast minority" of the company's 7,000 doctor clients had adjusted fees because of Medicare.

John C. Post, president of Professional Business Management in Washington, said that with the start of Medicare, "doctors have paid much more attention to fees in the past few months than in the past several years. I don't mean they are unnecessarily raising them, but they are taking a hard look at items."

* * * *

"WHERE THEY might be charging $5 for office calls for the past few years, they are raising it to $7," Post said. These fee revisions are resulting, he explained, because "they're putting themselves on record now as to the fees they reasonably expect" and "if they are careless or indifferent enough to put out a 1955 cost in 1966, they're going to be out of luck."

A large number of those doctors who have been increasing fees appeared to be motivated by eliminating what they considered to be "substandard" charges.

"The doctors who know of low fee men in the area are trying to get these men up to an average fee," commented Edward F. Phelps, vice president of PM Florida East Coast in Miami. There are some general practitioners "who are volume low-price guys," he explained, and the higher charging doctors want them to raise rates "because Uncle Sam will ask how come Joe Blow does it for $3 and you charge $5."

Some government authorities, including experts within the Social Security Administration, suspect the new program is prompting more fee increases than the doctors will admit. But they are remaining silent because they concede there is no solid evidence.

—Juneau Alaska Empire, Friday, July 1, 1966

Guest Editorial

By WENDELL P. KAY
Candidate for Governor

The people of Juneau are in an excellent position to judge the quality of our state government.

You, more than anyone else, are aware that "medicore" is the word which best describes the higher level of this administration.

You know that "greed" — greed of power and position—is the most fitting word to characterize the drive for a Third Term.

You know how rough the push is getting.

There are many issues: the present condition of our economy; growth and development of industry; morality in government; the real protection and expansion of our fishery; the development of a real tourist trade; the ethics of a Third Term, and many others.

Where do I stand? Frankly, our economy is hurting — urgent steps are needed. Our state effort to attract industry requires immediate expansion. I believe in the highest moral standards in government — on the top level as well as the bottom. We should drive to protect the entire continental shelf around Alaska from foreign fleets. There is no ethical basis for a Third Term under the Alaska Constitution.

Where do I stand? Frankly, our economy is hurting — urgent steps are needed. Our state effort to attract industry requires immediate expansion. I believe in the highest moral botton. We should drive to protect the entire continental shelf around Alaska from foreign fleets. There is no ethical basis for a Third Term under the Alaska Constitution.

Where does my opponent stand?

I have invited my opponent to debate the issues, so that you could all make a fair comparison. He has refused to meet me in debate. He prefers to debate Viet Nam with Senator Gruening.

I invite you to join me in voting for a fresh, clean start. Surely the talent is available to give Alaska an administration of excellence — one in which we can all take pride.

Honolulu Advertiser - July 1, 1966

It's Easy If You Know How

It's a very simple matter to use the hospital and doctor benefits provided by Medicare, which goes into effect today.

All a person has to do is show his Medicare card to his hospital or doctor.

Virtually all persons over 65 years of age are eligible for Medicare, and about 90 per cent of them in the State have signed up and received their cards.

Those who have lost their cards or who are not registered yet should contact the Social Security Administration's local office at 1181 Alakea St., or phone 588-971.

Medicare is under Social Security, and is being paid for from payroll deductions.

* * *

THERE ARE about 34,000 persons over 65 in Hawaii who have signed up. They automatically receive the hospital benefits under Medicare, and most of them signed up for the supplementary doctor services.

The supplementary services cost the patient $3 a month. The hospital benefits are provided without additional payment.

Here's what the hospital benefits provide, effective today, for all those with Medicare cards:

Hospital Care

Medicare will pay all but the first $40 for 60 days of hospitalization, and all but $10 a day for the next 30 days.

Home Health Services

Medicare pays 80 per cent of the cost for up to 100 visits a year by nurses and other health care workers, after hospitalization for three or more days.

Diagnostic Services

Medicare pays 80 per cent of the costs—with the patient paying the first $20—for hospital outpatient diagnostic services.

After Jan. 1, Medicare will pay for 20 days of extended care (such as in a nursing home) and all but $5 a day for up to 80 more days. This applies only after hospitalization, however.

The doctor services program works this way:

Medicare will pay 80 per cent of the "reasonable charges" of services in the home, his office or a hospital. The patient pays the first $50 of his total doctor bills each year.

The "reasonable charges" provision for doctor services is a controversial one, and patients should consult beforehand with their physicians on his fee schedule.

The doctor has the option of billing the patient directly, or sending his bill to an "intermediary" agency, in Hawaii's case that's the Hawaii Medical Service Assn. (HMSA).

The physician can charge a patient directly any amount he wishes for services, as he does normally.

But the patient will be reimbursed for only 80 per cent of what the Medicare program determines is the "reasonable charge" for such service.

If the doctor goes through HMSA, he is required to use the "reasonable charge" figure and the patient pays 20 per cent of it; Medicare the rest.





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